

To Establish a National Health Program

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON EDUCATION AND LABOR UNITED STATES SENATE

SEVENTY-SIXTH CONGRESS

FIRST SESSION

ON

S. 1620

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

PART 3

JUNE 2 AND 29, AND JULY 13, 1939

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TO ESTABLISH A NATIONAL HEALTH PROGRAM

FRIDAY, JUNE 8, 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, Taft, and La Follette.

The CHAIRMAN. The subcommittee will come to order.

Dr. Parran will be the first witness.

STATEMENT OF DR. THOMAS PARRAN, SURGEON GENERAL OF THE UNITED STATES PUBLIC HEALTH SERVICE

Dr. PARRAN. My name is Thomas Parran, Surgeon General of the United States Public Health Service.

Mr. Chairman and members of the committee, until the passage of the Social Security Act our Government had never developed a national health policy or program. Under the act the first feeble steps were taken to develop such a program. The bill under consideration is a logical outgrowth. It represents the most comprehensive approach ever made to the diverse and serious problems of health and medical care for the Nation.

The first objective of S. 1620 is to reduce drastically the volume of sickness and ill health by making available to all areas and all groups of the population in need of service the proven methods of prevention—prevention of deaths of mothers and babies; a Nation-wide attack on tuberculosis and the venereal diseases; promotion of industrial hygiene, with greatly intensified efforts toward control of the occupational diseases; the use of proven methods to lessen the burden of mental illness; the practical eradication of malaria which lays such a heavy burden upon large areas of the South. Pellagra and hookworm disease should go. Pneumonia should be curbed with serum and simple chemicals.

The modern physician makes increasing use of facilities for the diagnosis and treatment of disease which are most effectively supplied by hospitals. As a second objective, the bill therefore provides aid for the construction and maintenance of hospitals, but only where needed and for the support of existing hospitals, public and private alike, especially in the distressed and rural areas. The bill would aid also the construction of diagnostic and health centers in

sparsely settled areas remote from hospitals, to provide for rural doctors the resources of modern medicine, the workshops they need. In addition, they would serve as centers for rural public health work.

The third objective of the bill is to reduce disability and increase longevity by more prompt and adequate medical care of the sick. Adequate medical treatment of communicable diseases is essential both as a safeguard to the patient and as a means of preventing spread. But a large volume of disability results from the diseases which are not specifically preventable; in illness due to those causes, competent medical treatment constitutes our sole resource to ameliorate suffering, reduce disability, and promote recovery.

Fourth, through its provisions for temporary disability insurance, the bill extends indirect health protection to the worker and his family by compensation for wages lost through nonindustrial sickness and accident causing temporary incapacity. Under present laws, if a factory shuts down, the worker is entitled to unemployment insurance. If however the worker is merely unemployed because of an automobile accident or other similar cause, there is no cash in lieu of wages.

Workmen's compensation laws provide protection of this nature for most workers suffering accidental injury in the course of employment. But only a negligible proportion of our workers are protected against the wage loss resulting from the large volume of disability due to causes not specifically associated with occupation.

Finally, and most important, the bill proposes greater Federal effort for the purposes of research, that we may learn how to prevent and cure diseases which cannot be controlled under existing knowledge.

The bill very wisely proposes the grant-in-aid system. This is such a well-established part of our governmental structure that it seems unnecessary for me to defend the principle.

There are only two other alternatives to a grant-in-aid system: One, for the Federal Government to do nothing about this problem; and second, for the Federal Government to operate health and medical services.

I should like to point out, however, that there are more determining reasons for Federal assistance to the States in public health than in any other field of social endeavor. Disease germs, like forest fires, know no State lines. The means of disease spread is intensified by modern methods of transportation. A person may be exposed to smallpox in Muncie, Ind., today, spread it to those at the world's fair tomorrow. The mayor of New York City has pointed out in testimony before another committee of the Congress that thousands of sick people, too ill to labor in the cotton or wheat fields because of the ravages of tuberculosis, come to New York in the hope of getting jobs which half-sick persons can do, or hospital care.

It is true that the general death rate and the death rates from many preventable causes were lower last year than ever before. The same statement could have been made about the death rate in 1900. Such a statement means only that we have a continued improvement in the health status of the people as measured by the yardsticks of the past. These yardsticks, however, are not adequate. Each year medical science gives us additional knowledge with which to

combat more effectively one after another disease. Moreover, the general rates are necessarily averages for the country as a whole. In these averages are obscured rates which are disgracefully high.

A witness before this committee has spoken of the low death rate from tuberculosis in New York City, approximately 50 per 100,000 last year. Yet in one borough of New York in a health center district of several hundred thousand people there was last year a tuberculosis death rate of more than 250, 5 times the city average. Among unskilled and semiskilled male workers in 10 States in 1930, deaths from tuberculosis were exceeded only by those from diseases of the heart; among professional men in these States, tuberculosis ranked sixth in importance as a cause of death. In a group of 14 Southern States in 1931-33, respiratory tuberculosis ranked third in importance as a cause of death among Negroes, but occupied eighth place among the white population.

A striking reduction has occurred in the mortality of infancy and childhood. In the birth registration area of 1915, 100 infants of every 1,000 born alive died in the first year of life; the provisional infant mortality rate for 1938 was 51. But infant mortality rates of the order of 100 or more are common in many areas today. A medical analyst in a large western city reports that the infant mortality rate in families with an annual income below \$500 was 168 per 1,000 in the period 1930-32, while the rate in families above the \$3,000 income level was only 30. Furthermore, the decline in the rate has taken place largely in the later months of infancy. Deaths from congenital malformations and diseases of early infancy, occurring chiefly in the first month of life, are still found among the 10 most frequent causes of death in the population of all ages. Adequate prenatal supervision of the mother and competent medical and nursing care at delivery are essential to reduce this continuing high mortality of newborn infants.

The average infant born in 1938 had an estimated life expectancy of 62 years—a gain of almost 18 years since 1900. In the older age periods, however, the expectation of life has undergone no significant change in the present century. In 1900, a man attaining the age of 50 had an average of 21 years of life remaining; the present decade has brought no material alteration in this figure.

But death rates alone are not a measure of national fitness. They do not reveal the estimated 250,000 people who are suffering from silicosis, nor the ninety to hundred thousand cases of pellagra which occurred last year in the South, nor the epidemic of scurvy in Maine. It is true that deaths from pellagra have declined due to the use of nicotinic acid or dried yeast, but studies show that malnutrition is widespread and serious.

Death rates gives no indication of the economic burden which disability creates among the low-income groups in our population. In the period before the depression, a representative survey indicated that low-income wage earners suffered more than twice as much disability in a year as those in the upper income group. The national health survey revealed that persons in relief families lost 16 days per capita from sickness and accidental injury; above the \$2,000 income level, the figure was only 7 days per capita. Sixty-one percent of all permanently disabled persons observed in this survey occurred

in relief and marginal-income families—with annual income below \$1,000—these groups contained only 38 percent of the canvassed population.

We have had considerable testimony concerning the present national resources for health protection.

Less than a third of the counties and even a smaller proportion of the cities employ full-time professional health officers. In urban areas of the country, the present ratio of public health nurses to population is approximately 1 to 4,500. In the rural areas, the average ratio is 1 to 10,000, but in rural areas of the South Central States, the ratio is 1 to 22,000 population. Yet it was estimated 20 years ago that 1 public health nurse to 2,000 persons was necessary to provide even the minimum level of accomplishment in the field.

We have in this country some 100,000 physicians in active practice—an average of 1 physician to 807 persons. But in certain of the predominantly rural States—the Dakotas, Mississippi, North and South Carolina—each physician serves an average of 1,300 persons or more. In Kentucky, one physician serves an average of 1,100 persons in the State as a whole, but in nine counties of the State the average population per physician is 3,000 or more. The situation in Kentucky is not an isolated example; internal variation of a similar nature may be observed in the predominantly urban States. New York State is, on the average, well supplied with physicians; yet a few years ago in its largest cities there was an average of one physician to 535 persons, while in its small towns and villages, the ratio was one physician to almost 1,000 persons. These figures illustrate a general trend—the tendency of physicians to concentrate in the large urban centers, which, through their hospitals and clinics, offer opportunity for the application of modern medical technic.

Your committee has heard very divergent points of view concerning the hospital situation in the country. It has been stated, for example, that an average of 195,074 beds in existing institutions are empty. I would point out, first, that no hospital can operate at 100-percent capacity. Eighty to eighty-five percent bed occupancy is considered full capacity for general hospitals because of the necessary division of wards and sections by sex, disease, and so forth. For example, a temporary surplus of beds in the obstetrical ward cannot be used for the care of measles or scarlet fever. Medical and surgical conditions cannot be mixed. In some areas, the color division further complicates the problem.

The most determining point, however, is the lack of ability of patients to pay for hospital care. The data show that the public hospitals, which by and large are free, are more than filled to capacity, while private rooms in voluntary and proprietary hospitals remain empty. There is an anomalous situation in the fact that in many areas which have the lowest number of hospital beds per capita there is the highest percentage of unused beds. Lack of money, not lack of patients, keeps them empty.

Even a small subsidy to free care of patients in hospitals is of great assistance in securing medical care for the poor. Some of you may know that in North and South Carolina the Duke endowment started some years ago to provide a subsidy of \$1 per day for each

free patient in approved hospitals of those States. When this work was started only nine patients in every hundred being treated in the hospitals of the Carolinas were free patients. As a result of this subsidy of \$1, today the percentage of free cure has risen to 45, a fivefold increase in the number of needy patients who have been given needed hospital treatment. The fivefold increase in free patients is made up largely of those who previously went without care simply because the hospital could not afford to admit them.

Senator MURRAY. How is that subsidy provided that you described there?

Dr. PARRAN. It is provided by the Duke endowment, whereby any hospital which meets standards which they have prescribed, reasonable standards as to records and physical conditions in the hospitals—

Senator MURRAY (interposing). I did not catch the word "Duke" at first. I thought it was some other organization.

Dr. PARRAN. It is the Duke endowment.

The bill under consideration proposes to use public moneys, Federal, State, and local, to pay for the care of needy patients in existing public and private hospitals.

Senator MURRAY. Was there not an understanding that it would not apply to the private hospitals?

Dr. PARRAN. Quite the contrary, Mr. Chairman. The use of public moneys is contemplated under this act, and particularly under titles V, VI, and XIII, to pay for the care of needy patients in existing public and private hospitals. Under title XII it was not contemplated that public moneys would be used to assist in the construction of privately owned hospital facilities. It is perhaps on that point that the misunderstanding has arisen.

Under this bill, every available bed would be utilized before additional hospitals would be built. Even when this is done, however, there still remains a need in many areas for additional beds. There are 1,338 counties containing about 17,000,000 people, in which there is no registered general hospital. Obviously, each of these counties does not need a hospital. We have estimated, however, that we do need about 500 rural hospitals. Many of these would replace present tumble-down shacks. As a matter of fact, the experience of the Commonwealth fund in aiding the construction of rural hospitals has shown that, of some 13 or 14 hospitals which they have aided, in every instance but one, one or more existing so-called hospitals has been closed up—firetraps frequently, very inadequate facilities, and totally inadequate to meeting the needs of the community.

Senator MURRAY. Doctor, would not a great many of these so-called fire traps, that you have mentioned, be rebuilt or repaired, would the communities not be glad to rebuild their hospitals or build new hospitals if they have the financial aid to do it?

Dr. PARRAN. Most of them would; yes, sir; without a doubt, and that has been the experience of the Commonwealth fund in giving aid to communities which have asked for assistance.

Senator ELLENDER. Doctor, with respect to the assistance to be given to needy patients, there has been quite a lot of testimony to the effect that this bill does not make any difference between the

indigent and those who could afford to pay. Can you point out in the bill any language that indicates that no distinction is to be made between the needy and the indigent?

Dr. PARRAN. Senator Wagner has emphasized that very point, Senator Ellender, on a number of occasions. The bill does use the words "particularly in rural areas and among needy persons." The bill contemplates primarily the giving of aid for the medically needy, but then the question arises, how is it possible in any Federal legislation to define the medically needy? Very wisely that definition is left to the State. Moreover, under title III as now written, it would be possible for a State if it wished to pass appropriate State laws and tax itself, or to provide free insurance contributions, to give medical care to persons who are above what we call the marginal level. The bill does not prohibit it; it does not, however, coerce the States to do it.

A mere statement of the number of hospitals does not indicate the adequacy of hospital facilities. This is well illustrated by the general hospital situation in the States of the South in comparison with those of the Northeast. Each section contains about 30 percent of the total population of the country and each is served by approximately the same number of local general hospitals—1,217 in the Northeast, 1,177 in the South. But the bed accommodations in these hospitals of the Northeastern States total some 157,000—in the South, only 67,000.

May I point out the situation regarding tuberculosis hospitals. The average stay of a tuberculosis patient in the hospital approximates a little over 6 months. The best authorities agree that two beds per annual death from tuberculosis is the minimum necessary to meet the need for institutional care of the tuberculous. Yet 26 States have less than one bed per annual death from this disease. In Senator Wagner's State there are 3.25 tuberculosis beds in the up-State area, of which 2.5 are publicly owned and operated. In making estimates as to needed tuberculosis-hospital construction, the committee has not attempted to bring all States up to this level. It has proposed only to bring them up to the minimum standard of two beds per annual death.

There is wide variation among the States in facilities for institutional care of the mentally diseased. The State with the highest ratio of beds in proportion to population has 0.88 beds in mental institutions per 1,000 persons; the lowest ranking State has 1.06 beds per 1,000 population. A very simple formula was used in estimating the additional beds needed in mental institutions. In one-fourth of the States the existing accommodations in these institutions average 4.8 beds per 1,000 population or more. The committee estimated that 130,000 new beds would be required to bring the remaining States up to the standard of 4.8 which one-fourth of the States now meet or exceed.

In the case of local general hospitals the number of available beds varies among the States from 1.3 to 5.5 per 1,000 population. Professional judgment indicates that an average of 4.5 beds per 1,000 must be maintained to provide adequate facilities of this type. It is proposed that the States falling below this average should be aided in building additional hospitals when needed by provision of State

and local funds to match the Federal assistance. Only three States at present exceed this standard; and it is estimated that 180,000 additional beds in general hospitals will be required to bring all States up to the accepted standard of adequacy. I think it would be well to point out also that these estimates were based on a 10-year program of construction, during which the population inevitably will grow somewhat, and moreover it obviously rests with the Congress from year to year to make such appropriations as are shown to be needed by the actual shortage of facilities in the various States. It may be that there is an excess of hospital beds in some States or some parts of States. The difficulty is, however, that we may not move the beds and it is impracticable to move the patients over long distances.

Two generations ago the only function of a hospital was to serve as a place where the sick poor could go to die. With the development of modern medicine they have become a vital force in health conservation. Decade by decade, utilization of hospitals has increased. This trend is apt to continue, and will be intensified by the increasing average age of the population, since older people on the average suffer more sickness.

Senator TAFT. Doctor, may I interrupt you, because I have to go to the Appropriations Committee. On the question, the general question as to whether the bill permits the use of money to pay for beds in private hospitals, you would be in favor of having the bill permit that?

Dr. PARRAN. The bill very specifically does permit the payment on a per diem or some other basis for care of patients equally in private voluntary and religious hospitals as it does in public hospitals.

Senator TAFT. We can settle about the provision of the bill later, but you are in favor of that principle?

Dr. PARRAN. Yes; I am. But the bill does not provide for public moneys to aid in the construction of privately owned facilities.

We have had much discussion of the number of people in the country that need medical care. The statement of the committee has been misinterpreted. There are about 40,000,000 persons in this country in families with a total annual family income of less than \$800—income derived from earnings and relief. I quote this estimate from the report of the Interdepartmental Committee. It was based on the national distribution of consumer incomes and records of recipients of relief.

The committee has defined this group of 40,000,000 persons as the "medically needy." Even on casual consideration, it is evident that the standard of living permitted an average family of four persons on an annual income of \$800 or less allows small margin, or none, to pay for good medical care. A family at this income level may be self-sustaining in respect to the basic necessities; it is, however, needy in relation to its requirements for good medical care. The family on relief is also medically needy; but its indigence extends also to food, shelter, and clothing. The 40,000,000 persons to which the committee refers are in families such as these, receiving relief, or supported by marginal incomes.

It is evident that this entire group of 40,000,000 persons will not require medical care during a year. Almost one-half of the group will experience no sickness. But the Committee has estimated that

about 8,000,000 cases of illness disabling for a week or more will occur in these low-income families, "and under the conditions prevailing in 1935, about 2,000,000 of these cases will receive no medical care."

The Committee's estimate of the proportion of unattended illnesses in this group of the medically needy was based on the results of the national health survey. This survey, made by the Public Health Service in the winter of 1935-36, employed the method of the house-to-house canvass with which the Service staff has had long experience. Its findings were analyzed under the direction of able statisticians with an acknowledged position of leadership in the field of morbidity statistics. The results of this survey are in general agreement with those observed in the peak years of prosperity by the committee on the costs of medical care under the chairmanship of former Secretary Wilbur. They are, furthermore, harmonious with the findings of the California Medical Association, which estimated a few years ago that 218,000 persons in the State of California alone were currently in need of medical care but not receiving it.

Medical care of this group differs as between large and small cities and rural areas. Where relief has not broken down public funds in the large cities meet some of the costs of medical care of the dependent for illness requiring treatment in hospitals. The ambulatory cases among the sick poor in metropolitan centers receive treatment in out-patient departments, which are, however, greatly overcrowded. But these organized facilities for care of the sick are less widely developed in small cities and rural areas and governmental funds for their support are meager.

Private physicians provide much free care of the patients who come to them for treatment, but many patients receive no care because they are unwilling to ask for service when they cannot pay for it. This endeavor to balance a marginal budget by neglect of health is in part the cause of the high death and disability rates in this group. We have accepted responsibility in principle for public assistance to those otherwise unable to obtain food, shelter, and clothing. We must accept also a community responsibility for medical care of those who cannot provide it out of their own resources.

This bill does not establish any system of compulsory health insurance; nor does it require or coerce the States to do so. Very wisely, I think, it leaves a decision as to whether or not health insurance is to be adopted in any State to the State itself. It seems clear that one or another State may wish to adopt such a system, and it would seem quite illogical for the Federal Government to pass laws which would prevent a State from dealing with its medical problems in the way in which it wishes to do so.

Actual experience in some State will provide a sounder answer as to its usefulness than mere argument. In my opinion, group payment of the costs of medical care, through taxation or insurance, or both, for those groups of the population unable readily to pay the costs of such care for themselves would be an important factor in any complete national health program.

SENATOR ELLENDER. You would say that under the bill, should a State desire to raise its pro rata amount of money in such a way, so as to match with Federal funds, that that could be done?

Dr. PARRAN. Yes, sir.

Senator ELLENDER. And you would not want that written into the bill that it cannot be done?

Dr. PARRAN. I think it would be a very unwise policy for the Federal Government to interfere to that extent with the medical policies of the States which up to now have been reserved to the States, and which under his bill would still be reserved to the States.

It might be of interest, Mr. Chairman, to recount a few of the things which have been done under the existing Social Security Act, especially title VI. A greater advance in the public health in this country has been made in the past 3 years than ever before in a comparable period. Under title VI, for the administration of which the Public Health Service is responsible, marked progress has been made, particularly in the development and supervision of new local health departments, and the expansion of the fundamental services in health departments which previously functioned in a limited manner.

Federal funds budgeted by the States for the fiscal year 1939 under title VI of the Social Security Act and the Venereal Disease Control Act amount to approximately \$12,000,000. The States have budgeted 81 percent of these funds for the organization of new local health departments, or the provision of certain services required to bring existing departments up to minimum standards. At the close of the year 1938 an estimated total of 1,371 counties were receiving the benefits of full-time public health services through county or district health departments, a gain of 425 counties in 2 years. Full-time public health nurses employed by State and local agencies were increased by 1,720 between 1937 and 1938 alone, and 506 of these now nurses are serving rural areas and small cities under 10,000 population.

Because of limited funds and the need for a basic health organization, a relatively small amount—only 8 percent of the combined Federal funds under title VI of the Social Security Act and the Venereal Disease Control Act—has been budgeted by the States in 1939 for the development of such special programs as pneumonia control, cancer control, activities in industrial hygiene, and the services necessary to meet regional health problems.

In order to obtain qualified personnel, the States have found it necessary to use some Federal funds to give postgraduate training. For the fiscal year 1939, 11 percent of the total Federal funds available under title VI of the Social Security Act and the Venereal Disease Control Act have been budgeted for this purpose. In the period February 1936 through June 1938 a total of 8,820 persons have undertaken postgraduate study in public-health methods for periods varying from a few months to a year. Physicians trained for service as health officers, or administrators of special activities such as the control of tuberculosis or the venereal diseases, represented 22 percent of this group. Public-health nurses receiving special training numbered 1,917—50 percent of all trainees. Sanitary inspectors and engineers accounted for another 22 percent of the staff in training, and the remaining 6 percent included dentists, statisticians, and other special personnel.

All over the country the basic health organizations and trained personnel are being made available. A good start has been made but

added funds are needed. With them great strides can be made in bringing this Nation to a level of healthfulness beyond anything we have ever known.

To reduce disability and premature death in our working population, to discover and correct physical impairments, forms an integral part of the entire health program. As an expression of this function, most of the States have organized industrial hygiene units; in 28 States, these units are under the direction of the State health department. In many instances, these units are functioning with skeleton organizations. They need great expansion of their services. To accomplish this end is one of the important objectives of title VI of the bill. In those States in which industrial hygiene is administered by a department of labor or industrial commission, funds will be allotted for their use. It seems very unwise to complicate further the administrative provisions of the bill by creating a separate title and separate administration for industrial hygiene, as has been suggested by witnesses before this committee.

If industrial hygiene needs a separate administration, why not school hygiene? Why not dental hygiene? Why not mental hygiene?

I think one should realize that this whole effort to prevent and cure disease should be a united effort. It is difficult to separate the interrelated parts. Public health is an individual and a family problem in the last analysis, and not a problem of school hygiene or industrial hygiene or mental hygiene or dental hygiene. I anticipate if recommendations continue to be made before this committee for separate divisions, the bill may be broken up into various absolutely unworkable sections. Every specialty in medicine might wish to have a separate title, and separate administration, with utter chaos.

Senator ELLENDER. We had two witnesses who testified, one from New York and one from Illinois, as I recall, and one from Michigan, also. The two from New York stated that industrial hygiene was handled under the labor department, and in Michigan under the health department. Is there any good reason for that; is there any good reason why the State of New York should manage industrial hygiene under its labor department?

Dr. PARRAN. It is a matter of historical development Senator, and it would appear to me unwise for the Federal Government to attempt to dictate the practice in any particular State. It happened that New York was one of the first States to have a well-developed department of labor, and the work started there. In the meantime, for instance, in Connecticut the labor department did not take up this subject and the health department did.

Senator ELLENDER. In distributing funds for that purpose in those two States in contrast to Michigan where it is under the health department, would you have the Federal or the State Government to allocate the funds to these separate departments?

Dr. PARRAN. I suggest that title VI of the bill stand as written with respect to the industrial hygiene services, because under the provisions as now written, the New York State Department of Industrial Hygiene in the department of labor would be enabled to secure funds allotted by the Federal Public Health Service.

Senator ELLENDER. Direct?

Dr. PARRAN. Direct; subject only to the requirement that funds allotted to some agency other than a State health agency need to be approved by the State agency.

Senator ELLENDER. In other words, it could not be made direct even in those States; it would be under the supervision, as it were, of the health department of that State?

Dr. PARRAN. Supervision only to the extent of the approval of the plan, which I think on analysis you will agree is necessary, to have some balance. In New York State the school hygiene work is handled by the department of education; mental hygiene is handled by a separate department of the State government. If there were no control as to the balance between industrial hygiene, mental hygiene, school hygiene, and general public-health work, I think it is quite obvious that each of these unrelated problems would put in its budgets and plans and each one would want all of the money that is available and leave nothing for the other fellow.

Senator ELLENDER. As a matter of fact, and I would say in any event, the budget would have to come from the State health department, would it not?

Dr. PARRAN. It would be approved by the State health division.

Senator ELLENDER. And it would have to be passed upon finally by it, would it not, because, as I understand it, under this bill the allocation of funds would have to be done by and with the consent of the health officer of a State?

Dr. PARRAN. Yes; well, what is the alternative? Earmark so much money for industrial hygiene, create a special title, and earmark so much for school hygiene, for milk sanitation, and so forth?

Senator ELLENDER. I am just wondering why it is that it could not be more uniform. Why that duplication? You are bound to have duplication, let us say in the States of New York and Illinois—there may be some others for all I know—wherein money for industrial hygiene purposes is spent by one division under the labor department and for hygiene work under the health department for some other class of people, but all along the same methods.

Dr. PARRAN. You are quite right; and yet we have seen a great diversity in State laws and practice not only in this field but in tuberculosis. In some States, State tuberculosis hospitals are operated by a separate hospital board, or a separate tuberculosis commission or a department of welfare or a department of health.

Senator MURRAY. How many States have departments of industrial hygiene?

Dr. PARRAN. Some 30 or 31.

Senator ELLENDER. Separate?

Dr. PARRAN. They have divisions of industrial hygiene. In 28 of them, these divisions are operating under the department of health.

Senator MURRAY. And in some of the States where they need it most, they have not got that department at all, isn't that true?

Dr. PARRAN. If so, it is only a skeleton organization. These 28 States have recently set up divisions of industrial hygiene and they have made a good start; they have gotten at least one or two trained persons in those divisions of industrial hygiene. They could be expanded, and their services could be expanded, and, of course, there

would need to be new arrangements with the State department of labor which have control of factory inspection and related activities.

Senator ELLENDER. How many are there that have it under the jurisdiction of the Labor Department? I named two, New York and Illinois; do you know of any others?

Dr. PARRAN. My best information is that there are three; one additional State besides those two.

The provisions of this bill would give responsibility to the Children's Bureau for medical care of children, to the Public Health Service for medical care of certain high-cost illnesses (tuberculosis, cancer, pneumonia, venereal disease), and to the Social Security Board for medical care of persons other than children and for diseases other than those for which the Public Health Service is given responsibility. Rather than complicate further the administrative dispersion of responsibility among several unrelated agencies, I urge that the first objective of the bill be to coordinate Federal health service.

We can never attain national health and fitness simply by money grants out of several Federal pockets with no correlation between them, no joint planning, no uniform standards, and with diverse budgetary requirements, systems of reports, triplicating field staffs to deal with the States, and audit accounts.

Senator ELLENDER. In that connection, there was a witness, as I recall, who testified that quite a lot of this work was being done here in Washington under the Federal Government in the various departments of the Government. Would you have any views on that? In other words, you talk about coordination; I wonder if we could not begin that at home here?

Dr. PARRAN. I urge that as the first objective of the bill. As the head of one of the Government bureaus, I feel somewhat reluctant to make a specific recommendation particularly in view of the reorganization act under which the President continues to have authority further to coordinate the health services of the Government, and I may say that in my opinion, reorganization plan No. 1 was a fine step in the right direction in bringing public health, education and social security, among others, together.

Senator ELLENDER. Have you studied this reorganization plan to find out whether or not the President could, without legislation from the Congress, coordinate these departments that you have in mind?

Dr. PARRAN. That authority does exist in the bill. My plea is that this bill should not further create confusion and further disperse the present unrelated and scattered Federal-health activities, and for these reasons; public-health measures for the prevention of disease merge naturally with medical service for the diagnosis and treatment of disease. The Public Health Service has had a background of dealing with the States for almost 50 years. We have had no difficulty with the States in administering title VI; there has been no suggestion of Federal domination and Federal control. There has been, I think, one of the finest examples of Federal and State co-operation in administering title VI, and I may say also title V of the Social Security Act.

Accordingly, I urge specifically with respect to Senate 1620 that the administrative agency under title XIII be changed from the Social Security Board to the Public Health Service. To promote coordination and joint planning between the several Federal

agencies—if it is impossible to bring them entirely together—agencies which are administering services under this bill, I recommend that the bill be amended as follows:

(1) To provide reciprocal provisions requiring that the Public Health Service and the Children's Bureau establish systems of uniform budgeting, accounting, and reporting by State agencies; (2) to provide that rules and regulations regarding payments to States under sections 504, 514, 604, 1204, and 1304 shall be harmonious and made after joint consultation by the Public Health Service and the Children's Bureau, with a joint conference of the State and Territorial health authorities or with the executive officers of other State agencies charged with the administration of services under this act; (3) to provide for a single Federal Advisory Health Council composed of members of the professions and agencies concerned with the promotion of health and medical services and other persons informed on the need for or provision of health, and medical services, in place of the several Federal advisory councils provided for in sections 506, 516, 606, 1206, and 1306—a great multiplicity of councils exists.

Senator ELLENDER. How would you select them, Doctor?

Dr. PARRAN. If the Children's Bureau and the Public Health Service are the only two agencies dealing with the health and medical aspects of the bill, it would be very simple to have a council of seven, three, let us say, appointed by each of the agencies and the seventh the chairman of the State and Territorial health organization *ex officio*.

Senator ELLENDER. What would be the jurisdiction of that council?

Dr. PARRAN. As provided under these several sections. They are advisory councils supposed to advise with respect to the rules and regulations and with the general policies.

Senator ELLENDER. Would you have a separate council for each subdivision?

Dr. PARRAN. I would have only one for the titles, V, VI, XII, and XIII.

Senator ELLENDER. And another for what?

Dr. PARRAN. That is all.

Senator ELLENDER. That would be one council; in other words, the council that you suggest would have jurisdiction over the entire works, as it were?

Dr. PARRAN. It would replace an unknown number, certainly five councils which are now required under this bill.

Senator ELLENDER. How would that be managed in the States, let us say? Would you recommend the same thing, that instead of having different councils in the States, that there be one council in each State?

Dr. PARRAN. I hope that the bill would not require additional councils. One or another State would wish to have more, but I hope that the emphasis in the bill would be toward similar joint planning through one council. I am not prepared at the moment to say that there must be only one. Again I think we should leave the States the greatest of freedom.

Senator ELLENDER. Your recommendation would be, then, that one council would be sufficient.

Dr. PARRAN. This is a health problem, and that is a unit problem by and large.

Senator MURRAY. And a multiplicity of councils would be sure to promote conflicts and different ideas, would it not?

Dr. PARRAN. I do not see how it could be avoided.

Senator ELLENDER. You would have quite a lot of jealousies among the councils as to whom the money should be allocated, how it should be allocated, and all of that? I think your objection is very good. One of the witnesses testified, as I recall, that 268 councils would be created through the country. I believe if we can limit them to one from each State, that is, that we suggest as it were to the States, that one council be provided, and have it obligatory so far as the Federal Government is concerned, that it would be a decided improvement.

Senator MURRAY. Sometimes it is difficult enough to get cooperation with even one council, like the T. V. A., where we found great difficulty.

Senator ELLENDER. Doctor, what would be your suggestion as to how the council should be selected in the States?

Dr. PARRAN. The State agencies responsible for the administration of the several parts of the program should meet on the make-up of the council, or if there is this agreement among them, it should be possible for the Governor to straighten out any interdepartmental bickering as to relative jurisdiction.

Senator ELLENDER. What if we suggested—it is only a suggestion and we do not want to make the States do it—the medical association of each State select the members of each board created under the State law. What would be your view as to that method?

Dr. PARRAN. As I have observed its workings in Kentucky and Alabama, and I think South Carolina—there are three States in which that is the pattern. No other States saw fit to establish the same pattern when their boards were started many years ago.

Senator ELLENDER. How has the plan worked in the three States that you have just mentioned?

Dr. PARRAN. It seems to have worked well.

Senator ELLENDER. Do you know what caused a change in those three States?

Dr. PARRAN. There was no change; it was a matter of the original set-up back in the days when there were yellow fever epidemics, and these boards of health were organized to meet them. The medical associations were asked specifically to organize the boards in these States, and given certain authority under the law. No other State has seen fit, however, to invest responsibility for the health of all of the people in one professional group.

Senator ELLENDER. You say insofar as the council is concerned here in Washington, you would suggest that each division make its own selection or each department?

Dr. PARRAN. Joint action.

Senator ELLENDER. What if you put them all under one as we have just been talking about?

Dr. PARRAN. As the head of one Federal bureau having very harmonious relations with the Children's Bureau, which under the laws going back to 1912 give it certain responsibility for the public

health, I think it would be most inappropriate for me to make any suggestions on that score, especially in view of the fact that the Congress has never seen fit to change that set-up.

Senator ELLENDER. I won't put you on the spot. [Laughter.]

Dr. PARRAN. I may say, Mr. Chairman, that in my own experience as Surgeon General, we have had nothing but the finest cooperation with the Children's Bureau, and on many occasions we have seen to it that duplication is minimized and that we do work together in the most efficient possible way.

Senator ELLENDER. While you are on the subject, how have your relations been with the States?

Dr. PARRAN. With the State health departments?

Senator ELLENDER. Yes; the various States of the Union.

Dr. PARRAN. Dr. McCormick, the State health officer of Kentucky, gave some testimony on that subject, speaking for all of the State officers. I subscribe fully to what he said in emphasizing that it has been possible to expend the funds, \$8,000,000 a year under title VI, and now another \$5,000,000 a year under the Venereal Disease Act and \$600,000 under the National Cancer Act, without any suggestion or complaint from any responsible source concerning unreasonable Federal dictation or domination or coercion of the States.

Senator ELLENDER. Under the Social Security Act as it is now enacted, most of the plans are really submitted by the States, are they not?

Dr. PARRAN. All of them are.

Senator ELLENDER. Have you ever actually turned them down and said, "We don't want it this way; you must do it that way"?

Dr. PARRAN. We have never turned down any whole State plan. As a matter of fact, they are worked out usually in consultation with our representatives, representatives of the Children's Bureau and their own people.

Senator ELLENDER. Did you ever attempt to try and have them the same in one State as they have in another, as has been charged?

Dr. PARRAN. Quite the contrary. And one of the criticisms so often repeated about this bill is that its provisions are indefinite. That statement has come up time and again in these hearings.

Senator ELLENDER. Yesterday on four occasions.

Dr. PARRAN. What is the alternative of that? A plan under which the Federal Government would regiment every township and county health officer and city council into a uniform pattern? I hope not. Another criticism has been made that this bill gives to the Federal Government unlimited authority and unlimited discretion. If there are ways in which this committee can limit the discretion and the authority in the allotting of money to the States in order to put those allotments on a more objective basis, I should welcome very much such restrictions. I should like to point out, however, that the language of this bill restricts my authority much more than the language of the present title VI or the Venereal Disease Control Act.

Senator ELLENDER. Yesterday or the day before—last week, I think it was—one witness said, "The first year you are going to spend so much; the second year you are going to spend so much; the third year you are going to spend so much; and the fourth year it will be unlimited." Think of such a statement; they forget that we have to go

to the Congress, to some of these hard-boiled Senators and Congressmen, and have got to show them the necessity for a specific sum before they appropriate.

Dr. PARRAN. I am sure, Senator, that those people have no concept of the amount of factual data, the extent to which actual need must be demonstrated before the Appropriations Committees of these two bodies before any moneys are appropriated, and especially before any increased moneys are given.

Senator ELLENDER. If they were to appear before those committees once or twice they would be convinced of that.

Senator MURRAY. Those in favor of balancing the Budget laugh away such a thing as that when it is suggested. They think that the opportunities for getting appropriations are unlimited, and that all we have to do is to go in and ask for it and that we get it.

Dr. PARRAN. In connection with balancing the Budget, Mr. Chairman, I hope that this Congress will give more attention to balancing our health budget. It is cheaper to keep a woman from dying in childbirth than to take care of the orphans in an orphan asylum or to give aid to the dependent children. It is cheaper to aid in building tuberculosis sanitariums than it is to pay for the deaths from tuberculosis and the widows and children who are left. The State health officer of Tennessee made a statement the other day which impressed me very much. He estimates that it costs on the average \$150 to bury a person in Tennessee, and on that basis it is costing that State more to bury people dying from tuberculosis than it spends for its entire health program including tuberculosis and all the other diseases.

Senator MURRAY. So that money invested in this manner would be wisely invested and would tend to an ultimate balancing of the Budget?

Dr. PARRAN. It would be a direct economy. I don't know of any more economical expenditure of public funds than those spent wisely for health protection and health promotion.

The provisions of the bill regarding variable grants-in-aid are believed to be well conceived. They should insure allotments of money only to meet demonstrated health needs. If the poorer States are to have adequate health programs, it is essential that the Federal Government contribute a larger share of each dollar expended in these States than in the States having greater economic resources. Under title VI of the present Social Security Act the Public Health Service has been enabled to allocate funds in part from the financial and special health needs of the States. For example, the per capita allotments budgeted by the States from Federal funds under this title for the present fiscal year vary from 5 cents to 41 cents.

Finally, may I say, Mr. Chairman, that this is not a measure to socialize medicine in the country. Quite the contrary; it is a measure which will free medicine to render better service to all of the people. It proposes to share, to socialize more of the costs of medicine, but not to socialize medicine. The objectives of the bill can be attained without any basic change in the practice of medicine in this country.

Senator ELLENDER. Doctor, how would the passage of this bill and making it effective, affect the pocketbooks of the doctors?

Dr. PARRAN. Obviously the \$60,000,000 proposed to be allotted the first year under title XIII for the care of needy patients would go,

in large part, to the physicians as well as to existing hospitals. Some of this great load of charity which the doctors carry and under which many of them are staggering would be lessened.

Senator MURRAY. Doctor, during the serious conditions under the depression, is it not a fact that in many sections of the country many of the doctors were kept in practice by the moneys that they received through grants from the relief organizations?

Dr. PARRAN. It is quite true, and it is still true, Mr. Chairman, that in many rural sections, the only thing that enables the doctor to buy his gasoline or pay his office rent is the little money that he gets from current relief funds for the care of indigent patients.

Senator ELLENDER. Doctor, we had several witnesses who testified in behalf of the Dental Association of America to the effect that dentistry should be specifically taken care of under this bill. Have you any views that you would like to express along those lines?

Dr. PARRAN. Dental hygiene, of course, is important, and may I say that the dental profession has been much more advanced in its interest in the preventive aspects of its speciality than has the medical profession as a whole. Our dental brethren are ahead of us, and I should see no obstacles to enumerating dental hygiene along with the other conditions to which special emphasis should be given, but I should like to reiterate that it seems to me very unwise to set up an additional title for separate administration by dentists of dental hygiene matters.

Senator ELLENDER. You think it could be worked out in cooperation with the medical end of the plan?

Dr. PARRAN. That is the only possible way to work it. The problem is often not confined to dental disease; frequently remote parts of the body are involved.

Senator ELLENDER. Would you suggest in view of that, that on this board there be a dentist?

Dr. PARRAN. No. Once one starts to prescribe specifically the personnel, I fear that one would get into great complications unless the Congress itself would wish to write into the act the total membership of the board and how it should be made up. I should have no objections to that.

Senator ELLENDER. Doctor, several witnesses—one on yesterday—testified that a person should be permitted to take any treatment that he may desire. For instance, if he wants Christian Science he ought to have that, or a chiropractic doctor if he so desires. Do you think that anything should be written into this bill to permit that, or is the bill broad enough as it is to take care of the situation?

Dr. PARRAN. The bill is broad enough to permit each State to regulate its own medical practice acts in whatever way that State sees fit.

Senator MURRAY. And if a drugless system of care for a patient is the proper care for that particular patient, they would be able to get it under this bill just the same as if we had a separate section?

Dr. PARRAN. If such care is permitted by State laws, and if payment for such care out of public moneys is permitted under State laws.

Senator ELLENDER. In other words, they could include it under their plan?

Dr. PARRAN. Yes.

Senator ELLENDER. That is the suggestion that I made to both of them yesterday.

Senator MURRAY. They point out, I think, that 48 States now have a licensing system for chiropractic practitioners, and I assume that if any of those States thought that it was desirable for people suffering from certain ills that they should be treated by a chiropractic doctor, that they could arrange that under their State systems?

Dr. PARRAN. That matter is left in the hands of the State as a part of its regulation and control of medical practice.

Senator MURRAY. Drugless treatment is recognized by the medical profession as proper under certain conditions, I suppose, for certain ailments?

Dr. PARRAN. Before I can answer that, I would like you to define drugless treatment.

Senator MURRAY. I don't know anything about it myself. I used the words "drugless treatment" because these other gentlemen mentioned it, but it was used by those who appeared as witnesses and I assumed that the medical profession would know what they had reference to. I suppose it has reference to the treatment that you get from stretching the body and massaging it and electrotherapy.

Dr. PARRAN. Physical and mechanical methods of treatment are, of course, well recognized; also the X-ray, diathermy, and physiotherapy, et cetera.

Senator MURRAY. The doctors use them themselves in their practice?

Dr. PARRAN. Yes.

Senator MURRAY. Doctor, I think that I would like to have you describe for the record and for my own information, the Federal Public Health Department. Exactly what your functions are and how it has operated.

Dr. PARRAN. Yes, Mr. Chairman. This is one of the oldest Federal agencies. Its predecessor was the Marine Hospital Service, organized in 1798 by an act of the Second Congress. That act set up the first compulsory health-insurance system in this country, and I believe the first in the world. It provided that a tax of 20 cents and later 40 cents a month should be deducted from the wages of each sailor on a merchant ship in the United States, and the fund deposited with the collector of customs. That is the reason that we are in the Treasury Department. With those funds, hospitals were built, and that system continued for about 85 years. Then the Congress substituted a tonnage tax in lieu of the pay-roll check-off for sailors, which funds now go into the General Treasury, but they are not specifically for marine hospital purposes. Because our doctors were treating diseases, especially exotic diseases brought into the ports, they acquired proficiency, and in the early days when an epidemic started in the coastal or other cities these doctors were looked to to aid and assist the State health authorities.

For 55 years we have had a law on the statute books authorizing the Public Health Service to cooperate with and aid the State and local authorities.

Since 1912 we have been called the Public Health Service, and since 1902 we have been given specific functions in research.

Senator MURRAY. Your present department then is a continuation of that original set-up provided as you have described?

Dr. PARRAN. A continuation and a logical outgrowth, I think. We are concerned now with three broad fields of endeavor; that of giving treatment to merchant seamen, also the members of the Coast Guard, injured Federal employees, and a number of other legally qualified beneficiaries. That is done through a system of hospitals with seven or eight thousand beds all told, in other words, the giving of medical care to Government beneficiaries is one specific function.

Another function is constantly to seek to extend our knowledge of how to prevent and cure diseases. That has been carried out through the National Institute of Health and more recently the National Cancer Institute. In that field, the service has had a very creditable record of scientific accomplishment, it has cooperated with the leading scientific institutions of the country in the advance of knowledge on a thousand fronts.

Our third general function, carried out under many older laws and more recently under the Social Security Act, and the Venereal Disease Control Act, is to seek better to apply the knowledge we now have by cooperation with the States through the grant-in-aid money and through the giving of public aid and advice. Simply to give money from the Federal Government is only part of the way, and perhaps not the most important way that the Federal Government can assist the States. During many years, I think the greatest service we have rendered the States has been to give them the advice and guidance in the control of epidemics, in developing new and better methods of public-health practice, in studying for them problems which are common problems to all of the States, and obviously it would be inefficient if all of the States were to study such problems.

I don't know whether you want me to go into detail, but I have tried to give you just a skeleton.

Senator MURRAY. What are your relations with the States under your present set-up?

Dr. PARRAN. We have worked out our plans under the very broad authority in title VI of the Social Security Act with the States themselves. The law requires that the regulations should be written after a conference with the State and Territorial health officers. Those health officers themselves have recommended to us regulations, some of them more strict than I thought it wise to put into effect, simply because they are so anxious that this Federal-State pattern relationship should be developed on the very highest plane; they have recommended standards for personnel of which I approve but which during the first years of operating the bill seemed to me too rigid, too drastic. Our relations with the State authorities, I think, forms one of the finest patterns of State and Federal relationship.

Senator MURRAY. Is it not also true that the medical profession in the various States looks to your department and cooperates with your department fully?

Dr. PARRAN. They do, indeed. As an example, the American Medical Association 3 years ago bore half of the cost of developing a film on the treatment of syphilis; we bore the other half of the cost, and it was jointly sponsored. That film has been shown in practically all of the county medical societies in the whole country. There have been many other instances of cooperation and particularly in cooperation with the individual local, city, and county medical societies

Senator ELLENDER. Doctor, have you had any difficulty with the States in seeing to it that the plans are carried out as agreed upon?

Dr. PARRAN. It has been a rare exception, Senator, and then ordinarily we are aware of the situation through our field force and have been able to correct it without any recourse to legal action or the withdrawing of moneys. We have suggested in some instances that certain projects we thought were not well conceived in some of their parts, and the State health officers agreed. There has never been any radical difference of opinion.

Senator ELLENDER. In other words, they always discussed it with you in a nice way, as it were, without in any manner trying to be arbitrary?

Dr. PARRAN. Yes.

Senator ELLENDER. And you have no difficulty in showing them that they were not doing it according to the plan?

Dr. PARRAN. Just as frequently they show us, too. They frequently come in and know much more than we do about this problem and come up with plans which are extraordinary in their vision and concept and more efficient ways of doing business, and immediately we disseminate the information about that among the other States.

Senator ELLENDER. What cooperation do you get from the medical profession itself particularly with reference to this research work?

Dr. PARRAN. There are two lines of cooperation: First, the continuing contact which we have with the scientific institutions, the university medical schools, both voluntary and State, and other research centers; second, with the profession itself on many fields of study, such as on the prevalence of venereal disease, and studies of the incidence of cancer.

Again, in the case of an unusual epidemic, full cooperation is had by the profession who give the information to our research people so that they can bring the problem back to the laboratory and work it out. There have been some very beautiful examples of that with tularemia and others—studies of pellagra in the South form another example.

Senator MURRAY. Because of the serious economic burden upon the health of the Nation as a whole, you think that it is absolutely essential that the Federal Government should go into this subject of national health and attempt to aid the States in improving conditions?

Dr. PARRAN. I do, Mr. Chairman. If the Congress will bear in mind that there is a certain maximum rate of development beyond which efficiency is lowered. The President's committee itself emphasized the evolutionary character of this development, that it should be spread over a 10-year period.

Senator MURRAY. Have the States of the country given the proper consideration to the subject of silicosis?

Dr. PARRAN. They have not.

Senator MURRAY. In many States, silicosis is neglected entirely or has been neglected until very modern times.

Dr. PARRAN. Yes; it has been, and until recently in many States not subject to workmen's compensation. One of my first works in the Public Health Service was down in the Joplin district in the

Tri-State mining district, where silicosis was rampant and tuberculosis following right on its heels.

Senator MURRAY. And the only effort to improve those conditions came from the people who suffered from the disease themselves and not from the authorities that should have been interested in the subject?

Dr. PARRAN. You are quite right.

Senator MURRAY. Just here recently I was urged by the miners of Montana to aid in securing an addition to the tuberculosis hospital in Montana because there were so many miners walking the streets who were unable to get attention, and after considerable work and struggle, I got a P. W. A. project through to extend that hospital at Galen, Mont., which has been a very successful institution, as I understand it. You are familiar, I understand, with the Galen Hospital?

Dr. PARRAN. I have never been there, but I have heard of the institution and the work it is doing.

Senator MURRAY. That is true in many sections of the country. There are a great many people suffering from silicosis that are not getting proper consideration.

Dr. PARRAN. It is perfectly true, Senator, and the action you have taken is fine, but I think it has not gone far enough. If a tuberculosis hospital is to severe its maximum use, we must get at the case early. The only way to do that is by mass X-rays and physical examinations of susceptible groups of the population; in this instance, the miners. Also, wherever we find an undue prevalence and where the workers are exposed to dust, then steps should be taken to remove that cause. In other words, it seems to me, there are two further steps that should be taken in connection with the control of tuberculosis. It has been said by responsible authorities that within a generation we could make tuberculosis as rare as typhoid now is if we went at it on a national basis, with mass X-rays, and follow up the patients after they leave the sanatorium, use the most modern methods of treatment—and the cost is not very great in terms of the results that can be had. Next to syphilis control, I think one of our next and perhaps the next great objective in national health should be a national attack against tuberculosis. It will produce greater results for a given expenditure, I believe, than any other health problem.

There are many diseases about which we cannot do very much except alleviate suffering and perhaps shorten the period of disability, but here is a disease that we can do something about, yet all of our efforts are terrifically sporadic. Senator, in your State, you know the conditions there; they are tragic.

Senator ELLENDER. Doctor, don't you believe that under this bill that can be done?

Dr. PARRAN. It is one of the first objectives of title VI.

Senator MURRAY. You spoke also of malaria. Is it widespread? Are there widespread malarial conditions in the country yet?

Dr. PARRAN. There are. Malaria seems to go on a 7-year cycle, up and down. The reason for that is the subject of study, but we do

not know why. We recently passed through the peak of one of those cycles. A great deal of malaria work has been done and is being done with P. W. A. funds now in the South. Very fine work is under way, but under this bill it is contemplated that that work will be extended and intensified and continued.

Senator MURRAY. I am very much interested in that, because as a boy I had malaria and I went to New York in about 1808 and it disappeared and I never had it afterward. I guess I left the community in which I was subject to it.

Senator ELLENDER. Where did you contract it? In Montana?

Senator MURRAY. No; I contacted it in Ontario, Canada.

Senator ELLENDER. I thought the South was the only place where malaria exists.

Dr. PARRAN. Formerly malaria was one of the most severe diseases throughout the Great Lakes area and the Hudson River Valley, and now it has been pushed back.

Senator MURRAY. Well, doctor, we appreciate your testimony and hope that we may continue in contact with you during the further study of the problem. I am satisfied from your statement that we are going along the right lines, and all we need to do is to make the necessary amendments and corrections to the bill to carry out the purposes that we have in mind that you have so well expressed this morning.

Dr. PARRAN. Thank you very much, Senator.

May I say just another word in thanking you for the opportunity to be here? I was told this morning that the chairman of the subcommittee made a statement yesterday to the effect that he did not expect any final action of Congress on this whole bill at this session of the Congress. May I urge that at least the next step or two will be taken in regard to these matters, which are not controversial, and in regard to which there is great and obvious need? By so doing, we can begin to build up toward the whole program of public health if it is not possible to proceed on all fronts at this time.

Senator ELLENDER. The great difficulty in separating it is that you separate the easy ones from the hard ones, and leave the hard ones out, and if you do that, you may never get the hard ones through.

Dr. PARRAN. I had not thought of that.

Senator MURRAY. They are talking about adjourning by the 15th of July, Doctor, and there are so many other bills ahead of this, that it seems to me impossible to get this bill reported, because it will take time, considerable time, to transcribe this testimony and have it printed and then to act on all of the amendments that are going to be considered; and then we want to give full consideration and study to every proposal that has been made, every criticism that has been made against the bill, and it would seem to me that it would be utterly impossible to give the proper consideration to the bill and get it up on the floor at this session.

Dr. PARRAN. I can realize those very great difficulties.

Senator MURRAY. I would like to see it done, if it were possible. If we had started earlier, it might have been possible, but when we are in the present situation that we are now, and the testimony not yet concluded, I do not see how it is going to be possible.

Dr. PARRAN. Thank you very much.

SUPPLEMENTAL STATEMENT SUBMITTED BY DR. THOMAS PARRAN, SURGEON GENERAL
OF THE UNITED STATES PUBLIC HEALTH SERVICE

HOSPITAL ACCOMMODATIONS

According to information assembled by the American Medical Association there are 6,138 institutions in the United States that meet the association's requirements for registration. Included in this total are 325 Federal hospitals and 228 infirmary units of State and local institutions. Federal hospitals as a rule are maintained for selected beneficiaries without regard to place of residence. Infirmary units serve primarily the population of the sponsoring institution. It

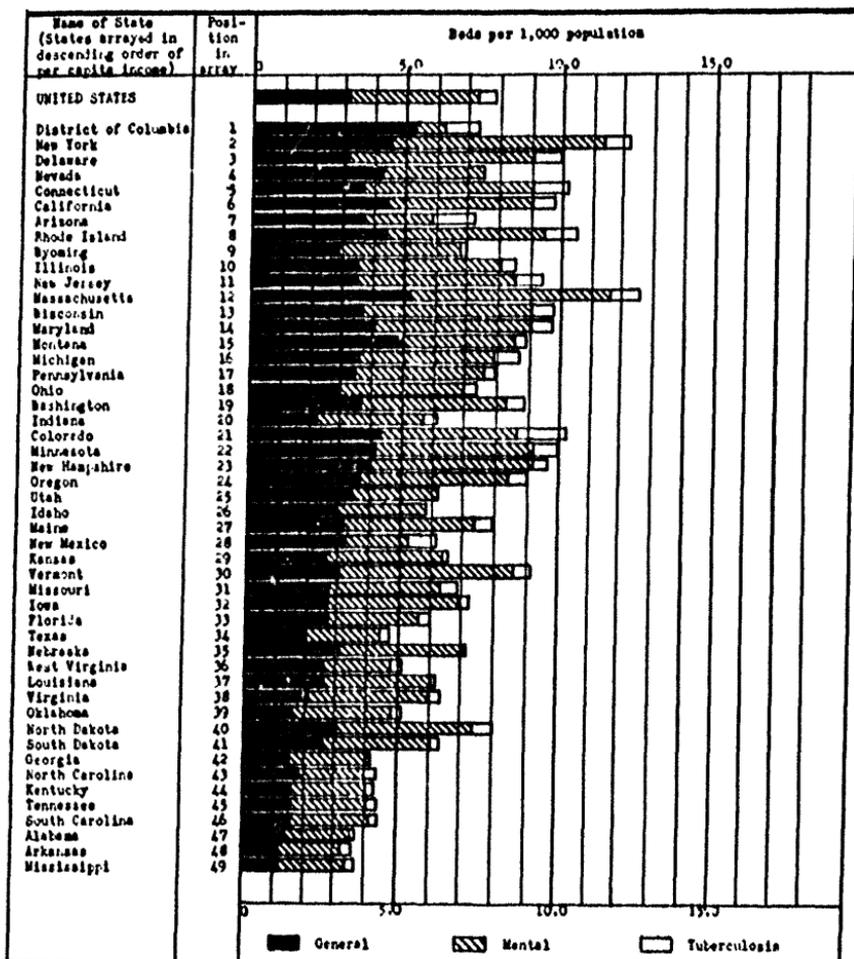


FIGURE 1.—Total hospital beds per 1,000 population according to medical type of hospital.

is customary, therefore, to omit Federal hospitals and infirmary units of institutions from consideration when computing local facilities. Mention should also be made of the fact that there are some 3,000 places not of registration status where persons may obtain some measure of hospital care. Included in the non-registered group are nursing homes, first-aid stations, health resorts, and a fair proportion of institutions which offer service popularly associated with hospitals. While many of such institutions render essential service within their respective spheres, the American Medical Association does not accord them the distinction

that is implied by the term registered. Inasmuch as one purpose of the National Health Program should be to improve the quality of medical care, it seems only appropriate that the registered group of institutions be taken as a basis for portraying the extent and distribution of existing facilities.

Additions to or subtractions from any such list might be indicated later on the basis of detailed field surveys to be made by the State health agency prior to the submission of plans on which Federal assistance is sought. As a matter of fact significant differences now appear in reports of various agencies with respect to available hospital facilities. These differences can be attributed to varying points of view concerning where the line should be drawn between institutions to be classed as hospitals and those that should not. In the opinion of those responsible for formulating the National Health Program hospitals registered by the American Medical Association represent a reasonable compromise between, for example, the very restricted group of hospitals recognized by the American College of Surgeons and an all-embracing list that encompasses every institution where a person might obtain bed care. Facilities for the several States, based on the Hospital Register of the American Medical Association, are described in an appended series of tables and charts. There follows also a brief discussion of these tabular and graphic data. The facilities and their use as described therein relate to registered hospitals exclusive of those operated by the Federal Government and the infirmary units of institutions. The economic position of each State is expressed by per capita income payments as reported by the National Industrial Conference Board.

MENTAL HOSPITAL ACCOMMODATIONS BY STATES

For all practical purposes, institutional care of persons with mental disorders may be regarded as an exclusive function of State and local governments. Together they operate 512,554 beds or about 96 percent of the total in mental hospitals. The State government being the principal operating agency, institutions tend to be large and service is organized on a State-wide basis. While it is true that there are 51 institutions of nonprofit and 185 of proprietary classification, these places maintain only 4 percent of the beds. Furthermore, private institutions serve in particular the well-to-do.

The ratio of beds to population varies with the States from 0.87 down to 0.01 (table 1). When the States are arrayed on the basis of beds to population it is found that in respect to accommodations the State represented by the upper quartile has 4.8 beds per 1,000 population, while 3.0 beds expresses the median State. States on the upper 25-percent performance level contain about one-fourth of the total population of the United States. While no absolute figure in beds can be taken to express the needs for institutional accommodations, there is every reason to suppose that provisions already made by States in the upper 25-percent group are not in excess of actual demand as shown by occupancy which actually is in excess of rated capacity. The lower figure for this group, namely, 4.8 beds, may, therefore, be taken as a reasonable standard that is amply supported by experience.

TABLE 1.—Distribution of mental hospital facilities according to agency operating the hospital, by States

State	Population July 1, 1937 ¹	All hospitals			Operating agency							
		Total number	Total beds	Beds per 1,000 pop- ulation	State governments		City and county governments		Nonprofit corpora- tions		Individual or partnership (proprietary)	
					Number	Beds	Number	Beds	Number	Beds	Number	Beds
United States.....	129,257,000	558	532,627	4.12	250	459,159	72	53,395	51	10,600	185	9,473
Alabama.....	2,985,000	4	6,064	2.10	3	6,014					1	50
Arizona.....	412,000	1	900	2.18	1	900						
Arkansas.....	2,048,000	2	4,021	1.95	2	4,021						
California.....	6,154,000	34	28,859	4.69	8	22,111	2	5,434				
Colorado.....	1,071,000	7	4,740	4.43	4	4,394				2	92	
Connecticut.....	1,741,000	15	9,435	5.42	4	8,555					22	1,222
Delaware.....	281,000	2	1,557	5.97	2	1,557				1	270	3
District of Columbia.....	627,000	2	569	.91							10	613
Florida.....	1,670,000	6	4,869	2.92			1	546				
Georgia.....	3,085,000	5	7,644	2.48	2	4,741					1	24
Idaho.....	493,000	6	3,670	7.44	2	7,429					4	128
Illinois.....	7,873,000	3	1,460	2.96	3	1,460					2	395
Indiana.....	3,474,000	25	36,342	4.61	11	32,563	1	3,082	3	250	10	474
Iowa.....	2,552,000	14	11,987	3.45	9	11,459	1	400	1	30	3	88
Kansas.....	1,864,000	12	10,573	4.14	7	9,962	1	70	2	440	2	101
Kentucky.....	2,920,000	8	6,912	2.71	5	6,815					2	97
Louisiana.....	2,132,000	7	7,045	2.41	4	6,891					2	154
Maine.....	856,000	6	7,374	3.46	3	6,935	1	100	1	275	1	64
Maryland.....	1,679,000	5	3,670	4.29	3	3,622					2	48
Massachusetts.....	4,426,000	14	8,431	5.02	5	7,256					7	290
Michigan.....	4,830,000	28	28,315	6.40	17	27,704					8	291
Minnesota.....	2,652,000	13	20,802	4.31	9	15,562	3	4,550	3	650	1	46
Mississippi.....	2,023,000	14	13,443	5.07	8	13,246					5	83
Missouri.....	3,969,000	5	4,484	2.22	3	4,444					2	46
Montana.....	539,000	18	14,074	3.53	5	9,157	2	4,100	4	567	7	190
Nebraska.....	1,364,000	1	1,900	3.73	1	1,900						
Nevada.....	101,000	5	5,324	2.90	4	5,179						
New Hampshire.....	510,000	1	332	3.29	1	332				1	145	
New Jersey.....	4,343,000	2	2,641	5.18	2	2,641						
New Mexico.....	422,000	24	22,110	5.09	8	15,200	6	5,804	3	845	7	261
New York.....	12,959,000	65	89,090	6.87	31	85,789	1	470	7	1,068	26	1,773
North Carolina.....	3,492,000	10	7,600	2.19	4	7,244					6	356
North Dakota.....	706,000	2	3,074	4.35	2	3,074						

¹ Estimate from U. S. Census Bureau.

TABLE 1.—Distribution of mental hospital facilities according to agency operating the hospital, by States—Continued

State	Population July 1, 1937	All hospitals			Operating agency							
		Total number	Total beds	Beds per 1,000 pop- ulation	State governments		City and county governments		Nonprofit corpora- tions		Individual or partnership (proprietary)	
					Number	Beds	Number	Beds	Number	Beds	Number	Beds
Ohio.....	6,732,000	27	27,196	4.04	12	25,962	1	170	1	65	13	996
Oklahoma.....	2,548,000	7	8,262	3.24	5	8,187					2	12
Oregon.....	1,027,000	4	4,950	4.82	3	4,938					1	1
Pennsylvania.....	10,176,000	42	40,946	4.02	12	20,621	13	16,962	9	3,034	8	329
Rhode Island.....	681,000	4	3,409	5.01	2	3,185			2	224		
South Carolina.....	1,875,000	3	4,845	2.58	2	4,811					1	38
South Dakota.....	762,000	2	2,390	3.15	2	2,390						
Tennessee.....	2,803,000	10	7,020	2.43	2	5,789					1	38
Texas.....	6,172,000	15	14,867	2.41	4	14,645	2	1,049				
Utah.....	519,000	2	1,362	2.68	2	1,362					4	18
Vermont.....	283,000	4	2,160	5.64	2	1,392					7	38
Virginia.....	2,799,000	9	10,335	3.82	5	1,335			1	800	1	38
Washington.....	1,658,000	7	7,549	4.58	4	10,010					4	38
West Virginia.....	1,865,000	5	3,964	2.13	4	7,516					3	38
Wisconsin.....	2,526,000	50	15,885	5.43	5	4,397	37	10,618	4	620	4	38
Wyoming.....	235,000	2	914	3.89	2	914						

To bring the ratios of beds to population in all States up to this standard of 4.8 would require the addition of 130,000 beds to existing accommodations. Most of these new beds would serve to augment facilities especially in those States now having insufficient accommodations. Existing institutions might be enlarged or new units could be established as local circumstances warrant. A very high proportion of the new beds would be required in States of low economic resources. The deficiency of the several States is visualized in figure 2 wherein States are arrayed in descending order according to economic status as expressed by per capita income.

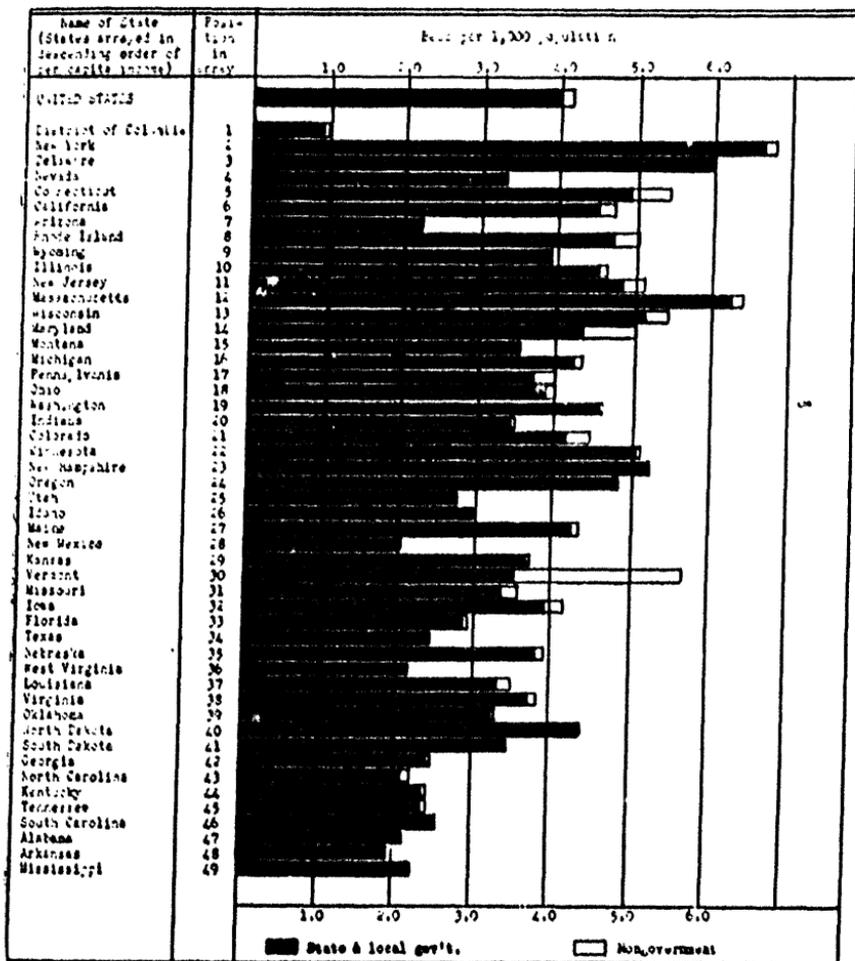


FIGURE 2.—Beds per 1,000 population in mental hospitals according to agency operating hospital.

TUBERCULOSIS HOSPITAL ACCOMMODATIONS BY STATES

Facilities for the care of tuberculosis patients are represented by 70,000 sanatorium beds and 10,000 beds set apart for the care of such cases in general and isolation hospitals. Of the beds in sanatoria proper, 80 percent are operated by State and local governments, 16 percent by nonprofit corporations, and 4 percent by proprietary agencies. The great majority of those beds in general and isolation hospitals also are under governmental control. For individual States, ratios of sanatorium beds range from 1.0 to 0 per 1,000 population (table 2 and figure 8).

TABLE 2.—Distribution of facilities in tuberculosis hospitals according to agency operating the hospital, by States

State	Population July 1, 1937 ¹	All hospitals			Operating agency							
		Total number	Total beds	Beds per 1,000 pop- ulation	State governments		City and county governments		Nonprofit corpora- tions		Individual or partnership (proprietary)	
					Number	Beds	Number	Beds	Number	Beds	Number	Beds
United States.....	129,257,000	491	70,584	0.55	70	19,966	240	35,762	121	11,539	60	3,017
Alabama.....	2,895,000	6	391	.14	1	100	4	213	1	78		
Arizona.....	412,000	13	574	1.39	1	98	1	40	5	247	6	189
Arkansas.....	2,048,000	2	707	.35	2	707						
California.....	6,154,000	42	4,434	.72			15	2,848		729	16	857
Colorado.....	1,071,000	16	1,719	1.60					11	1,679	1	40
Connecticut.....	1,741,000	10	1,925	1.11	5	1,459	2	211	3	255		
Delaware.....	261,000	3	224	.86	2	200			1	24		
District of Columbia.....	627,000	1	700	1.11					1	700		
Florida.....	1,670,000	5	607	.36	1	400	3	183	1	24		
Georgia.....	3,085,000	5	603	.19	1	250	2	317	1	36		
Idaho.....	493,000											
Illinois.....	7,878,000	27	2,911	.50			20	3,130	5	589	2	192
Indiana.....	3,474,000	10	1,529	.44	1	300	9	1,229				
Iowa.....	2,552,000	5	800	.31	1	420	4	380				
Kansas.....	1,864,000	3	420	.23	1	280	2	130				
Kentucky.....	2,920,000	3	682	.23	1	68	2	614				
Louisiana.....	2,132,000	4	326	.15	1	100						
Maine.....	856,000	4	485	.57	3	453			3	226		
Maryland.....	1,679,000	7	1,240	.74	4	966			1	30		
Massachusetts.....	4,428,000	32	4,398	.99	3	869	18	2,564	10	900	1	55
Michigan.....	4,830,000	27	4,027	.83	3	840	14	2,141	6	614	4	292
Minnesota.....	2,652,000	16	2,084	.78	1	480	14	1,560			1	44
Mississippi.....	2,023,000	2	495	.24	1	450			1	45		
Montana.....	3,969,000	8	2,014	.50	1	653			2	242		
Missouri.....	539,000	1	200	.37	1	200						
Nebraska.....	1,364,000	1	160	.12	1	160						
Nevada.....	101,000											
New Hampshire.....	510,000	2	240	.47	1	140						
New Jersey.....	4,343,000	21	3,936	.91	1	494	14	2,960	2	301	1	100
New Mexico.....	422,000	4	385	.91	1	65			3	320	4	181
New York.....	12,959,000	59	10,305	.80	4	1,050	36	6,000	19	2,655		
North Carolina.....	3,492,000	22	1,573	.45	2	625	8	532	3	153	9	265
North Dakota.....	706,000	1	405	.57	1	405						
Ohio.....	6,733,000	21	3,314	.49	1	240	15	2,647	1	40	4	387

Oklahoma	2,548	4	807	.32	3	782							
Oregon	1,727	4	575	.56	2	475	1	41	1	59	1		23
Pennsylvania	10,176	17	4,285	.42	3	2,408	6	766	8	1,111			
Rhode Island	681	3	785	1.15	1	420	1	265	1	100			
South Carolina	1,875	6	578	.31	1	276	4	232	1	70			
South Dakota	692	1	192	.28	1	192							
Tennessee	2,892	6	1,075	.37			3	760	2	275	1		46
Texas	6,172	19	2,128	.35	2	966	6	532	4	385			245
Utah	519												
Vermont	393	3	204	.53	2	127			1	77			
Virginia	2,706	7	1,210	.45	3	700	2	370	1	60	1		29
Washington	1,638	9	1,004	.61			7	859	1	60	1		85
West Virginia	1,865	6	761	.41	2	623	2	68	2	70			
Wisconsin	2,925	22	2,142	.73	2	290	18	1,752	2	110			
Wyoming	235,000	1	33	.14	1	33							

¹ Estimate from U. S. Census Bureau.

By following the more generally accepted measure of institutional accommodations, namely, total beds available for tuberculosis patients per annual death from tuberculosis, one finds that the ratio for the United States as a whole is 1.17. Ratios of combined beds in sanatoria and general hospitals for individual States vary from 2.60 down to 0.12; 8 States have 2 or more beds per annual tuberculosis death, while in 27 States this ratio is less than 1 (fig. 4). Generally speaking, the accommodations in a State are determined by the economic position of the State rather than by its tuberculosis death rate.

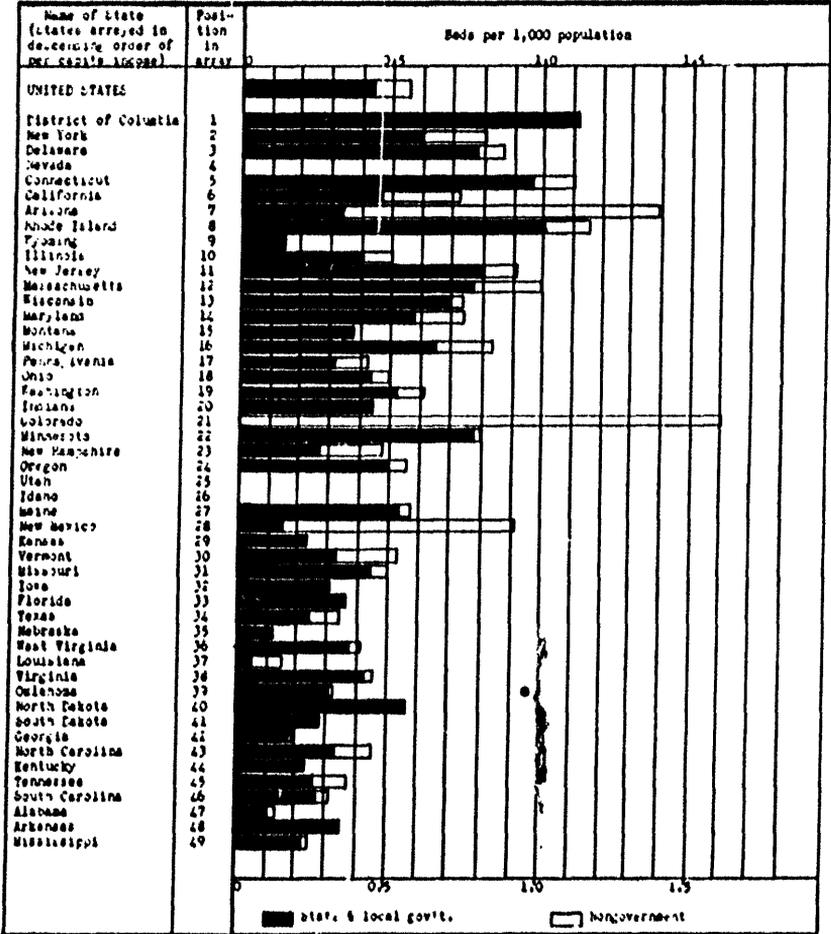


FIGURE 3.—Beds per 1,000 population in tuberculosis hospitals according to agency operating hospital.

States differ markedly in fiscal and administrative arrangements for hospitalizing the tuberculous. Nine States do not make legal provision for sanatoria; five of these subsidize care at local institutions, but in four States no State-wide provisions are made for hospitalizing patients. Some of the deficiencies in State-supported facilities or services may be compensated for by action of local governments or of voluntary agencies.

Clinical experience has demonstrated that two beds per annual tuberculosis death are required for hospitalization of the tuberculous in areas having a reasonably aggressive case-finding program. To bring facilities of the whole country up to this standard after allowing for a continuing reduction in number of deaths would require the addition of approximately 50,000 beds. Some of these beds may be incorporated into existing general hospitals and sanatoria, but in several States entirely new institutions should be established.

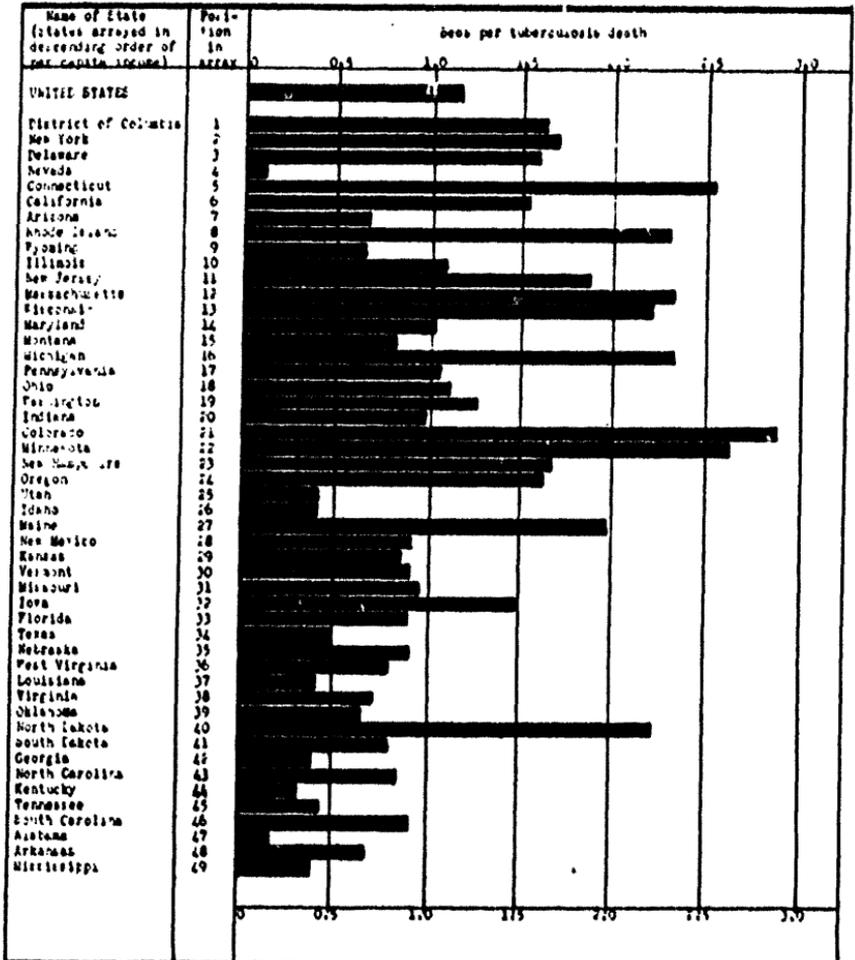


FIGURE 4.—Beds in tuberculosis hospitals and in tuberculosis departments of general hospitals per tuberculosis death.

GENERAL HOSPITAL ACCOMMODATIONS, BY STATES

Hospitals (exclusive of Federal and infirmary units of institutions) available for general service number about 4,500. Slightly more than half of these are operated by corporations not organized for profit, roughly one-third are proprietary and conducted without restrictions as to the use of income, while State and local governments participate to the extent of about 15 percent as operating agents (table 3). These proportions change somewhat when facilities are com-

puted on the basis of beds, since Government hospitals tend to be large, nonprofit of medium size, and the proprietary very small. The 405,000 beds in general hospitals are distributed by control as follows: About 27 percent are in hospitals

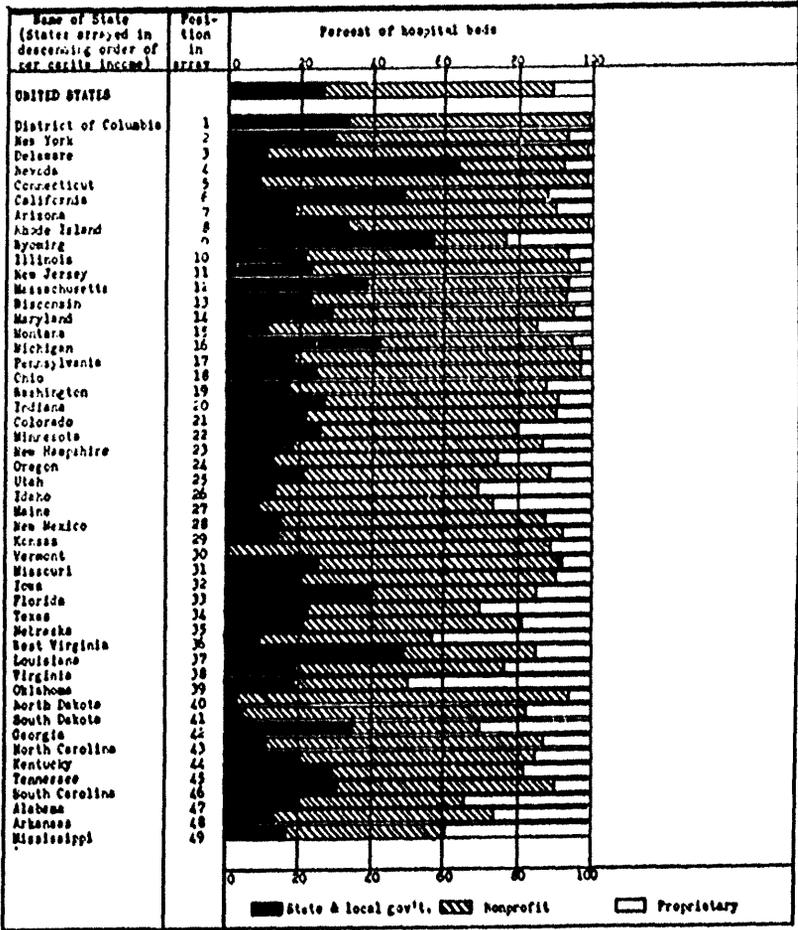


FIGURE 5.—Percentage distribution of general hospital beds according to agency operating hospital.

of State and local governments, 62 percent in nonprofit hospitals, and about 11 percent are in proprietorially owned hospitals. The percentage distribution of beds by control for the States is presented graphically in figure 5.

TABLE 3.—Distribution of general and allied special hospital¹ facilities according to agency operating the hospital, by States

State	Population July 1, 1937 ²	All hospitals			Operating agency								
		Total number	Total beds	Beds per 1,000 population	State governments		City and county governments		Nonprofit corporations		Individual or partnership (proprietary)		
					Number	Beds	Number	Beds	Number	Beds	Number	Beds	
United States.....	129,257,000	4,536	405,846	3.14	66	18,717	529	88,591	2,478	253,761	1,463	44,477	
Alabama.....	2,865,000	64	4,028	1.39				6	812	23	1,852	35	1,364
Arizona.....	412,060	28	1,487	3.61				6	270	17	1,059	7	158
Arkansas.....	2,048,000	48	2,590	1.26				5	351	15	1,569	24	670
California.....	6,154,000	261	27,187	4.42	2			47	12,783	100	10,702	112	3,480
Colorado.....	1,071,000	70	4,639	4.33	1	161		5	836	38	3,189	26	453
Connecticut.....	1,711,000	43	6,304	3.62				2	500	35	5,612	6	102
Delaware.....	261,000	9	809	3.10	1	86				7	708	1	15
District of Columbia.....	627,000	16	2,348	3.74				1	1,119	13	2,192	2	37
Florida.....	1,620,000	74	4,539	2.72	2	88		16	1,722	31	2,051	23	679
Georgia.....	3,085,000	88	4,783	1.55				15	1,668	48	1,996	50	1,419
Idaho.....	493,000	37	1,400	2.84				5	188	14	1,781	18	431
Illinois.....	7,878,000	234	27,832	3.53	2	565		21	5,481	165	19,571	46	1,915
Iowa.....	3,474,000	99	7,751	2.23	1	466		13	1,619	13	4,974	28	662
Kansas.....	2,552,000	121	6,966	2.73	1	900		13	484	22	4,901	42	680
Kentucky.....	1,864,000	94	4,851	2.60	1	300		12	496	22	3,775	30	370
Louisiana.....	2,929,000	75	4,931	1.69	1	38		9	960	39	3,160	28	373
Maine.....	859,000	52	2,724	3.18	3	2,709				2	2,041	27	288
Maryland.....	1,679,000	45	6,471	4.09	2	439		5	1,330	1	1,788	23	319
Massachusetts.....	4,426,000	175	23,137	5.23	4	3,899		19	5,035	118	4,565	37	1,461
Michigan.....	4,839,000	178	17,115	3.54	3	1,353		45	5,792	122	12,802	36	1,002
Minnesota.....	2,652,000	173	10,942	4.12	3	710		18	2,131	22	8,998	27	1,002
Mississippi.....	2,023,000	60	2,548	1.26	5	347		3	66	1	1,178	26	398
Missouri.....	3,999,000	166	11,074	2.77	2	184		13	2,629	119	2,376	31	380
Montana.....	539,000	44	2,687	4.98				6	277	1	1,740	14	118
Nebraska.....	1,364,000	85	4,350	3.19	2	320		4	891	4	2,623	46	816
Nevada.....	101,000	11	427	4.23				1	173		119	1	35
New Hampshire.....	510,000	28	2,049	4.02				6	369		1,398	5	282
New Jersey.....	4,343,000	165	14,849	3.42				12	3,448	29	10,868	14	513
New Mexico.....	422,000	31	1,261	3.23	2	201				20	982	9	178
New York.....	12,958,000	369	50,244	4.56	3	390		49	17,172	390	37,572	87	4,220

¹ Excluding hospitals of Federal control. All hospitals are included in the "general and allied special" category except mental and tuberculosis hospitals and hospital departments of institutions.

² Estimate from U. S. Census Bureau.

TABLE 3—Distribution of general and allied special hospital facilities according to agency operating the hospital by States—Continued

State	Population July 1, 1937	All hospitals			Operating agency								
		Total number	Total beds	Beds per 1,000 pop- ulation	State governments		City and county governments		Nonprofit corpora- tions		Individual or partnership (proprietary)		
					Number	Beds	Number	Beds	Number	Beds	Number	Beds	
North Carolina.....	3,492,000	116	6,500	1.86									
North Dakota.....	708,000	42	2,144	3.04	1	160	10	568	81	4,922	24	850	
Ohio.....	6,733,000	160	19,094	2.84	2	416	4	64	29	1,933	9	127	
Oklahoma.....	2,548,000	97	4,246	1.67	1	418	27	4,271	124	13,756	37	631	
Oregon.....	1,027,000	56	3,763	3.68	1	70	10	394	21	1,334	65	2,190	
Pennsylvania.....	10,176,000	273	35,416	3.48	12	1,815	4	416	25	2,336	28	941	
Rhode Island.....	681,000	16	3,026	4.44	1	1,006							
South Carolina.....	1,875,000	44	3,002	1.60					13	1,986	2	1,062	
South Dakota.....	692,000	42	1,823	2.63					8	941	10	289	
Tennessee.....	2,863,000	71	4,831	1.67					4	80	14	323	
Texas.....	6,172,000	248	12,222	1.98	1	50	7	1,416	30	2,541	34	874	
Utah.....	519,000	27	1,763	3.40					30	2,722	76	5,792	
Vermont.....	383,000	22	1,149	3.00					5	363	11	210	
Virginia.....	2,704,000	77	5,523	2.04							17	1,027	
Washington.....	1,658,000	83	6,240	2.76	1	338	5	710	39	3,174	22	1,301	
West Virginia.....	1,865,000	66	4,955	2.66					7	1,076	47	4,388	
Wisconsin.....	2,929,000	137	10,915	3.73	3	225	4	249	25	2,343	34	2,128	
Wyoming.....	215,000	19	673	2.66	1	650	14	1,822	85	7,648	37	786	
						100	3	268	6	130	9	155	

When accommodations in general hospitals are related to the population, the ratio for individual States varies from 5.3 to 1.3 per 1,000 inhabitants (table 8). Here, as in the case of mental and tuberculosis institutions, position of individual States with respect to per capita income rather than hospital needs of the population seems to determine the extent to which facilities are developed (fig. 6).

While the county may not always represent a suitable population unit for hospital planning, it is of interest that 1,338 counties containing 17,000,000 people are without a registered general hospital. Of the 1,737 counties with local general hospitals that meet the requirements for registration, 510 have

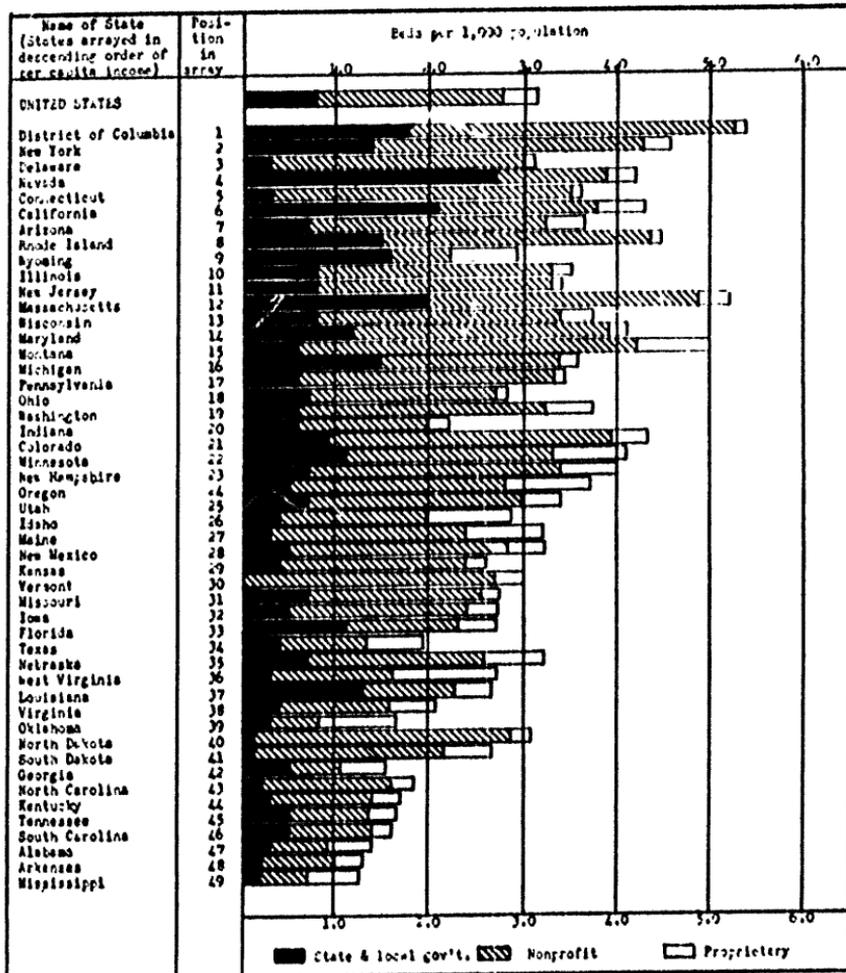


FIGURE 6.—Beds per 1,000 population in general hospitals according to agency operating hospital.

only proprietary institutions; 783 are served by nonprofit hospitals alone or in conjunction with those proprietorially owned; and only 482 counties contain local tax-supported institutions. The foregoing presentation of hospital status may be altered in some degree, depending on the number of nonregistered hospitals one chooses to take into consideration. Even if a high proportion of nonregistered hospitals be brought into the calculation the facilities added thereby would not increase materially available accommodations because the 1,500 or more nonregistered general hospitals of which there is central record contain about 25,000 beds.

Since the size of general hospitals varies within such wide ranges, the mere existence of facilities may not express service to patients. For example, a hospital within 30 miles of 50,000 people may be accessible from the standpoint of distance, but if that hospital contains only 10 beds obviously it cannot accommodate all the people who are in need of hospital care. If patient-days of care per 1,000 population be taken as the measure of service, great inequality exists between the several States. The average group of 1,000 citizens in the State with highest economic rating obtains 1,300 days of care per annum while at the lower end of the scale a corresponding group of citizens would be hospitalized for 207 days (fig. 7). Clearly these differences in hospitalization rates cannot reflect differences in need for care.

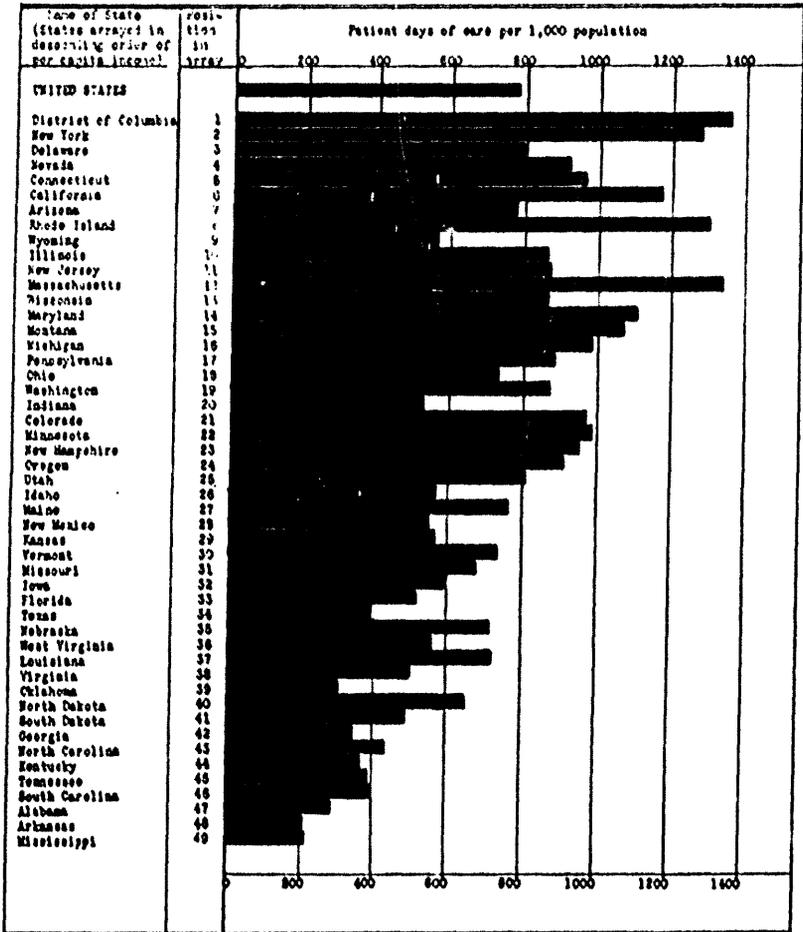


FIGURE 7.—Patient days of care per 1,000 population in general hospitals.

Low utilization rates (occupancy) of beds experienced by particular classes of hospitals in certain localities is often cited to support the contention that hospitals have been built in excess of need. The true situation does not bear out this contention. It has already been shown that facilities in individual States range from 5.3 per 1,000 population down to 1.3. Inspection of occupancy rates of hospital beds in the several States shows utilization to be lowest where accommodations and services are least adequately provided. This fact becomes obvious if one will compare figures 6 and 7 with figure 8. Occupancy when related

to sources of financial support, shows how apparent it is that lack of funds on the part of patients to purchase care interferes with the optimum use of hospital beds. In support of this statement the following data are presented:

Percentage of hospital income from patients:	Percentage occupancy
0- 0	75
10- 40	62
50- 80	57
90-100	49

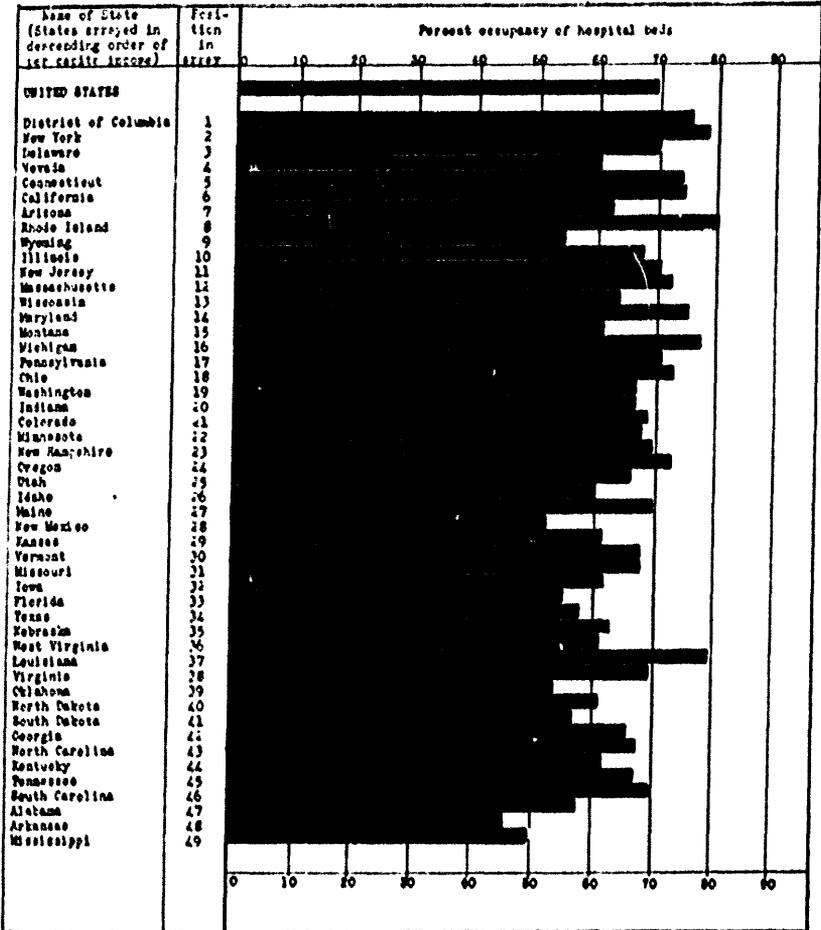


FIGURE 8.—Percent occupancy of beds in general hospitals.

It should be explained that optimum use of general hospital beds is roughly equivalent to 85 percent of the available bed-days computed on an annual basis. In hospitals of less than 25 beds it is seldom possible to attain such a degree of use while providing for proper segregation of patients according to disease, age, sex, and other characteristics. Furthermore it is always advisable to set apart a few beds to meet emergency demands. Apropos of this point attention may be called to the fact that about 25 percent of registered hospitals contain less than 25 beds, and about 50 percent of them contain less than 50 beds. The proportion of very small hospitals in the nonregistered class is considerably higher.

Self-evident, though often overlooked, is the fact that mere presence of a hospital in a county or one adjoining may have little meaning to underprivileged people unless funds for meeting the costs of service are assured. For the country as a whole hospital sponsorship gives a rough indication of the amount of service that is likely to be obtained by persons of low income or without means. Governmental hospitals, as one might expect, are supported mainly through taxation; on the other hand, fees collected directly from patients furnish 70 percent of the income for nonprofit hospitals, and for the proprietary group, more than 90 percent. Endowments produce about 6 percent of the income for nonprofit hospitals and they obtain in gifts an amount of perhaps the same magnitude, but income from these sources is negligible for the proprietary group. Payments made by governments to nonprofit and proprietary hospitals for the care of public charges are larger than the total of all private gifts. Thus, one may observe that most of the free and part-pay service of voluntary hospitals must be accomplished by passing the costs on to patients who, through payment of overcharges, create the necessary reserve. Individual hospitals, particularly in large cities, may constitute an exception to this general rule.

The total per capita payments to hospitals becomes progressively less as the States fall lower in per capita income (fig. 9). The upper limit is expressed

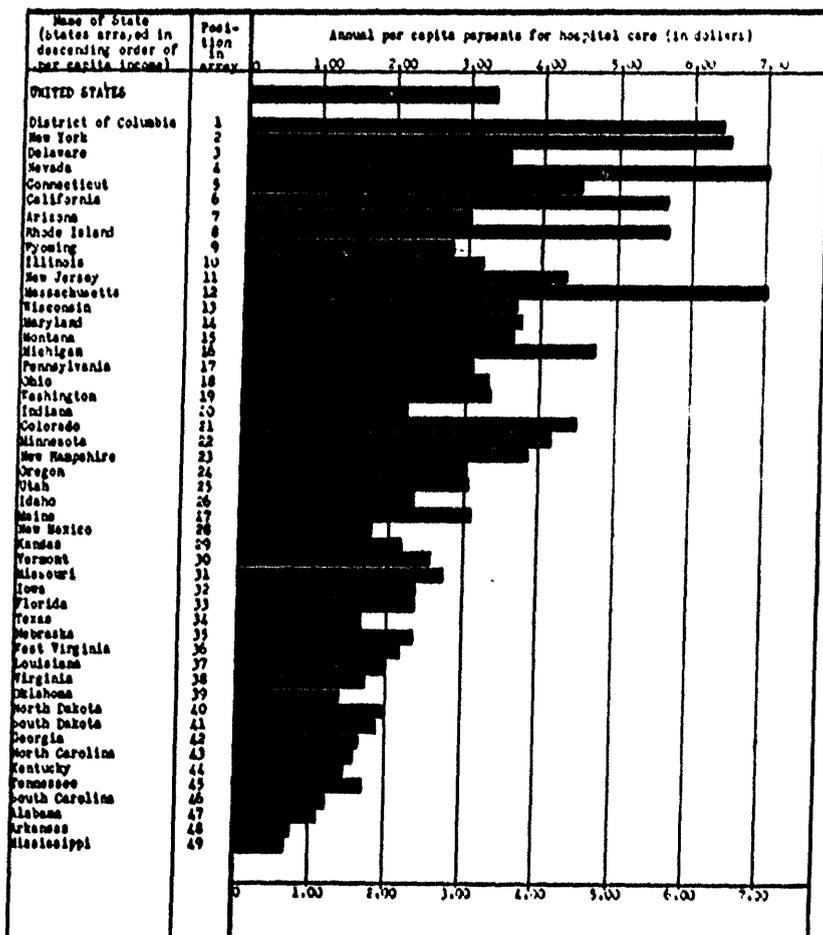


FIGURE 9.—Annual per capita payments for care in general hospitals.

by \$7.05 per capita per annum and the lowest 67 cents. It can readily be appreciated that the latter amount will not defray the cost of a reasonable amount of hospital care.

Upon examination of sources of income as reported by hospitals in the several States, one finds that an increasing proportion of hospital income is contributed by patients as the economic position of the States fall lower in the income array (fig. 10).

In proportion to their ability to meet hospital costs, persons residing in the low-income States assume a share of the burden comparable to that of the

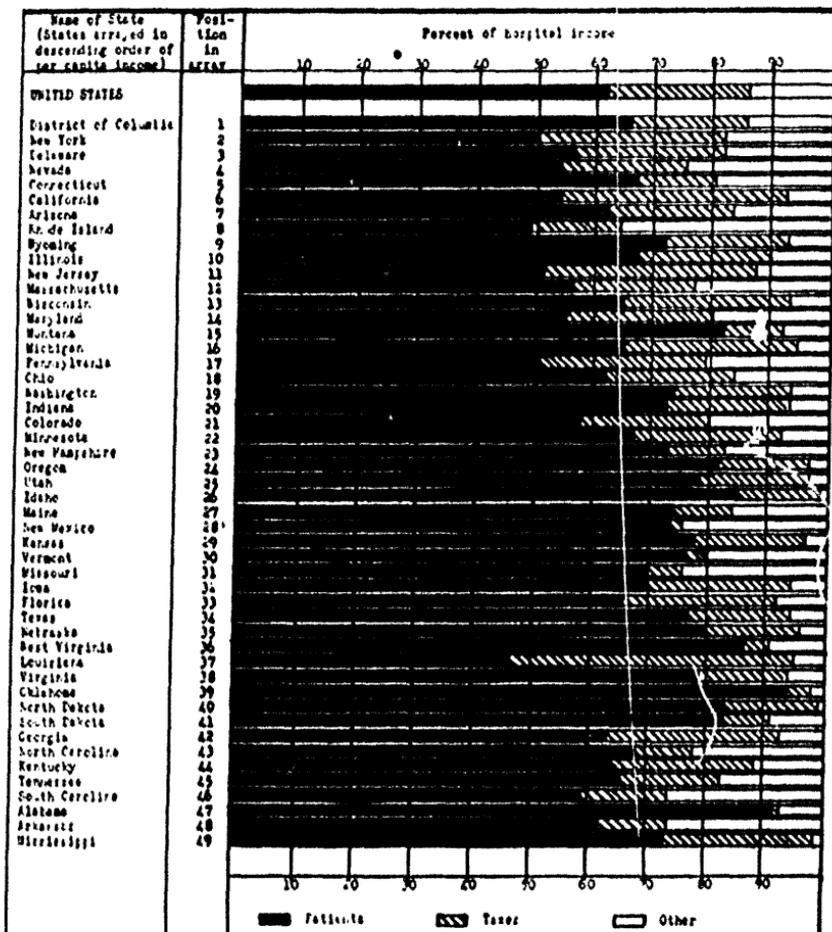


FIGURE 10.—Percentage distribution of general hospital income according to source of funds.

wealthier States (fig. 11). Thus it would seem that varying degrees of appreciation of the value of hospital care do not account for differences in hospital facilities or their utilization in the several States.

Since the demand for service in general hospitals is conditioned so largely by ability of patients to pay, local experience with respect to use may not always be taken as a reliable measure of need. This is particularly true of rural areas since there so large a percentage of the beds are supported by fees from patients. Despite the financial restrictions which now limit hospital utilization, 72,000,000 people residing in areas adjacent to hospital centers have

seen fit to establish average facilities approaching the standard of adequacy so frequently set by professional judgment, namely, 4.5 hospital beds for 1,000 population. To bring all State averages up to 4.5 will require the addition of 180,000 beds. Some of these beds would be added to existing hospitals, but most of them would call for new units to be located in areas now without hospitals or having hospitals whose physical or financial deficiencies preclude their becoming true community institutions.

Most discussions concerning hospitals tend to emphasize beds and their use, often disregarding entirely other resources which should be utilized. Ambu-

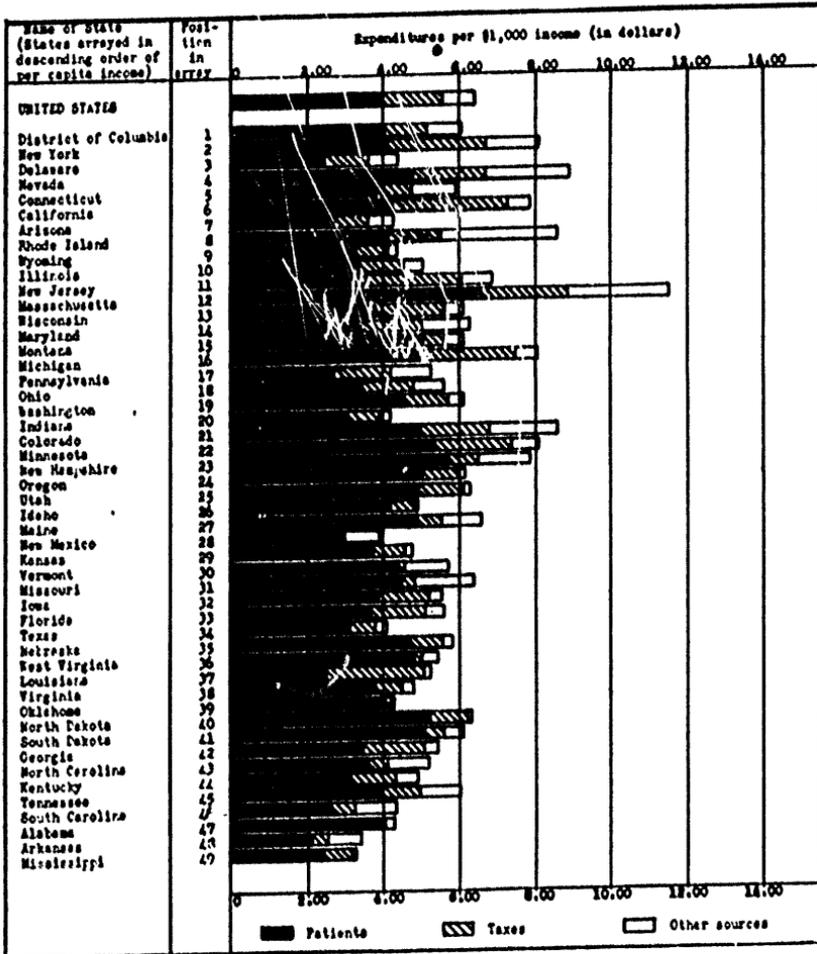


FIGURE 11.—Expenditures per \$1,000 income within State for care in general hospitals.

latory patients would profit by a access to the superior equipment for diagnosis and treatment that most hospitals afford. These facilities should be available for use by practicing physicians and public health agencies of the area. Second only in importance to its clinical facilities is the educational influence which the hospital might exert. In other words the hospital should be the health center of the community. It is to bring about larger and more varied uses of hospital facilities, than is the case at present, that the National Health Program proposes payments from tax funds for care in existing institutions and construction of new units where needed.

UNITED STATES PUBLIC HEALTH SERVICE,
Washington, August 2, 1939.

Hon. JAMES E. MURRAY,
Chairman, Subcommittee of Senate Committee on
Education and Labor, Washington, D. C.

MY DEAR SENATOR: I appreciate your courtesy in making available the enclosed manuscript entitled "A Criticism of the National Health Survey," prepared by the Bureau of Medical Economics of the American Medical Association.

There is transmitted also a copy of a memorandum prepared by the staff of the Division of Public Health Methods of the National Institute of Health discussing these criticisms. If these documents are made a part of the record of the hearings on S. 1620, we would appreciate receiving a page proof of both memoranda so that page references appearing in the Public Health Service memorandum may be checked against the American Medical Association memorandum.

Very sincerely yours,

THOMAS PARRAN, *Surgeon General.*

MEMORANDUM¹ RELATIVE TO A STATEMENT SUBMITTED TO THE SUBCOMMITTEE BY THE BUREAU OF MEDICAL ECONOMICS OF THE AMERICAN MEDICAL ASSOCIATION, ENTITLED "A CRITICISM OF THE NATIONAL HEALTH SURVEY"

The National Health Survey, conducted by the United States Public Health Service in 1935-36 was a logical outgrowth of a series of sickness surveys made by the Service to supplement available information on sickness and medical care. Such studies have been necessary because of the limited nature of routinely collected data in this field. For instance, local, State, and Federal agencies collect facts principally on births, deaths, and a restricted list of incompletely reported communicable diseases. On the frequency of accidents and disabilities resulting therefrom, only approximate estimates based on records of insurance companies, workmen's compensation commissions, and industrial and safety organizations have been available. As to the provisions of medical care, records of doctors, hospitals, and health agencies lack the uniformity and centralization necessary for statistical comparisons and cannot be expressed in terms of a general population group. Since physicians usually do not know of the existence of illness which they do not treat, any adequate picture of care received in relation to needs can be obtained only through family reporting.

These facts had been recognized prior to 1935, and field studies of sickness and medical care had been made by the Public Health Service so far as funds had permitted; but it had not been possible to do so on a large enough scale for them to be generally representative, especially with respect to disabilities of relatively long duration. Hence, the Public Health Service welcomed the opportunity of utilizing funds from the Works Progress Administration for a more extended survey, which would nonetheless be based on the rigorous technical principles already developed and proved. It was realized at the outset that the undertaking was a difficult one and that the results, in this as in previous surveys, would in some directions be necessarily approximate. However, it cannot be emphasized too strongly that only studies getting information direct from the family can give a comprehensive picture of sickness and medical care in relation to their social and economic setting—which was the broad purpose of the National Health Survey. To make this difficult undertaking a success, the Public Health Service put back of it its accumulated experience in field sickness surveys and the services of its scientifically trained personnel. Schedules and instructions were not innovations, but followed the established techniques of previous surveys. All stages of this extensive study² were carried out with the necessary scientific accuracy.

¹ From the Division of Public Health Methods, National Institute of Health. Prepared by direction of the Surgeon General.

² Since reference to the cost of the project has been made in the American Medical Association statement (p. 468), it may be advisable to give summary figures of expenditures up to the present time. For the National Health Inventory as a whole (including the National Health Survey, the Hearing Study, the Communicable Disease Study, the Health Facilities Study, and the Occupational Morbidity and Mortality Study) the total expenditures from Works Progress Administration funds have amounted to \$1,600,000. For the National Health Survey proper, the total expenditure has been \$3,000,000. It should be said that the inventory has been carried out through the

In view of the description of the Survey included in the American Medical Association statement and the many publications issued covering various aspects of the Survey,³ no description of the the scope, magnitude, or results will be attempted in this memorandum. Instead it is proposed to discuss specifically some of the points raised in the statement from the American Medical Association.

Perhaps the first point of importance is the question of the representativeness of the urban sample surveyed. As the American Medical Association statement indicates (p. 471), and as shown in Health Survey reports, persons living in cities under 25,000 were somewhat underrepresented. This fact was anticipated when the cities to be surveyed were selected, but there was no necessity of extending the study to the very large number of small places necessary to avoid it, since comparisons could be made by size of city in cases where the difference proved to be of consequence. Such procedure has been followed. For instance, it is recognized that the size of a community is an important factor in the nature of medical services received; hence, most of the data made available on this subject have been classified by size of city.

Comparisons by age, sex, color, size of family, and family income have been made between the population of the health survey (urban) and other data, particularly that of the United States census. Although certain discrepancies have been noted (as pointed out in Bulletin E, Population Series, and in the Scope and method paper above referred to), they have not been found to be sufficiently serious to invalidate any illness or medical care comparisons.

The comment is made in the American Medical Association statement (pp. 470 and 474) that the conclusions are published as applying to the entire United States although the data are from an urban survey. In most of the bulletins so far issued, the data are given as applying to the urban area only. The study was extended to 23 rural counties in 8 States, but the population has not been regarded as sufficiently representative of rural areas in general for these results to be combined with the urban data. Special studies of the rural material are in progress. In one bulletin an estimate was made of the number of persons unable to work or pursue usual activities on an average winter day. Although this estimate was based on a percentage of 4.5 found in the urban survey, it should be stated that the corresponding rate found in the rural survey was 4.4. In certain other bulletins estimates for the entire country were used as a first approximation, with an indication, however, that they were based on data obtained in urban areas.

Question is raised in the American Medical Association statement as to the qualifications of the personnel employed in the health survey. The survey was planned and directed by officials of the Public Health Survey who had had thorough professional experience in the making and analyzing of the results of field sickness surveys. Supervisors of the field work and later of the coding and tabulating were chosen by the Public Health Service purely on the basis of their administrative and technical ability and experience. The enumerators were carefully selected by examination and in the opinion of those in charge qualified to do the work assigned to them, which was that of recording conscientiously the information given them by the family. They were provided with written instructions and were carefully trained and supervised. With respect to the point raised on page 469 of the American Medical Association statement (i. e., the ability of an enumerator to determine whether an illness was present on the day of the visit) it should be stated that the enumerator was not directed to determine whether illness was present or to diagnose it. Similar to the taker of the census, he was a recorder of information given him by the family informant.

The American Medical Association statement (pp. 469, 473, and 474), raises a question as to the ability of the person interviewed to report accurately the illnesses which has disabled any member of the family for a week or longer during the 12 months immediately preceding the visit. The informant was a responsible member of the household (usually the wife or mother), and

National Institute of Health, under which come the Division of Public Health Methods and the Division of Industrial Hygiene; but this statement is limited to a description of the National Health Survey itself.

³ See especially: *The National Health Survey; Scope and Method of a Nation-wide Census of Sickness in Relation to its Social and Economic Setting.* By George St. J. Perrott, Clark Tibbitts, and Rollo H. Britten. Public Health Reports, September 1939.

in a better position to report the existence of illness in the family than anyone else. This method has been employed successfully in previous surveys.

It is known, of course, that there is a tendency for the informant to forget illnesses of relatively short duration. It was because of this fact that information was not requested on terminated cases disabling for less than a week (unless they were hospital cases, confinements, or fatal cases). However, a considerable number of illnesses disabling for more than a week (both attended and nonattended by physicians in about the same proportion) are also known to have been forgotten; thus, it is believed that the frequency rates of illnesses disabling for a week or more in the health-survey reports are a minimum statement.

This belief is evidently contrary to that held by the authors of the American Medical Association statement (pp. 470, 471, and 474), but is supported by a comparison with figures from a survey made by the Public Health Service in cooperation with the committee on the costs of medical care (when adjustment is made to bring about conformity with the definitions of the health survey). Furthermore, the suggestion that individuals often use illness as an excuse for absence from work seems entirely inconsistent with the known fact that sick persons frequently are compelled for financial reasons to remain at work.

In the case of rates of prevalence of disabling illness on the day of the visit, the higher rates in the survey than those in previous studies are partly due to improved techniques, partly to the fact that the national health survey was made in the winter months, partly to the inclusion of disabling types of illness not included as such in earlier surveys. It would not appear that an "unreal standard of illness" or the absence of data for rural communities⁴ can be regarded as explaining the difference between the prevalence rates of this and previous surveys.

In connection with a discussion of verification by physicians of family reports of diagnoses, the question is raised in the American Medical Association statement (p. 473) as to whether the family reports of diagnoses for cases on which physicians' statements were not received corresponded to those for cases on which such statements were received. A comparison of these two groups of cases has been made⁵ and a close agreement found, as will be shown in later reports.

Other comments in the American Medical Association statement bearing on the measures of illness used in the survey do not require detailed discussion, but some of them are listed below with such remarks as seem necessary.

Page 471: "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." (Effect of standard always kept in mind in setting up survey and in analyzing results; reports specifically indicate measures of illness used.)

Page 471: "The indefiniteness and inaccuracy of such a definition [continuous period of sickness] scarcely needs comment." (Continuous period established to avoid counting two diagnoses of a single illness as two separate illnesses; illnesses actually included only if disabling.)

Page 471: "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." (The true definition of disabling illness will be found on p. 469 of the American Medical Association statement; hospital cases, confinements, and fatal cases of less than 7 days' duration of disability included because of their obvious severity—the rate of such cases was 4 per thousand persons, out of a total rate of 171, or 2 percent.)

Page 471: "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." (These cases, of course, are not included in frequency rate of disabling illness during the 12-month period immediately preceding the visit.)

Page 474: "How great an influence did the standard of illness used in the National Health Survey have on the illness data recorded? If a real

⁴ See American Medical Association statement, p. 471, and preceding discussion in the text of this memorandum.

⁵ For illnesses disabling for a week or longer over the 12 months preceding the day of the visit (sole or primary diagnoses; including hospital cases, confinement and fatal cases, of whatever duration).

medical measure of illness were used as a standard, how much would the reported prevalence, frequency, and severity of illness be changed?" (Standard of illness obviously has a primary influence on rates recorded, as is recognized in the reports; no suggestion is made in the American Medical Association statement as to what is meant by "real medical measure of illness.")

The question is raised in the American Medical Association statement (p. 472) as to the measure of physician's care used in the health survey. At the time Bulletin No. 2, Sickness and Medical Care Series, was issued, data were not available which would permit determining the proportion of disabling illnesses⁶ receiving any medical care (i. e., physician's care at home, in the office, at a clinic, including out-patient departments, or in a hospital). The figures used in that preliminary report related, therefore, to care by doctors outside of hospitals. More recently, data have become available on the proportion of disabling illnesses⁷ which received any medical care, and the figures are being included in a revision of the preliminary report. For the information of the subcommittee, such percentages are given below for the different income groups.

Annual family income and percentage of cases receiving any medical care

	Percent
All incomes.....	81
Relief.....	70
Nonrelief:	
Under \$1,000.....	70
\$1,000 to \$1,500.....	81
\$1,500 to \$2,000.....	83
\$2,000 to \$3,000.....	85
\$3,000 to \$5,000.....	87
\$5,000 and over.....	89

A further point is raised as to out-patient departments of hospitals (p. 472) of American Medical Association statement). It may be said that the term "physician's care," as used in preliminary health-survey reports, includes that given in out-patient departments, as well as in other clinics.

The American Medical Association statement (p. 471) asks whether the health-survey prevalence statistics are not misleading if the figures include chronic diseases and impairments which do not require medical care. However, such rates indicate the proportion of persons who were unable to work or pursue usual activities on the day of the visit. The point is to be made that, although prevalence figures (which represent a cross-section at a given instant of time) are heavily weighted by the type of case referred to, the data presented on medical care in the health-survey reports have been based, not on prevalent cases, but on illnesses disabling for a week or more over a period of 12 months.⁸

As indicated in the American Medical Association statement (p. 472), it is desirable to compare the number of physician's calls among persons in each income group for the same type of illness, and further analyses are now in progress which will make this differentiation.⁹ However, since a larger number of calls are required for serious and prolonged than for mild and brief illnesses (American Medical Association statement, p. 472), and since the average duration of disability per case is greater in the low-income groups, the deficiency of medical service in such groups is really more marked than is indicated by figures merely showing the proportion of disabling illnesses receiving medical care.

The National Institute of Health, of course, has recognized that no standards of adequacy of medical care are available from data obtained in the National Health Survey. As the American Medical Association statement indicates (p. 474) comparison of the relative amounts of medical care received in the

⁶ Illnesses disabling for a week or more during the 12 months immediately preceding the visit.

⁷ Illnesses disabling for a week or more during the 12 months immediately preceding the visit.

⁸ It may be said that of the total frequency of the latter type of illnesses (171 per thousand persons) less than 2 percent were due to gross impairments (orthopedic, blindness, deafness). Even for the illnesses not attended by a doctor, less than 4 percent were due to gross impairments.

⁹ It might be said that for pneumonia (see Bulletin No. 11, Sickness and Medical Care Series) there were 8.1 doctor's home calls per home case in the relief group and 10.2 in the nonrelief group under \$1,000, as against 15.2 in the group with incomes above \$5,000.

different income groups has been used as a rough measure of adequacy in the absence of any better criterion. No doubt some persons in each income group did not choose to seek medical care (see American Medical Association statement, p. 474); but that fact does not militate against the income comparisons as a rough measure of need.

This memorandum has been prepared to answer in the briefest form possible the major points raised in the American Medical Association's statement. Further details would clarify the scientific basis of field sickness surveys such as that under discussion; but it is believed that the reports of results obtained in the National Health Survey are complete enough in themselves to make a more elaborate statement unnecessary.

STATEMENT OF ARTHUR J. ALTMAYER, CHAIRMAN, SOCIAL SECURITY BOARD, WASHINGTON, D. C.

Mr. ALTMAYER. I want to say, Mr. Chairman, that I feel as though I am bringing coals to Newcastle to come before this committee after the weeks that you have already spent on this subject, because I am not a technician in the field of health. I have had experience in the administration of labor legislation, particularly workmen's compensation, which has some medical features. I had an opportunity some twenty-odd years ago to make a survey of health-insurance movement, which was quite a live issue at that time, and during the intervening years I have had great interest in the problem of bringing more adequate medical care to our people.

If I may, I would like to read a statement, and if you wish to interrupt me at any time to ask questions, I will be glad to have you do so.

Senator MURRAY. You may proceed.

Mr. ALTMAYER. The Social Security Board, as you know, is charged by law with broad responsibilities to administer provisions designed to safeguard and advance the economic and social security of the people of the United States. Furthermore, the Board is charged by law—section 702 of the Social Security Act—with—

• • • the duty of studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age pensions, unemployment compensation, accident compensation, and related subjects.

In fulfillment of these duties, the Board has engaged in studies dealing with methods of enhancing security against sickness and disability.

I have been a member of the Interdepartmental Committee to Coordinate Health and Welfare Activities since its creation by the President in August 1935. It was this committee which, through its Technical Committee on Medical Care, developed the National Health Program which Senator Wagner's bill (S. 1620) proposes to implement.

In its report on proposed changes in the Social Security Act, which was transmitted to the Congress with the President's message of January 16, 1939, the Social Security Board made the following statement:

The Board is of the opinion that the enactment of the National Health Program would not only result in meeting more adequately the needs of those now receiving aid under the Social Security Act, but would also have a material effect in reducing the future cost of public assistance under the act.

Thus, the Social Security Board has already endorsed the principal objectives proposed in S. 1620. The Board is of the opinion that there is definite need for the expansion of the programs now provided for in titles V, parts 1 and 2, and VI of the Social Security Act, and, in addition, need for Federal grants-in-aid for the construction and temporary maintenance of hospitals, health centers, and related facilities, and for the development of State programs of medical care and of temporary disability compensation.

The Board is not expressing an opinion as to the rapidity with which this program should be put into effect. It does believe that there is immediate need for strengthening the administrative machinery that would be necessary both at the Federal and State levels as a prerequisite to the successful operation of any such expanded program as is contemplated by this bill. In that respect, we are in full accord with the statement just made by Dr. Parran.

S. 1620 proposes to amend title V of the Social Security Act, administered by the Chief of the Children's Bureau, and title VI, administered by the Surgeon General of the Public Health Service. In addition, it proposes to amend the Social Security Act by addition of three new titles: Title XII, to be administered by the Surgeon General of the Public Health Service; and titles XIII and XIV, to be administered by the Social Security Board. I address my remarks to the provisions of these two last titles.

TITLE XIII

General provisions of title XIII.—Title XIII provides for Federal grants-in-aid to the States for extending and improving medical care, including the training of personnel, under State plans approved by the Social Security Board.

Broad responsibilities left to the States.—The bill does not specify the details of a State plan to effectuate the purposes of this title, beyond the eight requirements laid down in section 1303 (a). It leaves to the States the complete responsibility for determining such fundamental matters as the persons to be served under the plan, the type and volume of medical services to be provided, the manner in which the plan is to be financed, the manner in which those who provide the service are to be reimbursed, and so forth. The only limitations in these respects are the provisions in section 1301 that the authorized appropriations are especially intended for the extension and improvement of medical care in rural areas and among individuals suffering from severe economic distress. These provisions are justified by the evidence that the inadequacies of medical care are especially great in rural areas and among persons in underprivileged circumstances.

The provisions of title XIII seem adequately broad and flexible to meet the needs of the several States, and to allow each State to develop the type of program best suited to its requirements. It seems proper that this title contain no specific criteria with respect to the type of program that a State develops, recognizing the diverse needs of the several States and the differences in existing facilities, customs, and practices.

There is nothing in title XIII limiting a State program to any special groups in the population, except that section 1301 indicates

the special applicability to rural areas and to individuals suffering from severe economic distress.

Senator MURRAY. There is great justification for that, Doctor, is there not?

Mr. ALTMAYER. Yes.

Senator MURRAY. In the drought areas of the country, which have suffered very severely as a result of medical care and attention being impossible for them to reach.

Mr. ALTMAYER. Yes. And it is interesting to note that in the Dakotas, and elsewhere, where there has been economic distress, there has been a development in providing systematic medical care under cooperative arrangements. That has been encouraged by the Farm Security Administration and is developed in cooperation with the medical societies of the States.

Under this title it would be possible for a State to develop a program limited to needy persons, or one that included the needy and those on the border line, or one that was developed for persons who are self-supporting in regard to other essentials of living but whose medical care is inadequate, with or without inclusion of the needy group. This appears to be sound; the Board is of the opinion that it is wise for Federal legislation proposing grants-in-aid to the States to leave such decisions to the several States which enter into a cooperative program with the Federal Government. The reasons for this opinion become evident from an examination of unmet needs and the diversity of conditions in the States.

Unmet needs for medical care.—First, we may consider the circumstances of those people who are in the least-favored economic groups. There are at least 40,000,000, and closer to 50,000,000, needy and border-line persons in the United States. Our latest estimates show that in 1935-36 about 48,500,000 persons were in families with less than \$800 a year annual income. More than 21,000,000 persons are in families dependent in whole or in part on Federal, State, or local governments for food and shelter, and they are likewise in whole or in part dependent on public aid or private philanthropy for medical care in sickness. Another group of about 20,000,000 or more persons—depending on the income limit selected—includes self-sustaining families of the marginal income class above the relief group who can purchase essential medical services only at the risk of curtailing food, clothing, shelter, and other essentials to health and decency; these also are aided, in greater or lesser measure, by public medical services or private medical charity.

Senator MURRAY. How are those who are absolutely dependent on outside aid for shelter and food, and so forth, getting medical care and attention now?

Mr. ALTMAYER. In various ways. It is left entirely to the local responsibility now. In some places they get their care from a private practitioner who receives no direct compensation, or who send his bill to a public authority, and there may or may not be an arrangement as to the fee that he will charge. In some places they have full-time doctors who do most of the work. It varies with the desires of the local community.

Senator MURRAY. But the medical care and attention which they get is not adequate?

Mr. **ALTMAYER**. No, sir; it is very decidedly not adequate. Neither among the needy nor in what you might call this supermarginal group of 20,000,000—I think all of the surveys that have been made indicate an appalling lack of proper medical care. At the health conference last July, that question was covered—the needs were covered and the question was asked by Under Secretary Wilson, who was presiding, whether anybody wanted to take exception to the picture of unmet needs, and no one there undertook to raise a single question. I think the fact has been demonstrated by decades of research, and to that extent this is really just summarizing very briefly the high lights.

Comprehensive surveys have shown that the poor are ill more often than the well to do, and that their illnesses or disabilities last longer. In the white urban population canvassed in the national health survey, for example, the frequency rate of more serious illness was 238 per 1,000 persons in the relief group, and 146 per 1,000 persons in families with incomes of \$3,000 or more. The extent to which the illnesses of the poor are more severe than those of the well to do is indicated by the fact that persons in the relief group included in this survey were incapacitated on the average 16 days per year, as contrasted with an average of 7 days of incapacity among those with incomes of \$3,000 and more.

In other words, they were sick more often, and when they were sick they were sick longer, and these statistics are gathered in such quantity and in such extent that the population and the geography of this country shows that there can be no question as to the direct relationship between income and morbidity.

Senator **ELLENDER**. Do they suffer from about the same illnesses?

Mr. **ALTMAYER**. I don't know about that. We have the figures, but I do not recall just what they show.

The receipt of medical care is also associated with income, the poor generally receiving the least service. Not only morbidity, but the amount of medical care and the kind of medical care is associated with the income. Although the poor are ill more often than the rich and though their illnesses last longer, fewer of their illnesses are attended by physicians, and those illnesses that are attended receive considerably less care than the illnesses of those with higher incomes. The national health survey found that in large cities 67 percent of the disabling illnesses occurring among the relief population were attended by a physician, as contrasted with 81 percent among families with incomes of \$5,000 and over; the difference in medium-sized cities was as between 69 and 81 percent; in small cities as between 65 and 78 percent. Of the disabling illnesses that received the care of a physician, those occurring among the relief population had, on the average, six or seven calls per case, as contrasted with nine calls per case among persons in families with incomes of \$5,000 or more. Although illness lasted longer among the lower-income group, there were fewer calls per case than among the higher-income group.

These and similar facts discovered by the national health survey conducted in the winter of 1935-36 applied during a period of economic depression. However, substantially the same picture had previously been found to apply in years of "national prosperity." For example, careful studies were made in the years 1927-32, under

the direction of a nongovernmental committee of about 50 persons, a majority of whom were physicians, under the chairmanship of Dr. Ray Lyman Wilbur, president of Leland Stanford University, a past president of the American Medical Association, chairman of the association's council on medical education and hospitals, and Secretary of the Interior under President Hoover. This responsible committee found that in good times as well as in bad times sickness and disability are more frequent, and that professional attendance and the volume of services received are considerably less, among the poor than among the families in better circumstances. Numerous other studies and surveys, conducted by official and nonofficial bodies in many parts of the country have established these facts as being general and continuous. A large volume and variety of evidence on this point is reviewed in the report of the technical committee on medical care, which is already in the record of these hearings, and much more could be readily assembled if there were any necessity or advantage.

The 40 to 50 million needy and border-line persons make up about one-third or more of the population of the United States; they are members of families with annual incomes of less than about \$800. In general, the States having the highest proportions of citizens in these groups with inadequate medical services are the States with the least resources. A considerable volume of testimony has already been submitted to show the need for Federal aid in securing to this group of citizens their rights to health. The medical needs of this large group of the population can be met by a program of Federal-State cooperation providing the additional public funds necessary to support essential medical services.

Above the economic level of these millions of persons in the needy and border-line groups there are nearly as many more individuals (about 36,000,000 in 1935-36) with incomes between \$900 and \$1,500. Impartial studies show that grave deficiencies exist in their medical services. In fact, in many instances, the recipients of public assistance and those in the border-line groups are more adequately cared for than the self-supporting persons with low incomes. This low-income group, which may be self-supporting and independent for all other family needs, cannot afford the costs of necessary medical care, especially in expensive and protracted illnesses, when the care must be purchased individually at the time the service is needed. These people are not used to going to public authorities for aid, and their sense of pride prevents them from going to a physician and seeking free medical treatment. A similar problem, though of lesser severity, exists for persons in families with incomes up to at least \$3,000.

If it is assumed that families with annual incomes of more than \$3,000 should be able to pay for their medical needs even under the most adverse circumstances, and this may not be a strictly valid assumption, because I am sure that all of us know of men and women in those income groups that have had illnesses that put them on the rocks financially and which they were unable to finance. We still have the great mass of our population in need of provisions to help them meet the burdens of medical costs and receive the services they need. This is true because about 90 percent or more of the people of this country are in families with incomes of less than \$3,000 a year.

The relation between medical service and economic status has been very nicely summarized in chart XXIX, appearing on page 66 of the pamphlet entitled "Factual Data on Medical Economics" (1939), prepared by the bureau of medical economics, American Medical Association, and introduced in the record of these hearings by Dr. Leland on May 23, 1939. In that chart the medical services of the indigent are presented as "a community responsibility," and an income of more than \$3,000 is taken to indicate a reasonable amount above which a family may be assumed to be able to meet its medical needs. This chart further indicates that the families in the income classes between the indigent and the \$3,000 level are able to care for their medical needs in different degree, according not only to the amount of income but also to the seriousness of illness, its duration, and the type of medical attention required.

As the chart demonstrates, there are varying proportions of families in all income groups above the level of the indigent but below the \$3,000 income level that are unable to meet medical costs of various types. The importance of this point is evident when it is recalled that about 92.5 percent of our population are estimated to have been in families with incomes of less than \$3,000 in 1935-36, and about 75.4 percent to have been between the relief and the \$3,000 levels.

The chief cause of the inability of families to pay for their medical care is the unpredictable nature of illness and the irregularity with which it strikes. Many families could afford to pay a specified amount at regular intervals, during times of employment and good health, to take care of the medical costs that seem to come to families inevitably, but—with the many other immediate demands on a low income—they cannot budget individually against the variable and uncertain costs which sickness may bring.

Every substantial study of the subject shows that if medical care is to be made more effectively available to all families with small or modest incomes at costs they can afford, the costs must be spread among groups of people and over periods of time. Some arrangement must be worked out whereby individuals will make regular periodic contributions into a common fund out of which the costs of medical care will be defrayed for those who are sick.

The use of insurance to protect individuals against sickness costs is, as you know, an old and well-tested method. Voluntary insurance plans have been extensively developed, but they cover only a relatively small fraction of those in need of such protection. Even if we count all who are covered merely by hospital insurance or others protected in limited measure against medical needs, and if we include commercial and nonprofit insurance, student health services, private group clinics, cooperative consumer health associations, medical society plans, industrial medical service plans, the coverages of fraternal societies and those protected by the insurance arrangements developed by the Farm Security Administration, we can account for only about 5.4 to 6.0 million persons having some protection against medical costs through insurance. Compulsory insurance is at present limited in the United States to workmen's compensation.

I cannot leave this brief review of unmet needs without remarking on the inadequate utilization of physicians, dentists, nurses, hospitals, etc., who are available. The same group of studies which

reveals inadequate medical services for our people also show that we do not fully utilize the personnel and facilities available to furnish these services. And that is the tragedy of the whole thing.

Senator MURRAY. Some of the witnesses have claimed that that is due in large measure to lack of education on the part of the people, that many of them would not go and get the treatment or utilize these agencies even if they could get them.

Mr. ALTMAYER. I think there is some element of truth in that, but I do not think that that is the major reason. They would soon become educated if they knew that these facilities were available to them on a decent, self-respecting basis.

Senator MURRAY. And there is room for an educational program, too?

Mr. ALTMAYER. Oh, yes; indeed.

An economic barrier stands between those in need of the services and those able and willing to furnish them. The point has been repeatedly cited by previous witnesses who have, for example, referred to empty hospital beds in communities where there are citizens in need of hospital care. Under title XIII, States can develop plans to level that economic barrier by distributing costs among large groups of persons and over periods of time. Whether the States choose to do this through tax-supported services, through social insurance, or through a combination of the two, is a matter for them to decide. By one method or another, they could bring more adequate services to those in need of care and provide more substantial financial support for practitioners, hospitals, and other facilities able and willing to furnish care. I agree thoroughly with Dr. Parran in that respect, too

Senator MURRAY. You do not think that that would interfere in any manner with the status of the medical profession as it operates now?

Mr. ALTMAYER. I do not think so at all. I think that the medical profession has a right to be concerned over any plan for spreading the cost of medical care, that that should not be developed in such a way as to impair—

Senator MURRAY (interposing). In fact, it would benefit them financially, would it not?

Mr. ALTMAYER. Yes; financially, and I think professionally. I see no reason why the introduction of a systematic provision for spreading the cost of medical care should not only protect the services that we have now, the quality of the services that we have now, but should advance it. It all depends on how the thing is worked out. That is always the job of administration, to bring in the technical groups and to bring in the groups who are interested in the effect. Not only the consumers, but the producers. That is the only way that we can get proper administration, but all parties in interest have a right to express themselves and to help in the development of the administrative machinery and its working.

Senator MURRAY. Many of us would hesitate to do anything or approve of any bill that would in any manner break down the medical profession, and I think that the testimony that you are giving is important from the standpoint of wanting to protect the medical profession in every way from having their profession broken down.

If this could be done without necessarily interfering with the medical profession, but on the contrary benefiting it, I do not see any reason why it should not be done.

Mr. ALTMAYER. I think that the advent of workmen's compensation, for example, has benefited the medical profession. That is a form of compulsory health insurance, and I think there is a lot still to be done in improving the machinery of workmen's compensation, working out satisfactory arrangements, but I think that the medical profession would agree that over the 25 years that we have had workmen's compensation, they have benefited rather than suffered.

Approval of State plans: The bill provides in subsection (b) of section 1803 that the Board shall approve a State plan if it meets the eight conditions specified in subsection (a) of the same section. We are of the opinion that these specifications are sound and desirable, as necessary safeguards to assure that the Federal funds will be expended for the purposes for which they are appropriated.

In view of the confusion and misunderstanding that seems to have arisen, it may be desirable to add another provision making clear the intent of title XIII that the States may utilize, to the fullest extent compatible with standards of quality and economy of service, the services of nongovernmental hospitals, facilities, practitioners, and agencies.

Matching proportions.—In its report of December 30, 1938, to the President and the Congress, on proposed changes in the Social Security Act, the Board pointed out that grants for the three assistance programs which it now administers—and those are the old-age assistance, the blind assistance, and the aid to dependent children—are made on a fixed percentage basis which is uniform for all the States, regardless of the varying capacity among the States to bear their portion of the costs—one-third in the case of the children and one-half in the case of the aged and the blind. The Board expressed the opinion that it is essential to change the present system of uniform percentage grants to a system of variable grants varying with the relative economic capacity of the States. The considerations which lead to that recommendation apply with equal force to programs for health services and medical care. The Board has already endorsed the principle of variable matching proportions embodied in section 1101 (e) of S. 1620.

Some difficulty may arise because of the limits specified for the range of matching proportions. Subsection 1101 (e) limits the Federal grants-in-aid under title XIII to a maximum of 50 percent and a minimum of 10 $\frac{2}{3}$ percent. By contrast, the corresponding limits are specified as 60 $\frac{2}{3}$ and 33 $\frac{1}{3}$ percent for titles V, VI, and XII. Inasmuch as services developed under the several titles need to be intimately correlated in the States and localities, administrative difficulties may arise if there are financial advantages to a State to provide a service preferentially under one title or another. The committee may, therefore, wish to consider the advisability of using the same matching range in all titles.

Federal and State advisory councils.—The bill authorizes the establishment of Federal advisory councils by the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, and the Social Security Board (secs. 506, 510, 606, 1206, and 1306). It ap-

pears to the Board that the creation of several advisory councils to advise with respect to the Federal administration of closely related programs would have some disadvantages, and the committee may wish to consider the advantages to be gained by the establishment in their place of a single Federal advisory council, or a national health council, to be established jointly by the agencies charged with administration. The single council would be in a better position to safeguard the professional standards and advise on the proper provision of medical care than the several councils for which the bill provides. The existence of a single Federal advisory council (with as many subcouncils as may be necessary to deal with the special problems of particular subjects coming within the field of the entire council) would greatly reduce the likelihood of confused and complex administrative arrangements at both the Federal and the State levels. It would also make possible more advantageous working relationships among the several Federal agencies.

Each title in S. 1620 provides for the establishment of an advisory council or councils by the State administrative agency. This might mean the establishment in each State of separate councils to advise on maternal and child health, crippled children, other child-health programs, public health, hospitals and health centers, and on the general medical-care program under title XIII. The reasons which lead us to recommend a single advisory council at the Federal level apply with equal force at the State level. We recognize that in practice each State might create only a single council, but there may be an advantage in making provision to this effect in the bill. The committee may, therefore, wish to consider the advantages of requiring a single advisory council in each State, with advisory functions applicable to all State plans developed under this bill.

Consultation with State administrators.—This committee may wish to consider the advantages to be gained, in the development of sound Federal-State relations under S. 1620, if provision were made for joint consultation of the Federal administrative authorities with a conference of those officers of the States who are responsible for the administration of State plans, such consultation to be held prior to the issuance of rules and regulations applicable to the allotment and payment of funds to the States. I understand that a comparable provision in title VI of the Social Security Act has been useful in the development of cordial Federal-State relations and has been helpful in the administration of that title.

TITLE XIV

Title XIV of S. 1620 provides for Federal aid to State systems of temporary non-industrial-disability compensation. "For the purpose of assisting the States in the development, maintenance, and administration of plans of temporary disability compensation," it authorizes the appropriation of the sum of \$10,000,000 for the fiscal year ending June 30, 1940, and for each year thereafter a sum sufficient to carry out the purposes of the title. The sums so authorized are to be used for making payments to States which have submitted, and had approved by the Social Security Board, State plans for temporary disability compensation.

Disability as a cause of insecurity.—Before addressing myself directly to some specific provisions of this title, I should like to review briefly the nature and magnitude of disability as an economic and social risk.

We do not have, and cannot have, precise knowledge of the prevalence of disability, but we do have substantially reliable estimates. One of the best sources of data on the incidence of disability in the population of the United States, and to which I have already referred, is the national health survey conducted by the United States Public Health Service in 1935-36, and covering some 800,000 families embracing 2,800,000 persons in 19 States. According to preliminary reports from this survey, on an average day during the winter months approximately 4.5 percent of the total population—about 6,000,000 persons—are unable to work, attend school, or pursue other usual activities on account of illness, injury, or gross physical impairment resulting from disease, accident, congenital defects, mental disease, and so forth. When careful account is taken of the technical details, and of groups in institutions not covered by the survey, and use is made of additional sources of information, it is tentatively estimated that the total number of persons disabled on an average day of the year is probably nearer to 7,000,000. It is estimated that of these 7,000,000, approximately 3,600,000 are disabled from conditions which last less than 6 months, while 3,400,000 have disabilities which last more than 6 months, of whom 2,400,000 are suffering from disabilities lasting more than 1 year; in other words, there is a considerable proportion that are in the permanent disability class. These are tentative estimates based on studies which are still carrying on.

According to the national health survey, on an average day during the winter months, approximately 2.86 percent of all gainful workers of ages 15 to 64 are disabled. This would indicate an annual average of 8.6 days of disability per worker. There is reason to believe that this figure is somewhat low.

It is probable that in 1937 the total loss of earnings alone on account of disability exceeded \$1,000,000,000, without giving weight to the loss of earnings among workers who are permanently disabled and out of the labor market. In a year with less unemployment the loss would be appreciably greater.

Senator MURRAY. Is there a lesser degree of disability in the more favorable locations of the country; that is, where the climatic conditions are not so severe?

Mr. ALTMAYER. Oh, yes; and it varies with the economic conditions of the States. The States with the least per capita income have the greatest amount of sickness.

The need for disability insurance.—The need for insurance against wage loss from disability arises not so much from the average wage loss as from the uneven and unpredictable incidence of that loss. For example, if every worker were disabled for exactly 10 days a year and lost \$35 in pay on that account, and if he knew in advance that this loss would be incurred, there would be no particular problem except for those living entirely without ability to save and budget against such a need. But, unfortunately, disability does not come only in average amounts. The need for insurance arises from the fact that for the individual worker the occurrence of illness is not

predictable and that in any 1 year while most workers will suffer no loss or only a small loss of earnings on account of disability, a smaller but predictable proportion will be disabled for moderate or long periods and will lose substantial parts, or all, of the amounts they would otherwise have earned. Generally speaking, no particular worker can know in advance whether in any particular period of time he will be among the fortunate many or the unfortunate few.

Under the State systems of workmen's compensation the worker disabled from a work accident or injury is compensated and assured medical care. Under the State systems of unemployment compensation, the worker who becomes unemployed due to lack of work is provided with unemployment benefits to help tide him over till he can find work. However, the worker who becomes unemployed because of nonindustrial disability receives no benefits. The anomaly of this situation is especially brought out by the fact that if an unemployed worker becomes sick even while receiving unemployment benefits, further benefits are then refused him until he is again able to work, because under the State unemployment compensation laws unemployment benefits are payable only to a worker both "able" and "willing" to work. As an economic risk, temporary disability bears many analogies to unemployment, and the destitution which the one causes is as real as that created by the other.

Furthermore, now that we have old-age insurance, the need for insurance against permanent disability is becoming more apparent. A large proportion of all permanent disability cases occur at the older ages and may be considered as a form of premature old age. We have provided for annuities to workers at 65 and over because people of advanced age are generally no longer able to work. Incapacity from old age does not, however, come uniformly at age 65. Some are still able to work and earn at 70 and 75 or older; and that was a very interesting finding in the railroad industry, as you may recall. At the time that the railroad retirement bill was up, it was amazing to find the number of older railroad workers still in active service. Others become invalids at 60 or earlier. The same logic which impels us to provide old-age annuities at 65 would seem to indicate that we should provide for the needs of those who become permanently disabled at earlier ages.

Inadequacy of voluntary insurance.—To afford protection against the risk of disability, both temporary and permanent, a considerable amount of what may be called voluntary disability insurance has been developed in this country. The Social Security Board has made a study of the extent and character of such disability insurance. This study showed that the total amount of benefit, paid out under voluntary disability insurance during 1935 amounted to approximately \$200,000,000, the greater part of which went to persons in moderate or well-to-do circumstances, rather than to wage earners with small earnings. Benefit payments under the types of insurance generally held by wage earners aggregated less than \$68,000,000 a year. These estimated totals may be compared with the estimated wage loss among gainfully occupied persons of over \$1,000,000,000 a year. It is estimated that less than 8,000,000 wage earners possess any form of insurance against temporary disability, and that in most instances the protection is quite inadequate. Apparently some 20,000,000 wage earners possess some form of insurance against per-

manent disability, but in the case of 15,000,000 of these, principally covered by industrial insurance policies, the insurance is small in value and offers protection only against comparatively rare dismemberments and blindness and cannot be considered as giving anything approaching adequate protection against the risk of disability. At present the vast majority of employed persons have no substantial protection against the hazard of wage loss from disability, and there is little basis for believing that the situation in the future will be fundamentally altered unless appropriate governmental action is taken. If adequate protection against the risk of disability is to be developed, the insurance must be made obligatory, as we have already done in protecting workers and their families against unemployment and old age.

Difference between temporary and permanent disability.—In approaching the task of formulating suitable insurance measures against disability we must recognize at the outset that the risk of disability is not a single undifferentiated whole, but that there are two types of disability having such different characteristics and consequences as to require two separate, though coordinated, systems of insurance. For insurance purposes, disability is divided between that which is temporary and that which is more or less permanent, though the dividing line is not always sharp.

Although some of the problems in insuring against these two types of disability are similar, others are quite different. The administration of benefits in temporary disability requires certification by a physician at frequent intervals as to the existence of the disability, just as in the case of workmen's compensation. In permanent disability the determination of incapacity for work may be made either once and for all or only at infrequent intervals. In the case of temporary disability the presumption is that the individual will shortly return to work, and the benefit should, therefore, be designed to tide him over the temporary period of unemployment caused by the disability. In the case of permanent disability the disabled worker, like the aged person, withdraws permanently from the labor market. It would seem, therefore, that the benefits which such workers would receive—that is, these permanently disabled people—should be geared to those which would be payable under the Federal old-age insurance system to similar persons retiring on account of old age.

As regards temporary disability compensation, the Board believes that this can be placed on a State basis following the precedent of unemployment compensation.

There are various methods by which the Federal Government may assist the States in developing programs of temporary disability compensation. The grant-in-aid pattern followed in title XIV of S. 1020 involves an additional cost to the Federal Government not covered by additional revenue. The chief alternative is the levy of a Federal pay-roll tax against which an off-set would be allowed for contributions made under a State disability compensation law.

State programs are practicable.

I do not wish to take the time of the committee to discuss the details of possible characteristics of State systems of temporary disability compensation. We have studied this subject at considerable length, examining both domestic and foreign practices. I wish only to say that in our judgment it is practicable to work out the details

of such systems and that practicable programs can be developed under the provisions of title XIV. Our experience in the administration of unemployment compensation, and the experience of the States in the administration of workmen's compensation, indicates that while there are complex problems to be solved these are not insuperable. A sound and orderly development could be expected if S. 1620 were enacted.

I might say in that connection that President Green of the American Federation of Labor made a very interesting suggestion at the time of the health conference. As I recall, he suggested that a system of temporary disability, nonindustrial temporary disability compensation could be worked out with the administration of the workmen's compensation.

Consider in my own State of Wisconsin, for example, we have unemployment compensation and we have workmen's compensation administered by the same agency, the industrial commission. If there were temporary disability insurance, all that would need to be done would be to collect the additional tax along with the unemployment-compensation tax already collected, the same machinery, use the same reports of the employers, from the same pay roll, and so far as the administration of benefits were concerned, administer them along with the workmen's compensation law, so that in a State that does have that set-up, it would be quite simple to work out a temporary disability program, and other States could work out similar programs.

Senator MURRAY. It is 12 o'clock, so we will let you go.

Senator LA FOLLETTE. With your permission, I should like to have the record show that unfortunately I have been unable to attend several of the past meetings of this subcommittee, and I want to note that it is not any lack of interest on my part either in the subject matter or the witnesses who have appeared that has caused my absence, but I have unfortunately, as chairman of another subcommittee of this same committee, been required to hold hearings on another bill.

Senator MURRAY. As chairman of this subcommittee, I recognize those conditions, Senator. We know of your interest and know the help that you have been giving the committee, and we expect that you will be able to continue to help us as we go along. I am sure that you would be here if you were able to.

We will adjourn now until 1:30.

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

AFTERNOON SESSION

(The hearing was resumed at 1:30 p. m.)

Senator MURRAY. The committee will be in order.

The first witness this afternoon is Dr. Luther M. Dicus, representing the American Optometric Association.

Dr. DICUS. May we request that Dr. Leslie R. Burdette, the president of the American Optometric Association, precede Dr. Dicus in presenting his statement?

Senator MURRAY. Yes: we will take Dr. Burdette, then.

Dr. Burdette, you may state your name and address and the name of the organization that you represent.

**STATEMENT OF DR. LESLIE R. BURDETTE, PRESIDENT OF THE
AMERICAN OPTOMETRIC ASSOCIATION**

Dr. BURDETTE. My name is Leslie R. Burdette, of Salem, Oreg. I am the president of the American Optometric Association.

The American Optometric Association, of which I have the honor of being president, was organized 42 years ago. It has a membership of 6,812 licensed practicing optometrists. There are 17,188 optometrists licensed in the 48 States of the Union and in the District of Columbia.

The American Optometric Association is the national organization representing organized optometry. As in other professional organizations, there are local, county, district, and State societies. The individual optometrist joins his local organization, except in sparsely settled States, where he joins the State association directly. These State associations are affiliated with the national organization. In joining the State association, the individual optometrist automatically becomes a member of the national association. Each State association at annual convention elects delegates to the national convention. The national officers are elected and the policies of the organization are determined at the national convention. The forty-second congress will be held later this month, the week of June 25 in Los Angeles, Calif.

May I state at the very outset that the American Optometric Association is in complete accord with the underlying principles and objectives of the Wagner national-health bill. The following resolution confirms our position:

Whereas the President of the United States has stated that the underprivileged third of the population finds itself in such condition as to be deprived of the necessities of life, and since there exists the anomaly that although there are sufficient optometrists licensed to render optometric services, that this one-third is unable to avail themselves of those services because of unusual circumstances; and

Whereas the American Optometric Association is cognizant of this need: Now, therefore, be it

Resolved by the Fortieth Annual Congress of the American Optometric Association in convention assembled at the city of Rochester, N. Y., on June 30, 1937, That the American Optometric Association does hereby tender to the President of the United States, the Congress, the Surgeon General, and all other officers and constituted authorities its fullest cooperation in any plan whereby those persons who have been unable to avail themselves of the care and services of the profession of optometry may do so; and be it further

Resolved, That the American Optometric Association does hereby appoint a committee which awaits the invitation and which will be supported by all available resources of this association to cooperate in the formulation and execution of any such plan; and be it further

Resolved, That copies of these resolutions be forwarded to the President of the United States, Members of Congress, the Surgeon General of the United States, and all other officers and constituted authorities having to do with public health.

(This was printed in the Official Journal of the Association in the issue of August 1937.)

The principle enunciated at our Rochester convention is based on the realization by organized optometry that our country must blaze new trails in adequately providing for the health needs of the people. Many of the old signposts cannot point the proper direction under present-day conditions.

A century ago when industry was beginning to develop, when our system of public schools began to grow apace, the present-day need for correcting eye defects was practically nonexistent.

Today we must consider the countless inventions, within our own lifetime, which call for the near use of the human eye. We consider the books in the schools, the lathes in the shops, the typewriters in the offices, and many other devices, and we realize the extent to which the visual load has increased. Evidence of the serious prevalence of eye defects has been compiled.

In conformity with the resolution which I have just read, the committee on national affairs of the American Optometric Association was represented at the National Health Conference held in Washington last July. Subsequently our committee conferred with the technical committee of the interdepartmental committee. It was this technical committee that reported:

Thirty percent of all children under 15 years of age have defective vision due to refractive errors.

For a moment let us leave these chambers and enter the schoolroom, where this problem must be faced. Here is what school superintendents have to say:

To give a child a book to read and then not provide him with such aid to nature's gifts that will enable him to read it cannot be called a judicious procedure.

And a second one:

* * * much of the retardation in regular grades came through physical defects affecting vision, hearing, or both. Many children were unfairly classified because of their inability to follow normal instruction due to their physical defects.

And a third one, in referring to teaching deaf children lip reading, states the following:

Too frequently children of defective hearing have defective vision too, but have no glasses and no means of getting glasses. As reading lips is hard, very hard on the eyes because of the strained attention, children with poor eyesight do not become good lip readers. To teach "lip reading" to a child that cannot see the lips move is to engage in a struggle futile from the start * * *.

These assertions are substantiated in many studies. We present but two. A study in New York in '37 and '38 shows that of 42,500 children examined 8,500 had defects of vision. Another study was recently conducted in Philadelphia jointly by the American Medical Association and the National Education Association. They found on the basis of a survey of 200,000 children that 20 percent of the total likewise suffered from eye defects.

The Milbank Memorial Fund made a special study in rural areas and found that the percentage is even higher—26 percent.

These studies substantiate surveys which have been conducted over a long period of time by local and State optometric associations in various parts of the country.

Childhood is the most crucial period in life. We cannot afford to gamble with the health of the children of our Nation. The inevitable conclusion is that these defects must be corrected. We assert that the best possible community investment is the proper physical development of our children.

Let us visualize the future of these children as one must in any long-range program.

They leave school and enter industry or agriculture. Considering industry first we find that Mr. Matthew Woll, who spoke on behalf of the American Federation of Labor before your committee, said:

Surveys have pointed out repeatedly the need for more specialized care such as for eyes and teeth.

We will substantiate this statement with a few facts and figures. The United States Bureau of Mines in the survey of the Union Pacific Coal Co. in 1938 found that only a quarter of the employees of that company had normal vision and that 28 percent had major defects of vision sufficient to require correction. The United States Public Health Service has made a study of 10 different industrial group classifications and has found that the percentage with defective vision ranges from 15 to 20 percent in the cement, foundry, cigar, and pottery industries to 40 to 60 percent in post offices, gas, chemical, and garment industries.

A study of the American Engineering Council, in examinations of representative groups, gives the percentage of defective vision ranging up to 75 percent for garment and paper-box workers and finds 50 percent or more among commerce houses and miscellaneous factory workers.

Defective vision is an important cause of industrial accidents. It is definitely a matter of concern to the employer, the employee, the public, and the Government.

It is self-evident that a person who cannot see clearly and efficiently is not only a menace to himself but also to his coworkers.

We concur with the statement made in the Bulletin No. 205 of the National Society for the Prevention of Blindness, wherein it is stated:

Fatigue of the eyes is a principal factor in many industrial accidents.

Any program aimed at accident reductions must insure correction of all eye defects and of ensuing fatigue due to eye difficulties.

Some may think that the need for the correction of the refractive errors exists only in cities and in industries where close eye work occurs. However, numerous studies in rural areas among the agricultural population discloses similar conditions among this section of our people as well.

In the study of the Milbank Memorial Fund already referred to, the figures for defective vision in rural and agricultural areas are found to range from 22 percent in ages 15 to 29 up to 89 percent at the age of 60 or over. In a comparative study of impairments in the eye, in rural and urban areas it was found that uncorrected defective vision which was 37 percent in the rural areas was only slightly less than the range among professional, business, or trade workers, which is from 43 to 57 percent.

It is particularly significant that the frequency of actual eye examinations among farmers and farm laborers is definitely less in spite of their equal needs.

Continuing to trace the life span from infancy into adult and productive middle age, we find that a vast proportion of our population drive automobiles either for pleasure or business purposes. The investigations conducted by various State associations of optometrists

into the cause of automobile accidents establishes the fact that a large number of these accidents were due to defective vision. These findings were substantiated by further studies supported in part by the American Optometric Association. They were conducted under the auspices of the National Research Council, and published in a report titled "Prevalence of Visual Defects and Their Relation to Automobile Driving." Organized optometry in the respective States has been active in a campaign for the eye examination of motor-vehicle drivers and has succeeded in establishing the present standards of such eye examinations.

As people approach middle age, there is another rapid peak increase in defective vision. At about 45 years of age, almost everybody suffers from presbyopia, or old-sightedness. The accommodation of the eye loses its former elasticity and a visual defect arises which must be corrected to give one comfort in going about daily affairs.

Referring again to Public Health Report, Reprint No. 1404, we find that after 50 years of age the percentage of eye defects vary between 70 and 80 percent among professional, business, labor, and agricultural groups. Thus we find that commencing at the preschool age, the percentage of visual defects ranges from 15 percent in that period to 30 percent during the school age, between 40 and 50 percent up to 50 years of age, and thereafter a minimum of 80 percent.

Nothing beyond a recital of these figures is necessary to point out to the committee that a most urgent need exists. These conditions are not due to the lack of qualified ophthalmologists and optometrists, but primarily to the low economic status of the greater portion of our population, which causes them to forego the expert services available. In a report from the United States Department of Agriculture covering a survey of small cities in the Midwest, issued 2 weeks ago on May 18, it was reported that none of the families earning less than \$500 a year expended any money at all for eye care; and in the next class of income up to \$750, less than one-half of 1 percent of income was spent for eye care. Not until incomes were \$2,500 did the average amount spent per family for the year exceed \$1 for oculists' services. Low-income families consult dentists less frequently than physicians, and visits to the oculists usually are omitted entirely.

In reprint No. 1627 of the Public Health Reports we learn that eye examinations, like other medical care, are more frequent in the higher income groups. Dr. Conrad Berens in the work which he coauthored with others entitled "The Causes of Blindness in Children," in speaking of the sociological aspect of the situation, said that a study of the case records shows that, except where the ophthalmologists are undertaking the corrective work voluntarily, recommendations for operations are, in many cases, not being carried out.

The same situation exists with respect to refractions and the remedial eyeglasses so often required.

Mr. Chairman and Senators, up until this point I have presented material showing the widespread need for eye care of all types, the fact that these needs are unmet and the major reasons therefor. You have the right to expect that after bringing these facts to your attention our association should be prepared to offer a program to meet these needs.

Under title 10 of the present Social Security Act providing for grants to States for aid to the blind, some initial progress has been made with regard to the problem of conservation of vision. Although this section provides only for financial assistance to those whose vision is so poor as to be termed blind, it is desirable that a complete program for the eye care of such people be undertaken in connection with the expansion of the care which the present bill S. 1020 undertakes to provide.

The complete program for the conservation of vision of all the people resolves itself naturally into a consideration, firstly of the care of children.

Under title 5, parts 1 and 2, we recommend the determination and correction of all visual defects in preschool and school children. Such correction of visual handicaps becomes a major part of the problem of conservation of vision, and an important factor in the ultimate prevention of blindness.

Among infants and school children, we have certain definite special problems which include crossed eyes and other muscular defects. Another critical period precedes the entrance of the child to school. Every child should have his eyes examined before entering. These preschool examinations will be important to determine subsequent changes affecting eyes as the near point load progresses with increased study.

We recommend specifically that under the provisions of title 5 that projects be approved for the purpose of providing an annual eye examination for all school children. This should not be confused with the present inadequate eye survey with the Snellen chart now in vogue in many communities.

Under title 6, entitled "Public Health Work," the services of the profession of optometry can be utilized in industrial hygiene activities. The use of industrial goggles, proper illumination, proper distance from moving parts, and many other related questions are within the province of optometry to help solve.

The National Safety Council has estimated that no less than 200,000 industrial accidents result in injury to the eye every year. The cost to industry and the loss to the individual amounts to tremendous sums. There are extensive statistics showing that most important industries have a very high incidence of eye injuries, ranging up to 86½ percent of all injuries sustained.

The safety director of the Pullman Co. has estimated that in 10 years 1,570 eyes were destroyed in industry in the State of Ohio alone.

We endorse as a preliminary program the recommendations of Dr. Murray, of the United States Bureau of Mines, who stated that a preliminary examination at the time of employment is most important for men in industrial work, for men in jobs hazardous to the eye an examination every 3 months, for young employees with high myopia if between the ages of 18 and 25 every 6 months, for men over 45 every year, in certain industries, like motormen and bus drivers, and those who come in contact with the public, every 2 years.

Under title 12, providing for grants in aid to States for hospitals and health centers, it is important that provisions be made for the establishment of eye refraction clinics, as well as eye clinics. This is

especially necessary in the larger cities and localities where there is a greater concentration of population. In New York and Philadelphia it has become necessary because of the great increase of case load per doctor's hour to refer all pathological cases to medical eye clinics and establish separate and distinct refraction clinics. This is quite in accord with the conclusions reached in the report of the Committee on the Cost of Medical Care when it was recommended that eye care could only be achieved through the cooperation of the ophthalmologist and the optometrist and a division of labor between them.

Under title 18, providing for grants to States for medical care, a periodic eye examination should be part and parcel of the program to be inaugurated thereunder.

Until recent years the conception of blindness was quite vague. However, with the passage of the social-security law and the necessity for a precise definition, a great deal of attention and study has been given to this problem. Experts are now agreed on the legal definition of blindness as those persons who have vision amounting to less than 20/200 of visual acuity. As recent as 1930 the United States Census listed 63,489 blind persons. On the basis of later figures not yet complete it is evident that the actual number of blind persons in the United States is far in excess of this number and may probably exceed 200,000.

We may accept as authoritative the statement that 72 percent are blind from preventable causes. I quote from publication No. 218 of the National Society for the Prevention of Blindness in discussing the blind in Colorado:

For every person who is completely blind there are 100 who are going toward blindness, already more or less crippled by poor sight and living in the fear of what they believe will be worse than death; and a thousand who are already limited and handicapped by defects of vision of which they may or may not be conscious.

In relation to the blind, with the inauguration of the aid to the blind program, the problem has been revealed as being of considerably greater magnitude than was anticipated at the time the bill was written and the indications are that the limit has not yet been reached. Consequently, the financial aspects of the aid to the blind program will be expanded far beyond anticipation. The rehabilitation of all possible persons legally blind therefore becomes of greater social importance than had been previously considered.

This is emphasized in the thirty-first report of the Ohio Commission for the Blind, dated March 1, 1939, when they state:

That financial assistance without carefully integrated service, therapeutical in nature, will do little to ameliorate the condition of those who are dependent because of a visual handicap.

It would be well to understand that the facts relating to the blind indicate that from 40 to 50 percent so characterized have some degree of useful vision which would permit of visual rehabilitation. Such rehabilitation would decrease the financial burden of caring for these persons.

We find, for example, in a report from the State department of institutions and agencies in the State of New Jersey issued January 1936 that out of 2,131 blind, 1,444 were totally blind or could only

distinguish light from darkness and 687 had visual perception, including those who could read newspaper headlines but not ordinary print.

I wish to bring your attention to the fact that in the Commonwealth of Massachusetts we find in the Annual Report of the Vision of the Blind for the year 1937 that out of a total of 206 children registered, there were 3 who were totally blind and that 25 percent had vision of 20/200 or less, and therefore came under the legal definition of blindness; but that 75 percent had vision better than the legal definition of blindness, ranging up to 20/50.

We also find in a report of the causes of blindness in children, following a survey of the Illinois State School for the Blind, that Dr. Conrad Berens stated:

• • • that of 246 pupils in that school, 20 percent were there unnecessarily, that their vision was of such quality that they could continue their education in the seeing world or could be restored to the seeing world by simple remedial measures.

We wish to emphasize therefore that once a blind person has been registered as such with the agencies caring for the blind that they usually continue to receive assistance for the rest of their lives. It therefor becomes important to examine the age distribution of these blind persons. We find, in Massachusetts, that 20 percent of all the blind in the State are below 40 years of age and an addition of 45 percent are below 60 years of age.

Concomitant with the increase of the life span, we find that there is an increasing number of blind in the older-age brackets. Thus, we find that among those individuals accepted for blind pensions during the 12 months ending June 1938, in the State of Pennsylvania, 50 percent were over 70 years of age and an additional 35 percent were over 50 years of age.

Similarly, in the State of New Jersey for 1936, 36 percent were over 65 years of age and an additional 24 percent over 50 years of age.

Rehabilitation for these people need not be undertaken with any thought of making them employable. Nevertheless, such visual rehabilitation is vitally important to assure psychological and social adjustment in old age.

Our profession has given serious thought to this problem of rehabilitation for many years. We have conducted research through our academies directed toward the development of techniques and devices for the visual rehabilitation of that large group of partially blind who are now included under the general definition of blindness.

There have been important optometric contributions in the field of perfecting devices which are designed to aid in the rehabilitation of the partially blind. A limited number of optometrists have become experts in the designing and fitting of these rehabilitation devices.

There is an increasing number of published reports of cases where telescopic spectacles have been designed and adapted for some children who, because of a congenital defect, were originally compelled to attend the schools for the blind.

These children were enabled to reorientate their entire existence by starting life as normal children in the public schools.

Telescopic spectacles, pinhole spectacles, microscopic spectacles, and cataract lenses have proven their value in rehabilitation of the adult, both industrially and socially.

Optometrists are further developing and adapting contact lenses or invisible glasses for use in those cases referred to in the Sight Saving Review of the National Society for the Prevention of Blindness of December 1939, where we find:

Many types of error are benefited beyond the greatest hopes of the patient and, to those unfortunates heretofore economically blind because of irregular corneas which nothing else could correct, a new world of useful vision is opened.

There is substantial proof that a large portion of the blind population can be rehabilitated. We recommend in the carrying out of the provisions of this act that such rehabilitation be undertaken. For this purpose, it would be necessary to institute adequate post-graduate training of personnel as provided in the various titles on S. 1620.

It is gratifying to note that the framer of this bill recognized the necessity for improved standards of health care and inserted provisions for the training of personnel.

The profession of optometry has been conducting post graduate courses for the past number of years and is continuing to conduct such courses. The provisions of S. 1620 afford the opportunity, however, of expanding these courses to reach a greater number of men so that their increased abilities can be directed towards a more effective rehabilitation program.

In the planning of an eye care program under the various titles of S. 1620, it is necessary to make a survey of existing personnel upon whom will ultimately rest the responsibility for carrying out such a program. Available data shows that there are 2,172 ophthalmologists, 6,449 eye, ear, nose, and throat practitioners who devote a part of their time to eye work, and 17,183 optometrists. At the present time without the extension of eye care as contemplated and provided for in S. 1620, we find that 70 percent of all those persons in the United States who require eye care voluntarily consult the optometrists for their eye needs. This occurs, primarily, because the great preponderance of the eye needs of the people for all ages is due, as the statistics we have previously pointed out show, to errors of refraction alone, with no pathological conditions present.

We cooperate with ophthalmologists by selecting and referring to them for treatment the cases of pathology. It is with this thought in mind that we concur with the conclusions and recommendations contained in volume No. 27, The Costs of Medical Care, by I. S. Falk, C. Rufus Rorem, and Martha D. Ring, where it is stated, on page 284:

It must be conceded that the public now requires the services of optometrists since, as the full report on this subject shows, the total number of properly qualified physicians in this country is quite insufficient to take care of the present volume of refraction work.

The study further points out that the ideal solution would require organized cooperation between ophthalmologists and optometrists and a division of labor between them.

It is apparent that any program instituted under the present bill is intended to be adequate and complete. In order to assure an effec-

tive and comprehensive program, it is necessary to utilize all existing licensed personnel, and to this end the optometrists of this country should rightly be allotted that portion of the work which is particularly within their field.

Another aspect of eye care that can be further developed by additional post-graduate work deals with the problems of adapting our eyes, originally intended primarily for distance vision, to the needs of our present mode of life with its manifold requirements for near vision. Optometry has been concerned with the task of aiding in the adaptation of children's eyes to the demands of present-day school life.

The particular problems on which our men have already done considerable research relate to what is known as the binocular function. When the eyes of infants and youngsters are learning to focus on nearby objects, there is an additional process in learning relating to the need of seeing singly with both eyes. We have found, for example, that an undue strain on the eye muscles of children not yet developed for school life will cause this binocular function to be interfered with and produce disturbing psychological and nervous disorders. This has proven of particular importance to educators in connection with the retardation of school children. Native intelligence would permit them to keep up with their classroom work, but because of the extra discomfort resulting from eyestrain they are retarded.

The severity of these symptoms are often entirely out of proportion to the slight imbalance of this binocular function. The reasons for this negative correlation between severity of symptom and slight disassociation of the binocular function are as yet only partially understood. Research has disclosed that the correction, through glasses, of small refractive errors will in many of these cases remove such symptoms of distress as headache, eye fatigue, and dizziness. These symptoms continued over a long period of time tend to completely disorganize the child and also the adult. Another treatment for these slight imbalances has been that of ocular exercises aimed at strengthening the binocular function. Research in this field, now being conducted in our optometric collages, has yielded some important information regarding the need for "reconditioning" or having the eyes "relearn" the binocular function. We admit that the disfunction of the binocular apparatus produces conditions which, like the common cold, are not fatal, but they are the cause of considerable ill health. There are many unsolved questions regarding this function and its relation to each person's ability to maintain comfortable vision while reading, to each person's capacity to concentrate while driving over long distances without feeling nauseous and distressed, to each person's maintenance of equilibrium while participating in recreational activities such as baseball, tennis, golf, and in such simple everyday matters as walking up and down stairs. Disturbances of this binocular function in a person who is either an airplane pilot or passenger result in airsickness and inability to judge distances.

In the last few years research has yielded another cause for the periodic break-down of this binocular function. We have found, although vision in each eye may be perfect with glasses, that a

slight difference in the shape or size of the objects as seen by each eye may produce the most aggravating symptoms, often requiring the patient to give up all useful activities. The correction of this condition, known as anisikonía, through the special design of a combination of lenses is the latest contribution toward the relief of eye distress.

In contrast to the distress resulting from a binocular disturbance, there are the cases of crossed eyes, or strabismus, where there is a complete absence of this binocular function and no distress.

Research has still failed to disclose complete methods of dealing with strabismus, although some data on surgical procedure and training is available. Only adequately subsidized research can supply the complete answer.

The United States Public Health Service has undertaken a type of eye study that should yield important scientific information as to the relation of change in vision with changes in environmental conditions. This type of information is vital if we are to prevent all our children from becoming quadrinocular. It can only be made available through studies covering a period from 5 to 10 years. These studies must concern themselves with the changes in the eye conditions of the same children over long periods of time, and have been started only recently. Studies of this nature, carried out in the several States and coordinated over a large geographical area, offer the only hope of discovering those environmental elements that cause individual eye changes.

The solution of the problems relating to eye care herein enumerated will undoubtedly be furthered under the provisions of this bill. We must also point out that advances in this field that may accrue as the result of such research would be meaningless unless adequate training of personnel was assured to apply in a practical, clinical way the results of such research.

The American Optometric Association recognizes the need for making available the necessary health care for the people of this Nation. We realize the vast problem which confronts Congress and those who will be concerned with the administration of this bill.

The technical committee on medical care has stated in regard to its recommendations—

that such a program, by furnishing a strengthened economic base, provides new opportunities for improvement in the quality of medical services through the concerted activities of official agencies, educators, and practitioners.

The American Optometric Association is ready, able, and prepared to cooperate in every possible way toward attaining the goal of complete and adequate care with the highest possible standards maintained. Recognizing that health is an integral part of social security, we feel that the Wagner national health bill will not succeed in providing the fullest measure of health security unless the professional services of the optometrists of this country are utilized.

I thank the chairman and members of the committee for their kind and considerate attention. May I at this time present Dr. Luther Dicus, of Washington, D. C., who is chairman of our committee on national affairs? Dr. Dicus practices in this city and is the chairman of the committee which has made a special study of this bill.

At this time I would like to present Dr. Dicus, one of our vice presidents and chairman of our committee on national affairs of the American Optometric Association.

Senator MURRAY. I should like to ask you, Dr. Burdette, if you find anything in the bill as it now exists which would prevent a full utilization of your profession in the health program?

Dr. BURDETTE. The next speaker will bring that point up. However, I will answer it if you prefer that I should.

Senator MURRAY. If the next speaker is going to do it, there is no use of duplicating. There is no conflict between your profession and ophthalmology?

Dr. BURDETTE. Any slight frictions which may have existed in the past are very rapidly disappearing.

Senator MURRAY. And the medical profession generally recognizes your profession and utilizes it in their practice, do they not?

Dr. BURDETTE. Yes, sir; we do cooperate.

Senator MURRAY. That is all. We will hear from Dr. Dicus now.

**STATEMENT OF DR. M. LUTHER DICUS, THIRD VICE PRESIDENT
AND CHAIRMAN OF THE COMMITTEE ON NATIONAL AFFAIRS
OF THE AMERICAN OPTOMETRIC ASSOCIATION**

Dr. DICUS. My name is M. Luther Dicus. I am vice president and chairman of the Committee on National Affairs of the American Optometric Association.

To come directly to the point, the specific purposes of the suggestions with which I shall close this statement is to guarantee that the people of this country, upon the enactment of S. 1620, shall have a continuation of the professional services rendered by optometrists and that optometry shall not be excluded from the operation of the act, directly or by implication.

We may be told and we already have been that whether or not optometrists are to be included in a public-health program is a matter which should be relegated to the individual States, when such States prepare their plans in order to share in the grants-in-aid. In theory, such might be the case. In actual practice, it has worked out differently in the past.

As far back as the F. E. R. A., rules and regulations were promulgated which were interpreted to exclude optometry from rendering its services to our patients who happened to be on relief.

Coming directly to the Social Security Act which S. 1620 is designed to amend, title X provides for grants to the States for aid to the blind. This title outlines the requirements of State plans and the legislative pattern is similar to that employed in S. 1620. In due course, the respective State legislatures met and various States decided to pass acts to implement and take advantage of title X.

The individual State optometric associations in various States presented their position and pointed out to the legislators that the trained and skilled services of optometrists in the rehabilitation of the partially blind should be utilized and included in legislation. The situation which then arose occurred in a number of States but I specifically mention by name Montana, North Carolina, and New

York because I have personally seen correspondence or spoken with those who were concerned with the matter when the incidents arose.

It was not difficult to convince the proponents of those respective State acts of optometry's worth and value, for these legislators were fully familiar with the great strides optometry had taken in matters of refraction, the great number of citizens who voluntarily selected the optometrist to care for their refractive needs and of the large amount of public good which the optometrists had been doing in their free clinics and other community activities.

Some of the State bills were actually amended so as to include the services of the profession of optometry. These amendments were subsequently withdrawn. The proponents of the State statutes were informed, whether correctly or incorrectly, that the rule laid down by the Social Security Board requiring that the eye examination for each individual applying for blind assistance must be made by an ophthalmologist, prevented the inclusion of optometry.

Perhaps the situation can be best explained by a quotation which I read to you from a lengthy letter to the chairman of the North Carolina Optometric Legislative Committee from the North Carolina State Senator who in 1937 introduced the North Carolina social-security law. He says in part:

I might also say that the North Carolina General Assembly in all likelihood would have passed the optometric amendment irrespective of the advice of the officials entrusted with the social-security program, but the optometrists informed me they would prefer not to jeopardize North Carolina's chance of participation under the Federal act.

The Social Security Board, under date of October 21, 1936, issued instruction 701 which required that a report on an eye examination must be prepared by an ophthalmologist or a physician skilled in diseases of the eye for each individual who made application for blind assistance.

It is unfortunate that in its application this ruling was so inflexible that it not only precluded optometrists from making the report on the eye examination but also was interpreted to preclude the optometrist from matters in his own optometric field with relation to the blind. I refer to the failure to utilize the optometrist in obtaining a census of the blind. In addition, the optometrist was prevented from prescribing correcting lenses for existing refractive errors of those who come under the definition of blindness.

Furthermore, the ability of the optometrist in the field of rehabilitation of the partially blind must be made available.

Unless the suggested changes are made, the same inflexibility of interpretation might prevail with respect to future administrative rulings. This might prevent a comprehensive eye program as contemplated under S. 1620.

Another important reason for the inclusion of specific amendments to S. 1620 in order to prevent misinterpretations, is the fact that presently in several States there is not uniformity of practice or administration. No criticism is offered or intended of the efficient manner in which the Social Security Board has taken hold of the organization and administration of a new and tremendous department of the Government.

We believe, however, that the situation should be clarified and that in S. 1620 the following specific amendments be included:

On page 5, line 17; page 8, line 6; page 13, line 9; page 16, line 3; page 20, line 15, page 23, line 8; page 33, line 17; page 38, line 4; and page 40, line 17, after the periods at the end of each of those lines and on page 29, line 22, after the word "plan", the following should be inserted:

But nothing in such rules and regulations so far as they relate to eye care shall discriminate in any manner against the profession of optometry.

We also suggest that on page 4, line 22; page 7, line 19; page 12, line 10; page 15, line 16; page 19, line 16; page 22, line 22; page 28, line 25; page 33, line 4; page 37, line 6; and page 40, line 10, after the words "members of the", insert the following "professions of medicine, dentistry, optometry, nursing, and pharmacy".

Our third and last suggestion is to add on page 46 after line 20, under the subheading "Definitions", a new subsection to be known as—

Sec. 1405. (d) The terms "medical" or "medical care" means medical, surgical, dental, optometrical, nursing, pharmaceutical, hospital, institutional, corrective, and other related services and care.

We sincerely believe that these amendments will clarify and strengthen the purposes of the Wagner National Health Act, and we earnestly recommend their consideration and inclusion.

Senator MURRAY. Thank you. There are no questions, doctor.

Dr. DICHS. I should also like to file a short statement here by Dr. Needles.

STATEMENT OF DR. WILLIAM I. NEEDLES, PRESIDENT, NORTHERN ILLINOIS COLLEGE OF OPTOMETRY, CHICAGO, ILL.

In recognition of the needs for an adequate national health program the profession of optometry is genuinely concerned over two important questions. First, that there shall continue to be adequate eye care of the type which optometrists have been providing with increasing efficiency during recent decades, and, second, that there may be a better general understanding of that specialized skill which has won for them the confidence and patronage of approximately 70 percent of the spectacle-wearing public, including nearly all of those in average or moderate circumstances. This can best be done by a brief description of the professional education which optometrists receive.

Some 40 years ago the State of Minnesota passed the first optometry practice act. This act provided for licensing all who sought to practice optometry, and stipulated that candidates for license must pass an examination before a State examining board. In subsequent years every State in the Union passed similar laws. Authority was vested in all of these boards to prescribe the character of education and professional training which candidates must possess in order to render them eligible for examination. Some 20 years ago, the members of all State boards of examiners in optometry formed a voluntary organization known as the International Association of State Board Examiners in Optometry. Certain officers and committees of this association were assigned the task of setting up a minimum curriculum and other educational requirements to which the various schools and colleges of optometry must conform in order to earn the classification of a grade A school, after which the various State boards accepted these regulations and requirements as their own.

When the first inspection of optometry colleges in the United States was made, there were some 26 of them in operation. This number was rapidly reduced, however, because the majority of them were not able to meet the rigid requirements necessary for a grade A rating, and such schools discon-

tinued operation. This retirement of the weaker schools resulted in the gradual evolution of a few outstanding colleges which could meet and anticipate the highest requirements. At present there are eight grade A colleges in the United States and two in Canada. Five of these are departments of universities, this list including Columbia University, New York, Ohio State University, University of California, University of Montreal, and the University of Toronto. The remaining five, including the Los Angeles College in Los Angeles, the Massachusetts School in Boston, the Northern Illinois College in Chicago, Pennsylvania State College in Philadelphia, and the Southern College in Memphis, are independent colleges operating under State charters.

These independent colleges maintain standards, facilities, and instruction comparable to that of the universities. They employ standard laboratories, texts, and faculty. Among the specialized subjects which must be taught by all grade A schools are the following: General anatomy and physiology; anatomy and physiology of the eye; geometrical optics, physiological optics, ocular pathology, conservation of vision, hygiene, theoretical and practical optometry, and clinical practice. While the individual curricula vary in the different schools, all include this prescribed material, but offer individually in addition various extra subjects such as chemistry, mathematics, physics, bacteriology, zoology, psychology, sociology, English, economics, ethics, history, and foreign languages.

Every grade A college of optometry requires a minimum course of 4 years, of which at least 1 year must be spent in actual clinical work upon patients in a fully equipped clinic which is maintained at that school. This clinical work usually constitutes part of the fourth or senior year of study. These clinics are for charitable purposes in the nature of their organization, and the requirements of the national board provide that each student must be supplied with sufficient patient material to render him proficient for private practice.

Entrance to all grade A optometry colleges is dependent upon satisfactory completion of a high school or other secondary school course in which specified preliminary subjects are included. Among these specified subjects are English, a foreign language, algebra and geometry, American history, physiology or zoology, and physics, and sufficient electives to total 16 credits. The preliminary requirements, therefore, are equal to those of standard colleges of arts and sciences in universities, and the student caliber is of the same level.

In summarization, it may be noted that—

1. Students entering the study of optometry have the same preliminary background and qualifications as those entering the other recognized professions or sciences.

2. The colleges teaching optometry are under strict inspection and supervision on the part of both the national board and the individual State boards of examiners.

3. The curricula of the schools qualify the student in knowledge of standard basic sciences equal to that of those engaged in other recognized professions. In addition, the student receives at least 2 years of intensified training in optometry and related subjects and 1 year of specialized clinical practice.

4. Before being permitted to practice the student must still undertake and pass a detailed examination conducted by the individual State boards.

Optometrists have taken upon themselves the responsibility for establishing educational requirements such as to qualify them as the specialists in the field of refraction. All modernly trained optometrists are capable of recognizing various forms of pathology, and it is their uniform custom to refer such cases to other specialists, including both physicians and dentists. The old type of less thoroughly trained optometrists are rapidly being removed from the field by death and retirement, and it is safe to prophesy that during the next decade the profession of optometry will be composed entirely of those who are modernly trained specialists. In view of the increased demand for this service which must result from a national-health program and the limited personnel including all types of refractionists, it is vitally important that provision be made in the wording of this bill for a proper continuance of the services of optometrists to the public.

Dr. DICUS. May Mr. Kohn have the privilege of about 2 minutes? He is our national counsel.

Senator MURRAY. Very well.

STATEMENT OF HAROLD KOHN, NEW YORK CITY, NATIONAL COUNSEL, AMERICAN OPTOMETRIC ASSOCIATION

Mr. KOHN. There is nothing I should like to add except to call attention to the fact that this month, on the 25th, the legislative body of the American Optometric Association will meet; that they have already taken up consideration of this act, and they propose to spend a good deal of time in further study. If we can be of any assistance to you in making further suggestions, we would be very happy to do it. The situation this far is that we are with the spirit and underlying features of the act. If subsequently we should have any suggestions, we should like leave to file them in the form of a suggested amendment or something of that nature, say, perhaps in July.

Senator MURRAY. That would be very satisfactory. You may do that. As far as I understand it, there is no conflict between ophthalmology and optometry? Ophthalmology deals with the organic diseases, those which the ophthalmologist may find in the eye, and the optometrist does the mechanical work?

Mr. KOHN. Determining the refractive error.

Senator MURRAY. And some of the finest people in the country patronize the optometrist without ever going to the ophthalmologist at all; is that not so?

Mr. KOHN. That is so, 70 percent of them, by actual statistics. If the examination discloses a condition requiring the attention of an ophthalmologist, they are immediately sent to them.

Senator MURRAY. So that there is no lack of harmony between the two professions?

Mr. KOHN. Generally speaking, absolutely not. Once in a while there is a little professional jealousy in small communities. That sometimes happens, but that is very rapidly being overcome through interprofessional relationship committees of the Ophthalmological Society and of our association.

Senator MURRAY. The next witness is Miss Katharine F. Lenroot, Chief of the Children's Bureau of the Department of Labor.

STATEMENT OF MISS KATHARINE LENROOT, CHIEF, CHILDREN'S BUREAU, DEPARTMENT OF LABOR, WASHINGTON, D. C.

Miss LENROOT. I am very glad to have an opportunity to speak to this bill. I would like to have the information that the Children's Bureau has to present given in two parts. I should like to make a brief opening statement dealing primarily with administrative matters, and then I should like to have Dr. Eliot follow with more detailed information, particularly on the technical and professional aspects of the program.

Senator MURRAY. That procedure will be followed.

Miss LENROOT. First, I want to say that although the Children's Bureau is, of course, particularly interested in the parts of the bill relating to maternal and child-health services incorporated in the suggested amendments to title V, we have a deep interest in the entire bill.

The act creating the Children's Bureau directed it to investigate and report upon all matters pertaining to the welfare of children and

child life. Nothing—not even economic conditions—affects children more directly than the health of the people. The opportunity which children have for care, affection, and support by their parents depends upon the survival and health of those parents. Basic measures of sanitation, control of communicable diseases, prevention and treatment of the diseases of middle life, compensation for loss of wages due to disability, all affect directly the health and well-being of the child. Moreover, measures for promotion of maternal and child health cannot be developed fully unless in the community in which the mothers and children live, or fully accessible to it, are hospitals, health centers, and diagnostic and treatment clinics.

With reference to the purpose of provisions relating to maternal and child welfare, and a comparison with present provisions of the Social Security Act, section 2 of the pending bill amends title V, parts 1, 2, and 5 of the Social Security Act, and section 5 amends definition provisions of the Social Security Act which affects title V. The parts of title V that are affected by the proposed amendment provide for Federal cooperation with the States for promoting the health of mothers and children, and for services for crippled children.

These provisions of the act of 1935 authorized a program of services which, together with other services for the welfare and assistance of children, in the language of the report of the Committee on Ways and Means of the House of Representatives, represented "the heart of any program for social security." Committees of both House and Senate in reporting the social-security bills before them in 1935, pointed to the high maternal mortality rate in this country; the curtailed appropriations for maternity and infant welfare occasioned by the depression; inadequacy of maternal and child health services, particularly in rural areas; and very limited provisions for the diagnosis, hospitalization, and aftercare of crippled children.

The report of the Committee on Economic Security which preceded the introduction of the 1935 act recommended that the Children's Bureau be entrusted with responsibility for developing both grants-in-aid for maternal and child health, and consultative, educational and promotional work with the State health departments in this field.

The amendments proposed in S. 1620 would build upon the foundation which has been laid in more than 3 years of Federal-State cooperation under these provisions, in which all States, Alaska, Hawaii, and the District of Columbia have participated.

I want to speak here of the very excellent cooperation that we have had from all of the States. All of them were in a position to submit plans for maternal and child health services very promptly after the passage of the 1935 act. Not only in our Federal and State relationships but also in the relationships among the Federal agencies, and particularly between the Public Health Service and the Children's Bureau, both of which are dealing with State health departments, we have had the most cordial and harmonious relationships all the way through from the very beginning and have consulted freely and fully on all points which would affect common policies.

To go back to the proposed amendment, instead of \$3,800,000 now authorized as an annual appropriation under title V, part 1, the proposed bill would authorize an appropriation of \$8,000,000 for the

fiscal year ending June 30, 1940, \$20,000,000 for the fiscal year 1941, \$35,000,000 for the fiscal year 1942, and thereafter a sum sufficient to carry out the purposes of this part of the title. The types of service that would be given with the expanded appropriations would include all the services now being carried on, and in addition would expand the medical care given during maternity and infancy, including medical, surgical, and other related services, care in the home or in institutions, and facilities for diagnosis, hospitalization, and aftercare. The latter phrases are taken largely from the existing language in title V, part 2, providing services for crippled children, and provide the same breadth of program in the field of maternal care and an extension to this field of the experience developed in providing medical and surgical care for children who are suffering from orthopedic and certain other physical handicaps.

Part 2 is expanded so that services now being afforded to a limited group of physically handicapped children can be extended to other physically handicapped children in need of special care. You have just heard a discussion of the needs of children with vision defects. There is great need in that group and in the group of those with hearing defects, and other types of physical handicaps.

In addition, provision is made for extending and improving services, supplies, and facilities for the medical care of children who do not come within the groups of the physically handicapped. Instead of an appropriation of \$2,850,000 annually now authorized by title V, part 2, the proposed bill in sections 511 and 512 authorizes the sum of \$9,000,000 for medical care of children and \$4,000,000 for services to crippled children and other physically handicapped children in need by special care, in 1940, which would be increased to \$20,000,000 for the former and \$5,000,000 for the latter for the year 1941, \$35,000,000 for both programs for the year 1942, and thereafter to such sums as may be needed.

With the exception of increased amounts authorized, and a broadening of the maternity care program and extension of medical care to other classes of children than those now covered, the only changes in the proposed bill relate to methods of allotting and paying funds, matching provisions, conditions of approval of State plans, provision for a Federal advisory council or councils, and authority to make rules and regulations. Though the provision for medical care of children is included in part 2 of title V for certain administrative reasons, it would appear that similarity of the conditions of allotment, payment, and approval of plans under parts 1 and 2 would make it possible for a State to submit a single plan for maternal and child health, including maternity care and medical care of children, provided that under State law the State health agency has jurisdiction in these fields or can develop working agreements with other State agencies now charged with such responsibilities under State law.

There are now 25 States that administer the crippled children's program through the health departments, and the others administer that program through other departments of the State Government at the present time. In many States responsibility for medical care of children is in some State agency other than the State health agency.

It would appear to be of utmost importance that medical, nursing, and hospital care, provided for women at childbirth and for children when sick, be under the same State and local agencies as those providing preventive services. Under part 1 of title V as amended in the pending bill, the State health agency is given full administrative authority, as under the present provisions of title V, part 1 of the Social Security Act. Under part 2, though for a period of 5 years other State agencies may administer medical services for children or services for crippled and other physically handicapped children, at the end of that time responsibility would be given to the State health agency and a single plan of service could be developed for all maternity and child-health work within the State. Such a plan to coordinate these services under the State health agency seems to be highly desirable and entirely feasible from an administrative point of view.

When Dr. Eliot appeared before this committee on May 5, she was asked to have prepared a statement showing the present provisions of title V, parts 1, 2 and 5, and the proposed amendments.

I have here such a statement which has been prepared under the direction of Dr. Eliot, and which gives in the third column, comments as to the effect of the language of the national health bill. I would like to have it incorporated in the record if the committee desires so.

Senator MURRAY. It will be filed with the clerk and we will have it printed.

(The statement referred to was filed with the committee, and is printed, as follows:)

EXHIBIT I—COMPARISON OF NATIONAL HEALTH BILL AND SOCIAL SECURITY ACT, TITLE V, PARTS 1, 2, AND 5

NATIONAL HEALTH BILL

SOCIAL SECURITY ACT

COMMENTS

Title V, Parts 1, 2, and 5

Title V, Parts 1, 2, and 5

EFFECT OF LANGUAGE OF NATIONAL HEALTH BILL

PART 1.—MATERNAL AND CHILD-HEALTH SERVICES

PART 1.—MATERNAL AND CHILD-HEALTH SERVICES

APPROPRIATION

APPROPRIATION

SEC. 501. For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and in areas suffering from severe economic distress, to extend and improve services, supplies, and facilities for promoting the health of mothers and children, and medical care during maternity and infancy, including medical, surgical, and other related services, and care in the home or in institutions, and facilities for diagnosis, hospitalization, and aftercare; and to develop more effective measures for carrying out the purposes of this part of this title, including the training of personnel, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$8,000,000; for the fiscal year ending June 30, 1941, the sum of \$20,000,000; for the fiscal year ending June 30, 1942, the sum of \$35,000,000; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this part of this title. The sums authorized under this section shall be used for making payments to States which have

SEC. 501. For the purpose of enabling each State to extend and improve, as far as practicable under the conditions in such State, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of \$3,800,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

Purposes of this program expanded to include medical care during maternity and infancy.

Authorized appropriations for the fiscal years 1940, 1941, and 1942 are specified and amounts increased to permit enlargement of program. Appropriations for succeeding fiscal years are authorized in amounts sufficient to carry out the purposes of this program.

Specific provision is included for the development of more effective measures for carrying out this program, including the training of personnel.

Certain other minor changes in language have been made to bring it into harmony with language of similar provisions in other titles.

submitted, and had approved by the Chief of the Children's Bureau, State plans for extending and improving such services.

ALLOTMENTS TO STATES

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

ALLOTMENTS TO STATES

SEC. 502. (a) Out of the sums appropriated pursuant to section 501 for each fiscal year the Secretary of Labor shall allot to each State \$20,000, and such part of \$1,800,000 as he finds that the number of live-births in such State bore to the total number of live births in the United States, in the latest calendar year for which the Bureau of the Census has available statistics.

(b) Out of the sums appropriated pursuant to section 501 for each fiscal year the Secretary of Labor shall allot to the States \$980,000 (in addition to the allotments made under subsection (a)), according to the

All allotments are to be made under this section. Amounts of allotments to be determined in accordance with rules and regulations to be prescribed by the Chief of the Children's Bureau with approval of the Secretary of Labor. Fixed allotment of \$20,000 to each State eliminated.

Basis for allotments will be 4 specific factors for respective States:

- (1) Total number of births;
- (2) Number of mothers and children in need of services;
- (3) Special problems of maternal and child health;
- (4) Financial resources.

In the act only the first of these factors is specified.

The phrase in the first sentence of sec. 502 (a) of the bill "and at such time or times thereafter as may be necessary" has been added to give specific authority to the Chief of the Children's Bureau to withhold from allotment prior to the beginning of a fiscal year sums to be allotted during the year on the basis of special problems of maternal and child health; also to permit reallocation of sums unpaid to the States at the close of the preceding fiscal year.

Eliminated—sufficient flexibility being provided through use of variable matching grants (see sec. 504 (a) and 1101 (e)).

NATIONAL HEALTH BILL

ALLOTMENTS TO STATES

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

APPROVAL OF STATE PLANS

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

(1) provide for financial participation by the State;

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

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

SOCIAL SECURITY ACT

ALLOTMENTS TO STATES

financial need of each State for assistance in carrying out its State plan, as determined by him after taking into consideration the number of live births in such State.

(c) The amount of any allotment to a State under subsection (a) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 504 until the end of the second succeeding fiscal year. No payment to a State under section 504 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

APPROVAL OF STATE PLANS

SEC. 503. (a) A State plan for maternal and child-health services must (1) provide for financial participation by the State;

(5) provide for the extension and improvement of local maternal and child-health services administered by local child-health units;

(2) provide for the administration of the plan by the State health agency or the supervision of the administration of the plan by the State health agency;

COMMENTS

Reallotment of funds allotted to the respective States but unpaid to them during the fiscal year for which appropriated and allotted is provided for instead of the present provision making allotments under subsection (a) available only to one State for two additional years. This change follows in substance, similar provisions in the present language of title VI of the act. (Sec. 602 (a) and (b)).

No change.

Replaces present paragraph 5 and broadens the provision to require extension of the entire program to cover all political subdivisions of the State by the beginning of the 1945 fiscal year.

Revision in language to permit greater flexibility to meet variations in administrative machinery of the States, and to permit the State health agency to utilize other State agencies and political subdivisions of the State in carrying out under supervision various parts of the program.

This provision does not exclude the utilization of private agencies and institutions by the State health agency or by other State agencies or political subdivisions of the State, but it places full administrative responsibility for the program on the State health agency.

Revision in language to harmonize with similar language in other titles and to strengthen the present requirements relating to efficiency in the operation of State plans; specifically for strengthening merit systems and for maintaining standards of medical and institutional care established by State agencies.

The provision for cooperation with other agencies is made more specific by provision for an advisory council or councils to insure cooperation with members of professions and agencies and with persons informed on need for services.

No change except that "Chief of the Children's Bureau" is substituted for "Secretary of Labor," the change being made throughout the amendment of title V; the actions of the Chief of the Children's Bureau being subject to the approval of the Secretary of Labor. This language also is revised to harmonize with similar language in other titles.

New.

(3) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan;

(6) provide for cooperation with medical, nursing, and welfare groups and organizations; and

(4) provide that the State health agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

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

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

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

(7) provide for cooperation and, when necessary, for working agreements between the State health agency and any public

NATIONAL HEALTH BILL

APPROVAL OF STATE PLANS

agency or agencies administering services related to the services furnished under the State plan, including public agencies concerned with welfare, assistance, social insurance, education, or medical care; and

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

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

PAYMENT TO STATES

Sec. 504. (a) From the sums appropriated therefor under section 501, and the allotments made in accordance with section 502, payments shall be made to each State which has a plan approved under section 503 for each year or part thereof covered by such plan beginning with the fiscal year ending June 30, 1940, in amounts which shall be used exclusively for carrying out the purposes of section 501. These payments shall be in such proportion to the total amount of

SOCIAL SECURITY ACT

APPROVAL OF STATE PLANS

(7) provides for the development of demonstration services in needy areas and among groups in special need.

(b) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (a) and shall thereupon notify the Secretary of Labor and the State health agency of his approval.

PAYMENT TO STATES

Sec. 504. (a) From the sums appropriated therefor and the allotments available under section 502 (a), the Secretary of the Treasury shall pay to each State which has an approved plan for maternal and child-health services, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

COMMENTS

Eliminated.

New.

Revision in language to harmonize with language of similar sections in other titles without any change in present procedure.

Variable matching based upon financial resources of respective States replaces the 50-50 matching ratio. The fiscal year or part thereof covered by the State plan is the unit period for computing amounts to be paid to the States. The quarterly limitation in the present Act is eliminated to permit greater flexibility in making payments to States.

Special provision is added in last sentence in subsection (a) to prevent claims by States

public funds expended under the State plan, during each year or part thereof covered by such plan, as is determined in accordance with subsection 1101 (e) upon the basis of the financial resources of the State, not counting so much of such total expenditures as are included in any other State plan submitted for grants to the State under any other part of this title or any other title of this Act or any other Act of Congress. In no event shall the total sum paid to the State for any fiscal year or part thereof covered by its plan be in excess of the total sum expended or obligated for amounts planned for expenditure from Federal Funds.

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

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Labor shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such investigation as he may find necessary.

(2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum

for Federal funds to replace amounts planned for expenditure out of State and local public funds.

Mechanics of determining amounts of particular payments, making certifications to the Secretary of the Treasury, and making payments by the Secretary of the Treasury prior to audit or settlement by the General Accounting Office are retained.

PAYMENT TO STATES

by which the Secretary of Labor finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except that to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

(c) The Secretary of Labor shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States from the allotments available under section 502 (b), and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Labor.

Eliminated. (See comment on section 502 (b) of the act.)

OPERATION OF STATE PLANS

SEC. 505. Whenever the Chief of the Children's Bureau finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of a plan approved under

OPERATION OF STATE PLANS

SEC. 505. In the case of any State plan for maternal and child-health services which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for

Language revised to harmonize with similar language in other titles without change in meaning. Action by "Chief of Children's Bureau" instead of action by "Secretary of Labor", the actions of the

part 1 of this title, that in the administration of such plan there is failure to comply substantially with any requirement of subsection 503 (a), he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

FEDERAL ADVISORY COUNCILS

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

RULES AND REGULATIONS

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

hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 503 to be included in the plan, 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.

Chief of the Children's Bureau being subject to the approval of the Secretary of Labor.

New. The Department of Labor has suggested in its report on S. 1620 that this and similar sections be amended to provide for a single advisory National Health Council in place of the several Federal advisory councils provided for in part 2 of title V, and titles VI, XII, and XIII. The Chief of the Children's Bureau and other officials responsible for the administration of similar titles would be authorized to consult with and receive the advice of the National Health Council. Provision for the creation of the National Health Council would be contained in an amendment of section 1101 of the act.

New.

NATIONAL HEALTH BILL

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

APPROPRIATION

SEC. 511. For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and in areas suffering from severe economic distress, to extend and improve services, supplies, and facilities for the medical care of children, and services to crippled children and other physically handicapped children in need of special care, such services, and facilities to include medical, surgical, corrective, and other related services and care in the child's home or in institutions, and facilities for diagnosis, hospitalization, or other institutional care, and aftercare; and to develop more effective measures for carrying out the purposes of this part of this title, including the training of personnel, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$13,000,000; for the fiscal year ending June 30, 1941, the sum of \$25,000,000; for the fiscal year ending June 30, 1942, the sum of \$35,000,000; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this part of this title. The sums authorized under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for extending and improving such services.

SOCIAL SECURITY ACT

PART 2—SERVICES FOR CRIPPLED CHILDREN

APPROPRIATION

SEC. 511. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State, services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1938, the sum of \$2,850,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

COMMENTS

The purposes of this program expanded to include medical care of children as well as services for crippled and other physically handicapped children in need of special care.

Authorized appropriations for the fiscal years 1940, and 1941, and 1942 are specified and amounts increased to permit enlargement of program. Appropriations for succeeding fiscal years are authorized in amounts sufficient to carry out the purpose of this program.

Provision is included to provide specifically for the development of more effective measures of carrying out this program, including the training of personnel.

Certain other changes in language have been made to bring it into harmony with language of similar provisions in other titles.

ALLOTMENTS TO STATES

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

ALLOTMENTS TO STATES

SEC. 512. (a) Out of the sums appropriated pursuant to section 511 for each fiscal year the Secretary of Labor shall allot to each State \$20,000, and the remainder to the States according to the need of each State as determined by him after taking into consideration the number of crippled children in such State in need of the services referred to in section 511 and the cost of furnishing such services to them.

All allotments are to be made under this section. Amounts of allotments for medical care of children and for services for crippled children, etc., respectively, are provided for the 1940 and 1941 fiscal years and in amounts to be determined by the Chief of the Children's Bureau for succeeding fiscal years.

Within these limitations amounts of allotments are to be determined in accordance with rules and regulations to be prescribed by the Chief of the Children's Bureau with the approval of the Secretary of Labor. Fixed allotment of \$20,000 to each State is eliminated.

Basis for allotments will be four specific factors for respective States:

- (1) Child population;
- (2) Number of children in need of services;
- (3) Special problems of medical care of children;
- (4) Financial resources.

In the act only the first of these factors and the cost of furnishing services are specified.

NATIONAL HEALTH BILL

ALLOTMENTS TO STATES

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

APPROVAL OF STATE PLANS

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

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

SOCIAL SECURITY ACT

ALLOTMENTS TO STATES

(b) The amount of any allotment to a State under subsection (a) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 514 until the end of the second succeeding fiscal year. No payment to a State under section 514 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

APPROVAL OF STATE PLANS

Sec. 513. (a) A State plan for services for crippled children must—

- (1) provide for financial participation by the State;
- (5) provide for carrying out the purposes specified in section 511;

COMMENTS

The phrase in the first sentence of section 512 (a) of the bill, "and at such time or times thereafter as may be necessary" has been added to give specific authority to the Chief of the Children's Bureau to withhold from allotment prior to the beginning of a fiscal year sums to be allotted during the year on the basis of special problems of medical care of children; also to permit reallocation of sums unpaid to the States at the close of the preceding fiscal year.

Reallocation of funds allotted to the respective States but unpaid to them during the fiscal year for which appropriated and allotted is provided for instead of the present provision making allotments under subsection (a) available only to one State for two additional years. This change follows in substance similar provisions in the present language of title VI of the act (sec. 602 (a) and (b)).

No change.

Replaces present paragraph 5 and requires extension of the entire program to cover all political subdivisions of each State by the beginning of the 1945 fiscal year.

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

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

(2) provide for the administration of the plan for a State agency or the supervision of the administration of the plan by a State agency;

(3) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan;

Revision in language to permit greater flexibility to meet variations of administrative machinery of the States.

Provides for administration by the State health agency, but permits the administration by some other State agency for a period of not more than 5 years where that agency is already charged with responsibility for a medical-care program including medical care of children or services for crippled children.

This provision does not exclude the utilization of private agencies and institutions by the State health agency or by other State agencies or political subdivisions of the State, but it places full administrative responsibility for the program on the State health agency (or the official State agency).

Requires that all plans for medical care of children or services for crippled children be administered by the State health agency by the beginning of the 1945 fiscal year.

Revision in language to harmonize with similar language in other titles and to strengthen the present requirements relating to efficiency in the operation of State plans; specifically, for strengthening merit systems for maintaining standards of medical and institutional care established by State agencies.

NATIONAL HEALTH BILL

APPROVAL OF STATE PLANS

such care, such methods to be prescribed by the State agency after consultation with such professional advisory committees as the State agency may establish;

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

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

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

(8) provide that the State agency (or agencies) administering the plans or other State agency administering services under the plans shall have authority to make and publish such rules and regulations as are

SOCIAL SECURITY ACT

APPROVAL OF STATE PLANS

(6) provide for cooperation with medical, health, nursing, and welfare groups and organizations * * *

(4) provide that the State agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

(6) * * * and with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children.

COMMENTS

The provision for cooperation with other agencies is made more specific by provision for an advisory council or councils to insure cooperation with members of professions and agencies and with persons informed on need for services.

No change except that "Chief of the Children's Bureau" is substituted for "Secretary of Labor," the change being made throughout the amendment of title V, the actions of the Chief of the Children's Bureau, being subject to the approval of the Secretary of Labor. This language also is revised to harmonize with similar language in other titles.

That part of 513 (a) (6) of the act relating to cooperation with vocational rehabilitation agencies has been enlarged to provide for cooperation with public agencies dealing with related services and for working agreements with such agencies when necessary.

New.

necessary for efficient operation of the services, having special regard for the quality and economy of service.

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

PAYMENT TO STATES

SEC. 514. (a) From the sums appropriated therefor under section 511, and the allotments made in accordance with section 512, payments shall be made to each State which has a plan approved under section 513 for each year or part thereof covered by such plan beginning with the fiscal year ending June 30, 1940, in amounts which shall be used exclusively for carrying out the purposes of section 511. These payments shall be in such proportion to the total amount of public funds expended under the State plan, during each year or part thereof covered by such plan, as is determined in accordance with subsection 1101 (c) upon the basis of the financial resources of the State, not counting so much of such total expenditures by the State and its political subdivisions as are: (1) Expended for the care, in hospitals, institutions, and other organized facilities, of cases of mental disease, mental defectiveness, epilepsy, and tuberculosis as are not in excess of the average annual expenditures for these purposes in the three years prior to the effective date of this part of this title; or (2) included in any other State plan submitted for grants to the State under any other part of this title or any

(b) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (a) and shall thereupon notify the Secretary of Labor and the State agency of his approval.

PAYMENT TO STATES

SEC. 514. (a) From the sums appropriated therefor and the allotments available under section 512, the Secretary of the Treasury shall pay to each State which has an approved plan for services for crippled children, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Labor shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the differ-

Revision in language to harmonize with language of similar sections in other titles without any change in present procedure.

Variable matching based upon financial resources of respective States replaces the 50-50 matching ratio. The fiscal year or part thereof covered by the State plan is the unit period for computing amounts to be paid to the States. The quarterly limitation in the present act is eliminated to permit greater flexibility in making payments to States.

Special provision is added in last sentence in subsection (a) to prevent claims by States for Federal funds to replace amounts planned for expenditure out of State and local public funds.

NATIONAL HEALTH BILL

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COMMENTS

PAYMENT TO STATES

PAYMENT TO STATES

other title of this Act or any other Act of Congress. In no event shall the total sum paid to the State for any fiscal year or part thereof covered by its plan be in excess of the total sum expended or obligated for amounts planned for expenditure from Federal funds.

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

OPERATION OF STATE PLANS

SEC. 515. Whenever the Chief of the Children's Bureau finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of a plan approved under

ence is expected to be derived, and (B) such investigation as he may find necessary.

(2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum which the Secretary of Labor finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

OPERATIONS OF STATE PLANS

SEC. 515. In the case of any State plan for services for crippled children which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for hear-

Mechanics of determining amounts of particular payments, making certifications to the Secretary of the Treasury, and making payments by the Secretary of the Treasury prior to audit or settlement by the General Accounting Office are retained.

Language revised to harmonize with similar language in other titles without change in meaning. Action by "Chief of Children's Bureau" instead of action by "Secretary of Labor," the actions of the Chief of the

part 2 of this title, that in the administration of such plan there is failure to comply substantially with any requirement of subsection 513 (a), he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

FEDERAL ADVISORY COUNCILS

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

RULES AND REGULATIONS

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

ing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 513 to be included in the plan, 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.

Children's Bureau being subject to the approval of the Secretary of Labor.

New. The Department of Labor has suggested in its report on S. 1620 that this and similar sections be amended to provide for a single advisory National Health Council in place of the several Federal advisory councils provided for in part 1 of title V and titles VI, VII, and XIII. The Chief of the Children's Bureau and other officials responsible for the administration of similar titles would be authorized to consult with and receive the advice of the National Health Council. Provision for the creation of the National Health Council would be contained in an amendment of section 1101 of the act.

New.

NATIONAL HEALTH BILL

PART 5—ADMINISTRATION

Sec. 541. (a) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$2,500,000 for all necessary expenses of the Children's Bureau in administering the provisions of this title, except section 531, and in making such studies, investigations, and demonstrations, and such provision for the training of personnel as will improve the quality of the services and promote the efficient administration of this title, except section 531; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient for such purposes.

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

(Sec. 5 of the bill)

Sec. 1101. (a) When used in this act—

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

(2) The term "United States" when used in a geographical sense (except when used in titles V, VI, XII, XIII, and XIV) means the several States, Alaska, Hawaii, and the

SOCIAL SECURITY ACT

PART 5—ADMINISTRATION

Sec. 541. (a) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1936, the sum of \$425,000, for all necessary expenses of the Children's Bureau in administering the provisions of this title, except section 531.

(b) The Children's Bureau shall make such studies and investigations as will promote the efficient administration of this title, except section 531.

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

Title XI

Sec. 1101. (a) When used in this act—

(1) The term "State" (except when used in section 531) includes Alaska, Hawaii, and the District of Columbia.

(2) The term "United States" when used in a geographical sense means the States, Alaska, Hawaii, and the District of Columbia.

COMMENTS

Authorized appropriation for the 1940 fiscal year is specified and amount increased to permit enlargement of program, including funds for demonstrations as well as for studies, investigations, and for training personnel.

No change.

Puerto Rico is included as a "State" for the purposes of title V, etc. (except section 531, relating to vocational rehabilitation).

Puerto Rico is included as a part of the "United States" for the purposes of title V, etc.

District of Columbia. When used in titles V, VI, XII, XIII, and XIV it means the several States, Alaska, Hawaii, Puerto Rico, and the District of Columbia.

(e) The "financial resources" of the several States shall be measured by per capita income accruing to the inhabitants thereof, as determined jointly by the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board, between January 1 and July 1 of each year on the basis of data for the most recent three-year period for which satisfactory data are available, and shall be expressed in series of matching proportions which shall fix, in a manner appropriate for effectuating the purposes of this Act, the proportion by which funds available as grants-in-aid to each State under titles V (parts 1 and 2), VI, XII, and XIII of this Act shall be related to the total amount of public funds expended under the State plan in respect to the provisions of these titles; for title V (parts 1 and 2), VI, and XII, the highest proportion (being application to the State with the lowest financial resources) to be 66 $\frac{2}{3}$ per centum and the lowest proportion (being applicable to the State with the highest financial resources) 33 $\frac{1}{3}$ per centum, with intermediate ratios; and, for title XIII, the highest proportion to be 50 per centum and the lowest proportion 16 $\frac{2}{3}$ per centum, with intermediate ratios.

This provision requires joint determinations by the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board of the "financial resources" of the several States, measured by the per capita income of the inhabitants thereof. These determinations are to be expressed in series of matching proportions, fixing the proportion by which funds available as grants-in-aid to each State under titles V (pts. 1 and 2), etc., shall be related to the total amount of public funds expended under the State plan for these services. The range of these proportions of Federal grants-in-aid under title V (pts. 1 and 2) is from one-third to two-thirds.

Miss LENROOT. I would also like to have incorporated in the record a brief memorandum regarding the payment provisions in the amendment of title V. In brief, while the language of these provisions is considerably recast, the present procedure is in substance retained, that is, the determination of the amounts to be paid to the States, after making adjustments based on overpayments or underpayments in prior periods, certification to the Secretary of the Treasury and payment by the Secretary of the Treasury prior to audit or settlement by the General Accounting Office are retained. The new payment provisions incorporate the variable-matching grants principle as the basis for fixing the relative proportions of Federal and State and local public funds. In addition to the simplification of the language, the chief change effected is the elimination of the quarterly period as the basis for computing amounts of grants to the States. The experience of the Children's Bureau indicates that the matching formula should be applied over the entire period during the fiscal year to which the plan relates instead of to a single quarter.

Senator MURRAY. It will be filed with the clerk, and we will have it printed.

(The statement referred to was filed with the committee and is printed, as follows:)

EXHIBIT II.—PAYMENT PROVISIONS IN AMENDMENT OF TITLE V, SOCIAL SECURITY ACT, SECTION 2, OF S. 1620

The payment provisions are contained in sections 504 and 514. While the language of these provisions is recast considerably, the present procedure is, in substance, retained; that is, the determination of the amounts to be paid to the States, after making adjustments based on overpayments or underpayments in prior periods, certification to the Secretary of the Treasury, and payment by the Secretary of the Treasury prior to audit or settlement by the General Accounting Office are retained.

There is no subsection (c) in section 504 because of the elimination of the allotments formerly made under section 502 (b) and paid under section 504 (c).

The new payment provisions incorporate the variable-matching grants principle as the basis for fixing the relative proportions of Federal and of State (and local) public funds.

In addition to the simplification of the language in subsection (b) in both section 504 and 514, the chief change effected is the elimination of the quarterly periods as the basis for computing amounts of grants to the States. There has been some confusion caused by the ambiguity in the language of subsection (a) of these sections of the act which does not clearly indicate whether the quarterly periods therein provided concern only the procedure for payment of funds to the States or whether they require equal matching quarter by quarter. The Solicitor of the Labor Department, desiring to avoid any question concerning the proper procedure, has adhered to the view that this section requires that 50-50 matching be on a quarterly basis. The requirement of quarterly matching has placed a considerable burden upon State agencies, which appears not to be required by sound administration, and has resulted in a high degree of rigidity in the control and disbursement of funds granted to the States. To correct this situation the Children's Bureau believes it desirable that subsection (a) should specifically provide that the entire period covered by each State plan, which in no case shall extend beyond the end of the fiscal year, shall serve as the basis for computing amounts of grants to the State and, in addition, that there be specific authority for payments of funds to each State in installments from time to time as required.

The experience of the Children's Bureau indicates that the matching formula should be applied over the entire period during the fiscal year to which the plan relates. Thus, if the plan is an annual plan covering the entire fiscal year, the

determination of the amounts of funds for which the State qualifies to receive payment would be on the basis of the entire fiscal year. If, as may happen in some cases, the State plan covers only a part of the fiscal year, then the computation of the amounts to be paid to the State shall be based upon the period within the year covered by the plan.

While the States will be required to submit detailed reports of expenditures for past quarters and careful estimates of expenditures for succeeding quarters, and while no payments will be made to a State at any time in excess of the amount which it has qualified to receive under the variable-matching requirements of the bill, it appears to be highly desirable that payments to the States shall not be restricted to quarterly periods, but that they be made "from time to time" as needed. The requirement that payments be made "not less often than semiannually" is a sufficient safeguard against payment of sums over periods that are too extended and against the accumulation of grants-in-aid in the States in excess of current needs.

A sentence has been added at the end of section 501 (a) which provides as follows:

"In no event shall the total sum paid to the State for any fiscal year or part thereof covered by its plan be in excess of the total sum expended or obligated for amounts planned for expenditure from Federal funds."

The effect of this sentence will be to prevent a State from claiming that it has qualified to receive grants-in-aid where it has not extended or improved its program. In other words, it will not be enough for a State to plan for an increased program, but it must show that it has actually carried out the program substantially as planned. While there would seem to be no reasonable doubt that the present language of sections 504 and 514 of the act is sufficient to meet this situation, questions of this nature have arisen in the administration of title V of the act, and it appears desirable to provide in the act for this additional safeguard in view of the great expansion in the programs of service and the large increases in the funds involved in their administration.

Miss LENROOT. At the time of Dr. Eliot's appearance before the committee, she was asked also to submit a comparison of the allotment of the sums proposed for maternal and child health on the basis of present provisions of the act with the sums that would be allotted under the proposed provision. I have here the tables showing the estimated amounts that would be allotted to each State under the proposed plan and under the present plan, and the methods of computation. And I should like to have these inserted, if the committee please.

Senator MURRAY. They will be filed with the clerk and made a part of the record.

(The statement referred to was filed with the committee, and is printed, as follows:)

EXHIBIT III.—STATEMENT REGARDING METHOD USED IN MAKING DISTRIBUTION OF FUNDS FOR FIRST YEAR UNDER PROPOSED AMENDMENT TO TITLE V, PARTS 1 AND 2 OF THE SOCIAL SECURITY ACT

The three separate tabulations which have been submitted illustrate a suggested method of distributing among the various States the funds provided for the first year under title V, parts 1 and 2, of the proposed amendment to the Social Security Act. Since the time available for preparing these distributions has not permitted the application of certain desirable tests, and since indices to be available in the future may prove superior to certain indices which have been used, it should be emphasized that these distributions should be considered as tentative and for illustrative purposes only.

PRIMARY DISTRIBUTION, BASED ON POPULATION AND ADDITIONAL BASIC GRANT

In distributing the Federal funds for each program the first step has been to prorate approximately 25 percent of the total proposed appropriation on the

basis of the appropriate population figures for the respective programs—live births, children under 18, or children under 21. This distribution is in recognition of the need for certain general services in these programs and conforms with a recommendation included in the proposed amendment.

In the case of certain States with small populations, such basic distribution provides insufficient funds to cover the minimum cost of even a very modest program. To those States receiving less than \$20,000 on the basis of population alone, therefore, an additional sum has been allotted to bring the total basic grant up to a minimum of \$20,000. (A minimum of \$10,000 is used for the crippled children's program.) It should be noted that the amounts required for such additional grants will be reduced as the appropriation is increased, assuming, of course, that the proportion distributed on the basis of population is not decreased. In order to permit the making of grants for professional training at a later date, a total of \$250,000 of Federal funds has been reserved from the proposed appropriations for maternal and child health and medical care for children.

DISTRIBUTION BASED ON NEED FOR SERVICES AND SPECIAL PROBLEMS

The remainder of the proposed appropriation (somewhat less than three-quarters) has been distributed by means of an index of the proportionate need of the States for the services provided. This index, the composition of which is described below, appears in the tables as a sample distribution of \$1,000,000 (column 2). In order that the total funds made available (including State matching funds) may parallel the index of proportionate need, the Federal funds are distributed in accordance with the indicated Federal part of the respective needs (column 4).

USE OF VARIABLE MATCHING RATIOS

In accordance with the provisions of subsection 1101 (e) of the proposed revision of the act, variable matching ratios have been tentatively established, based on the average per capita incomes of the several States for the years 1935-37, inclusive. The income figures have been supplied by the Bureau of Foreign and Domestic Commerce, and the matching ratios worked out by the Social Security Board. These range from 33 $\frac{1}{4}$ percent (proportion of Federal funds) for the State with the highest average per capita income to 60 $\frac{3}{4}$ percent for the State with the lowest average per capita income.

As directed in the proposed revision of the act, these matching ratios have been applied to determine the amount of matching funds to be required for each separate State. Since a great majority of the matching ratios indicate more than 50 percent of Federal funds, the aggregate amount of matching funds required for all States is somewhat less than the proposed appropriation of Federal funds.

DETERMINATION OF PROPORTIONATE NEED FOR SERVICES

Columns 2, 3, 4, and 5 of the three tables submitted indicate the proportionate needs of the individual States for the services provided and the distribution of this amount between Federal and matching funds by means of the matching ratios. The steps involved in determining the relative needs of the States have been to prepare a composite index reflecting the economic conditions of the States and certain special problems, and to apply this index to the number of persons eligible for the services provided. In the Maternal and Child Health program the number of mothers and children eligible for the services provided is represented by the number of live births in each State in 1937, the latest year for which figures are available. In the case of the medical-care program and the Crippled Children's program, the number of eligible for such service is represented by the total number of children under 18 and under 21 years of age,

respectively. The factors used in preparing the composite index, together with the weightings assigned, are as follows:

Maternal and Child Health:	
Average income per capita, 1935-37.....	(8)
Infant mortality rate, 1934-36.....	(1)
Maternal mortality rate, 1934-36.....	(1)
Sparsity of population (square miles per 1,000 population in excess of the average for the most densely populated quartile State), 1930.....	(1)
Medical care for children:	
Average income per capita, 1935-37.....	(8)
Total mortality rate for children under 15, 1930.....	(1)
Average expenditure per capita for hospital care, 1935.....	(1)
Sparsity of population, 1930.....	(1)
Crippled Children:	
Average income per capita, 1935-37.....	(1)
Number of crippled children per thousand population under 21 (see below).....	(4)
Mortality rate from heart disease among children under 15, 1934-36.....	(1)
Mortality rate from diabetes among children under 15, 1934-36.....	(1)
Sparsity of population, 1930.....	(1)

In comment on the above factors, it may be stated that search is continuing for additional and better measures of economic need. Registers of crippled children are now being completed but are not yet sufficiently complete to permit their use in the distribution of funds. At the present time, therefore, it is necessary to assume a uniform proportion of crippled children in each State. The effect of this assumption is greatly to increase the influence of the total child population in the distribution of funds for the crippled children's program.

SPECIAL TREATMENT OF ALASKA, HAWAII, AND PUERTO RICO

Certain statistics available for the various States, and used in the above distributions, are not available for Alaska, Hawaii, and Puerto Rico. In making the present illustrative distribution, therefore, the composite index used for each of these Territories has been arbitrarily taken as that of the State with the highest index. This index has been multiplied by the appropriate population figure of each Territory to arrive at the final index of proportionate need. Each of these Territories has also been assigned a matching ratio of 66⅔ percent (proportion of Federal funds), the same as the State with the lowest per capita income.

STATEMENT REGARDING PER CAPITA INCOME ESTIMATES USED IN PREPARING MATERIAL FOR HEALTH BILL HEARINGS

PER CAPITA INCOMES USED IN THE DISTRIBUTION OF FUNDS

The per capita income figures used in the distribution of funds among the States, and in preparing matching ratios, have been supplied only recently by the Bureau of Foreign and Domestic Commerce of the United States Department of Commerce. These figures refer to "Income payments to individuals," for the years 1935-37. Insofar as possible, they reflect income payments by State of residence of the individuals receiving the payments.

Among the important characteristics in these figures, it should be noted that they do not include business earnings which are saved and are not paid out; they exclude employer and employee contributions to social-security programs, but include social-security benefits paid to individuals. They also include direct relief and public-assistance disbursements.

PER CAPITA INCOMES USED IN CHARTS

Since the per capita income figures described above were not available in time to use in making the various charts which have been prepared, use was made of per capita income figures published by the National Industrial Conference Board.

These figures refer to "Per capita accountable income received," and appear to be constructed under essentially the same plan as the Department of Commerce figures. The figures used, however, refer to the years 1935 or 1936, depending upon the time of preparation of the charts.

Conditional apportionment of funds available for grants to States for Maternal and Child Health Services

State	Proposed distribution under new method of allotment	Distribution under present plan	State	Proposed distribution under new method of allotment	Distribution under present plan
United States....	\$8,000,000	\$8,000,000	Montana.....	144,496	\$77,199
Alabama.....	309,113	239,271	Nebraska.....	80,696	94,069
Alaska.....	25,819	55,236	Nevada.....	23,411	56,111
Arizona.....	52,292	102,866	New Hampshire.....	26,399	46,837
Arkansas.....	168,635	142,725	New Jersey.....	124,990	138,732
California.....	226,338	261,642	New Mexico.....	71,653	115,385
Colorado.....	73,274	114,742	New York.....	359,349	436,001
Connecticut.....	46,332	61,518	North Carolina.....	343,817	278,367
Delaware.....	25,081	3,970	North Dakota.....	65,459	76,320
District of Columbia...	20,408	6,923	Ohio.....	262,928	271,936
Florida.....	109,956	137,337	Oklahoma.....	176,255	167,949
Georgia.....	291,085	264,054	Oregon.....	56,753	83,887
Hawaii.....	60,612	51,891	Pennsylvania.....	403,832	468,354
Idaho.....	49,183	72,691	Puerto Rico.....	365,029	293,723
Illinois.....	266,142	270,658	Rhode Island.....	33,110	42,265
Indiana.....	156,349	116,468	South Carolina.....	200,796	196,949
Iowa.....	139,621	123,582	South Dakota.....	61,632	73,514
Kansas.....	107,266	116,691	Tennessee.....	219,564	197,353
Kentucky.....	230,756	58,372	Texas.....	474,675	433,256
Louisiana.....	188,218	308,876	Utah.....	54,260	77,958
Maine.....	58,683	81,423	Virginia.....	35,676	50,257
Maryland.....	67,361	95,355	West Virginia.....	196,231	190,152
Massachusetts.....	136,806	159,016	Washington.....	74,427	99,392
Michigan.....	213,670	239,811	West Virginia.....	139,701	144,052
Minnesota.....	148,654	142,099	Wisconsin.....	147,784	144,631
Mississippi.....	281,373	190,760	Wyoming.....	30,666	62,167
Missouri.....	185,676	189,631	Professional training....	220,000	.....

Sample distribution of Federal funds for Maternal and Child Health program

[Rough tentative distribution for illustrative purposes only]

State (1)	Theoretical distribution of \$1,000,000 based on estimated need for service, special problems of maternal and child health, and matching ratios				Estimated distribution of funds for first year					
	Proportion- ate total need (2)	Matching ratios (per- cent of Federal funds) (3)	Apportionment of needed funds by means of matching ratios		Based on live births (6)	Amounts needed to bring each State's basic grant to mini- mum of \$20,000 (7)	Proportion- ate to need (based on column 4) (8)	Total Fed- eral funds (9)	State matching funds (10)	Total Fed- eral and State funds (11)
			Federal funds (4)	State matching funds (5)						
Total United States	\$1,000,000		\$590,762	\$409,238	\$2,000,000	\$463,983	\$5,536,017	\$8,000,000	\$5,740,577	\$13,740,577
Alabama	41,308	65.9	27,222	14,086	54,016		255,097	309,113	159,951	469,064
Arizona	6,154	66.0	3,446	2,708	9,200	10,800	32,292	52,292	41,087	93,379
Arkansas	25,361	66.5	16,865	8,496	30,893		158,042	188,935	95,178	284,113
California	32,494	47.2	15,337	17,157	82,615		143,723	226,338	253,192	479,530
Colorado	10,206	55.7	5,655	4,521	17,193	2,807	53,274	73,274	58,277	131,551
Connecticut	5,699	49.3	2,810	2,889	19,967		28,332	46,332	47,648	93,960
Delaware	1,212	44.5	539	673	3,818		5,051	25,051	31,243	56,294
District of Columbia	3,014	33.3	1,004	2,010	10,822	9,178	9,408	29,408	58,904	88,312
Florida	15,364	58.4	8,973	6,391	23,870		84,086	109,956	78,325	188,281
Georgia	39,109	64.1	25,069	14,040	56,164		234,921	291,085	164,026	454,111
Idaho	5,318	58.5	3,111	2,207	9,091	10,909	29,153	39,153	34,869	84,022
Illinois	33,049	53.3	17,615	15,434	101,072		165,070	266,142	233,186	499,328
Indiana	19,652	58.2	11,437	8,215	49,173		107,176	156,349	112,292	268,641
Iowa	18,452	59.4	10,960	7,492	36,915		102,706	139,621	95,431	235,052
Kansas	14,603	64.1	8,703	5,900	25,710		81,556	107,266	72,711	179,977
Kentucky	30,218	61.2	19,370	10,848	49,240		181,516	220,756	129,238	350,994
Louisiana	25,495	57.9	15,781	9,714	40,335		147,883	188,218	115,850	304,068
Maine	7,216	61.2	4,126	3,088	13,367	6,633	38,683	43,041	59,735	102,593
Maryland	8,666	51.0	4,593	4,073	24,329		43,041	67,361	59,735	127,096
Massachusetts	17,186	51.4	8,823	8,343	54,126		82,680	136,806	129,354	266,160
Michigan	26,862	53.0	14,237	12,625	80,255		133,415	213,670	189,481	403,151
Minnesota	20,015	56.8	11,369	8,646	42,115		106,539	148,654	113,061	261,715
Mississippi	37,709	66.7	25,152	12,557	45,674		235,699	281,373	140,476	421,849
Missouri	24,744	58.5	14,475	10,269	49,931		135,645	185,576	131,648	317,224

* Includes \$250,000 reserved for later allotment for professional training.

** Includes \$173,012 of State matching funds for professional training, estimated on the basis of weighted average of matching ratios for all States.

Sample distribution of Federal funds for Maternal and Child Health program—Continued

[Rough tentative distribution for illustrative purposes only]

State (1)	Theoretical distribution of \$1,000,000 based on estimated need for service, special problems of maternal and child health, and matching ratios				Estimated distribution of funds for first year					
	Proportion-ate total need (2)	Matching ratios (percent of Federal funds) (3)	Apportionment of needed funds by means of matching ratios		Based on live births (6)	Amounts needed to bring each State's basic grant to minimum of \$30,000 (7)	Proportion-ate to need (based on column 4) (8)	Total Federal funds (9)	State matching funds (10)	Total Federal and State funds (11)
			Federal funds (4)	State matching funds (5)						
Montana.....	\$4,840	54.0	\$2,614	\$2,228	\$8,985	\$11,015	\$24,496	\$44,496	\$37,904	\$82,400
Nebraska.....	10,904	59.4	6,477	4,427	19,525	475	60,696	80,696	55,156	135,852
Nevada.....	793	45.9	364	429	1,527	18,473	3,411	23,411	27,593	51,004
New Hampshire.....	3,075	56.9	1,750	1,325	6,692	13,308	16,399	36,399	27,571	63,970
New Jersey.....	15,411	53.4	8,229	7,182	47,876	-----	77,114	124,990	109,074	234,064
New Mexico.....	45,901	60.1	5,512	3,659	12,131	7,869	51,653	71,653	343,817	419,223
New York.....	45,553	64.3	29,291	25,016	162,636	-----	195,713	358,349	429,231	787,580
North Carolina.....	7,651	63.4	16,262	2,800	69,332	-----	274,485	343,817	190,891	534,708
North Dakota.....	33,259	54.1	17,993	15,266	11,079	8,921	45,459	65,459	37,789	103,248
Ohio.....	23,624	63.2	14,930	8,694	94,316	-----	168,612	262,928	223,076	486,004
Oklahoma.....	7,054	55.6	3,922	3,132	36,346	-----	139,909	176,255	102,629	278,884
Oregon.....	50,917	55.0	28,004	22,913	13,552	6,448	36,753	56,753	45,321	102,074
Pennsylvania.....	2,754	50.8	1,399	1,355	141,407	-----	292,425	403,832	330,408	734,240
Rhode Island.....	27,073	65.1	17,625	9,448	8,878	11,022	13,110	33,110	32,067	65,177
South Carolina.....	7,057	62.8	4,432	2,625	35,653	-----	165,163	200,796	107,646	308,442
South Dakota.....	29,062	63.9	18,571	10,491	10,440	9,560	41,532	61,532	36,449	97,981
Tennessee.....	65,543	60.7	39,785	25,758	45,536	-----	174,028	219,564	124,042	343,606
Texas.....	6,280	58.4	3,656	2,604	101,751	-----	372,824	474,575	307,262	781,837
Utah.....	2,827	58.8	1,662	1,165	11,128	-----	34,260	54,260	38,651	92,911
Vermont.....	25,978	61.9	16,080	9,898	5,546	14,454	15,575	35,575	24,927	60,502
Virginia.....	10,332	54.2	5,600	4,732	45,546	-----	150,685	196,231	120,782	317,013
Washington.....	18,109	60.5	10,956	7,153	21,950	-----	52,477	74,427	62,892	137,319
West Virginia.....	19,320	55.7	10,761	8,559	37,033	-----	102,668	139,701	91,210	230,911
Wisconsin.....	2,092	53.6	1,121	971	46,943	-----	100,841	147,784	117,537	265,321
Wyoming.....	931	66.7	621	310	3,972	16,028	10,505	30,505	26,407	56,912
Alaska.....	6,502	66.7	4,337	2,165	1,128	18,872	5,819	25,819	12,890	38,709
Hawaii.....	48,921	66.7	32,630	16,291	7,876	12,124	40,642	60,642	30,276	90,918
Puerto Rico.....	-----	-----	-----	-----	59,254	-----	305,775	365,029	182,241	547,270
Reserved for later allotment for professional training.....	-----	-----	-----	-----	-----	250,000	-----	250,000	173,012	423,012

Miss LENROOT. Because the principle of variable matching grants has been introduced in the pending bill, it omits the provision of title V, of the present act for what we call a B fund, from which grants can be made without matching on the basis of the State's financial need for assistance in carrying out its plan as determined by the Secretary of Labor after taking into consideration the number of live births. The amount of the B fund represents about a quarter of the total appropriation.

If the committee should not see fit to retain the principle of variable matching which in my judgment is an extremely important and valuable feature of the bill, provision for a B fund representing approximately one-quarter of the total appropriation should be re-incorporated and a similar fund should be provided in part 2. Absence of provision for such a fund has handicapped seriously the program of services for crippled children in some States, and has made it difficult for the Federal Government quickly to mobilize needed resources to deal with infantile paralysis epidemics.

I would like now to refer to the amendments to the proposed bill suggested by the Department of Labor.

In a letter to the chairman of the Committee on Education and Labor from the Secretary of Labor dated May 1, 1939, certain amendments were proposed which would provide for closer collaboration among the several agencies charged with responsibility for the administration of the health program on the part of the Federal Government. I should like to have two paragraphs from this letter relating to joint consultation, joint conferences with State and Territorial health officers, and a single advisory health council, incorporated as a part of my statement.

Senator MURRAY. It may be incorporated as part of the record.

(The statement referred to was filed with the committee, and is printed, as follows:)

EXHIBIT IV.—EXCERPT FROM LETTER OF MAY 1, 1939, FROM THE SECRETARY OF LABOR TO HON. ELBERT D. THOMAS, CHAIRMAN, COMMITTEE ON EDUCATION AND LABOR, UNITED STATES SENATE

* * * * *

In order to provide for closer collaboration among the several agencies charged with the responsibility for the administration of the health program on the part of the Federal Government, it is the suggestion of this Department that your committee consider the desirability of two changes in the various titles of the bill. It is suggested, first, that provision be made for joint consultation by the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, and the Social Security Board in order to develop uniformity in requirements established for the submission of budgets, accounts, and reports by the cooperating State agencies. The second suggestion is that there be created a single advisory National Health Council in place of the several Federal advisory councils authorized under sections 506 and 516 of title V and similar sections of titles VI, XII, and XIII. This council might be composed of approximately 15 to 21 members, with rotating terms of 3 or 4 years each, appointed jointly by the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, and the Social Security Board. The council would be composed of members of the professions and agencies concerned with health and medical care and related social and economic problems and other persons informed on the need for, or provision of, such care. The council would serve in an advisory capacity to the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, and the Social Security Board.

It is suggested also that the proposed amendments of title XI of the act include a provision for joint conferences by the Chief of the Children's Bureau,

the Surgeon General, and the Social Security Board with State and Territorial health authorities or the executive officers of other State agencies charged with the administration of services contemplated by titles V, VI, XII, and XIII of the bill with reference to the adoption of regulations relating to the making of allotments and payments of funds to the States under those titles.

* * * * *

Miss LENROO. The proposal in section 516 for an advisory council or councils composed of professional persons, persons connected with agencies concerned with the programs to be developed, and other persons informed on the need for, or provision of, such services for children, simply incorporates in the statute the present practice of the Children's Bureau. I shall ask to have incorporated in the record a list of the advisory committees appointed by the Secretary of Labor at the request of the Chief of the Children's Bureau to advise her concerning the administration of title V, parts 1 and 2.

Senator MURRAY. The exhibit will be filed with the clerk and made a part of the record.

(The document referred to was filed with the committee, and is printed, as follows:)

EXHIBIT V.—GENERAL ADVISORY COMMITTEE ON MATERNAL AND CHILD-WELFARE SERVICES

Appointed by the Secretary of Labor to advise the Children's Bureau concerning the development of general policies affecting the administration of title V, parts 1, 2, and 3 of the Social Security Act

- Chairman, Fred K. Hoehler, director, American Public Welfare Association.
 Grace Abbott, professor of public welfare, the School of Social Service Administration, University of Chicago. (Deceased.)
 Fred L. Adair, M. D., professor of obstetrics and gynecology, University of Chicago; American Committee on Maternal Welfare; chairman, Children's Bureau Advisory Committee on Maternal and Child-Health Services.
 Mrs. Roscoe Anderson, National League of Women Voters.
 W. W. Bauer, M. D., director, bureau of health and public instruction, American Medical Association.
 Mrs. Dorothy Bellanca, vice president, Amalgamated Clothing Workers of America, Congress of Industrial Organizations.
 Mrs. Edwin Bevens, General Federation of Women's Clubs.
 Kenneth D. Blackfan, M. D., professor of pediatrics, Harvard University School of Medicine.
 M. O. Bousfield, M. D., director for Negro health, Julius Rosenwald fund.
 C. O. Carstens, executive director, Child Welfare League of America, Inc. (Deceased.)
 A. J. Chesley, M. D., secretary and executive officer, Minnesota Department of Health; secretary-treasurer, Conference of State and Provincial Health Authorities of North America.
 H. Ida Curry, chairman, Children's Bureau Advisory Committee on Community Child-Welfare Services.
 Harriet Elliott, dean of women, the Woman's College of the University of North Carolina; American Association of University Women.
 John A. Ferrell, M. D., associate director, international health division, The Rockefeller Foundation; American Public Health Association.
 Homer Folks, secretary, State Charities Aid Association.
 Mary G. Hawks, National Council of Catholic Women.
 Henry F. Helmholz, M. D., Mayo Clinic; professor of pediatrics, University of Minnesota Graduate School of Medicine.
 T. Arnold Hill, director, department of industrial relations, National Urban League.
 W. Freeland Kendrick, chairman, board of trustees, Shriners' Hospitals for Crippled Children.
 Paul H. King, The International Society for Crippled Children, Inc.
 The Reverend Bryan J. McEntegart, director, division of children, Catholic Charities of the Archdiocese of New York.

Robert B. Osgood, M. D., emeritus professor of orthopedic surgery, Harvard University School of Medicine; chairman, Children's Bureau Advisory Committee on Services for Crippled Children.

Mrs. J. K. Pettengill, president, National Congress of Parents and Teachers.
Emma C. Puschner, director, national child welfare division, the American Legion.

Robert H. Riley, M. D., director, Maryland State Department of Health.

Mrs. Abble C. Sargent, Associated Women of the American Farm Bureau Federation.

Mrs. Dora H. Stockman, the National Grange.

Mrs. Nathan Straus, National Council of Jewish Women.

Linton B. Swift, general director, Family Welfare Association of America.

Katharine Tucker, R. N., director, department of nursing education, University of Pennsylvania.

ADVISORY COMMITTEE ON MATERNAL AND CHILD-HEALTH SERVICES

Chairman, Fred L. Adair, M. D., professor of obstetrics and gynecology, University of Chicago; chairman, American Committee on Maternal Welfare.

Twenty-eight other members, including 22 physicians, 1 dentist, 3 public-health nurses, 2 other public-health workers.

Subcommittee on Maternal Health, Fred L. Adair, M. D., chairman.

Subcommittee on Child Health, Henry F. Helmholz, M. D., professor of pediatrics, University of Minnesota Graduate School of Medicine, chairman.

ADVISORY COMMITTEE ON SERVICES FOR CRIPPLED CHILDREN

Chairman, Robert B. Osgood, M. D., emeritus professor of orthopedic surgery, Harvard University School of Medicine.

Eighteen other members, including 12 physicians, 1 physical therapist, 1 public health nurse, 1 medical social worker, 1 director of special classes, 1 supervisor of vocational rehabilitation, 1 State director of a crippled children's program.

SPECIAL ADVISORY COMMITTEE ON PUBLIC-HEALTH NURSING

Chairman, Katherine Tucker, R. N., director, department of nursing education, University of Pennsylvania.

Eight other members, public health nurses.

SPECIAL ADVISORY COMMITTEE ON DENTAL HEALTH

Chairman, Guy S. Milberry, D. D. S., dean, University of California College of Dentistry.

Eight other members, all members of dental profession.

Miss LENROOT. These committees have been of major assistance in the development of policies. If a single advisory national health council serving the several Federal agencies entrusted with administrative responsibility under the program were substituted for the council authorized in section 516 of the pending bill, as recommended by the Secretary of Labor in her letter to the chairman of this committee, I believe it would retain all the advantages of the present general advisory committee and would facilitate the development of uniform policies affecting like features of the programs. The Children's Bureau would still have the authority to establish special advisory committees as they appear to be needed for the more efficient administration of its responsibilities.

The responsibilities of the Children's Bureau under title V, parts 1 and 2 of the act, are discharged under the supervision of the assistant chief, Dr. Martha M. Eliot. Two divisions, each headed by a physician, and a public-health nursing unit work under her direction. I should like to have inserted in the record a statement showing the professional staff of the Children's Bureau engaged in the administration of title V, parts 1 and 2.

Senator MURRAY. It may be made a part of the record.
(The document referred to was filed with the committee, and is printed, as follows:)

EXHIBIT VI.—PROFESSIONAL STAFF OF THE CHILDREN'S BUREAU, UNITED STATES DEPARTMENT OF LABOR, ADMINISTERING TITLE V, PARTS 1, AND 2 OF THE SOCIAL SECURITY ACT

Within the Children's Bureau, general responsibility for the development of policies and the supervision of activities for the Maternal and Child Health and Crippled Children's program is vested in the Assistant Chief Martha M. Elliot, M. D. Dr. Elliot is a pediatrician with 21 years of clinical, research, teaching, and administrative experience. Two divisions and a public-health nursing unit give professional direction and consultation service.

Division of Maternal and Child Health.—Director Edwin F. Dally, M. D., an obstetrician with 6 years' experience as instructor in obstetrics at the University of Chicago School of Medicine. Assistant Director Jessie M. Bierman, M. D., formerly instructor in pediatrics, University of California Medical School, and former director of the Montana State Division of Maternal and Child Health.

The staff includes an obstetric consultant, a pediatric consultant, and a specialist in nutrition.

Crippled Children's Division.—Director Robert C. Hood, M. D., pediatrician, formerly attending physician to the Crippled Children's School in the Cincinnati General Hospital and instructor in pediatrics in the University of Cincinnati Medical School. Assistant Director A. L. Van Horn, pediatrician, formerly instructor in Western Reserve University School of Medicine, and formerly director of the bureau of child hygiene of the Ohio Department of Health.

On the staff of the Crippled Children's Division are two part-time orthopedic consultants and a medical social work consultant.

Public-Health Nursing Unit.—Director Naomi Deutsch, R. N., public health nurse, formerly field director of Henry Street Visiting Nurse Association, director of the Visiting Nurse Association of San Francisco, and assistant professor of public-health nursing at the University of California.

Regional consultant staffs serving the Maternal and Child Health and Crippled Children's Division and the Public Health Nursing Unit give field consultation service to the State agencies. To each of five field regions a medical consultant, a public-health nurse consultant, and a medical social worker are assigned. Four of the five medical consultants are pediatricians and have engaged in the private practice of pediatrics. All have had training in public-health administration and in State or local administration of maternal and child-health services.

The regional public-health nursing consultants are certified public-health nurses who have had various types of experience including community experience in public-health nursing with public and private agencies, supervisory and advisory experience with State and National agencies, experience in hospital administration and in teaching public-health nursing, and experience in orthopedic nursing and in aftercare services for poliomyelitis.

The medical social work consultants (who serve primarily the Crippled Children's program) have had experience in medical social work in hospitals and in the administration of such services. Some of them have had experience in medical social work with crippled children and with mothers and infants.

Miss LENROOT. Experience under the present act and review of the extent of need and the possibilities of effective administration of an expanded program made by advisory committees, the State and Territorial health authorities, special conferences, and organizations concerned with child health, has demonstrated the following:

1. Following the passage of the Social Security Act, all the States and Territories were in a position to inaugurate promptly a program of maternal and child health.

2. The program of services for crippled children took somewhat longer to develop, due to certain administrative problems, but is now fully under way in all jurisdictions.

3. Under both programs the States have taken up from year to year increased proportions of the amounts made available by the Federal

Government, as shown by the following charts, which I ask to have incorporated in the record for the purpose of showing the proportion of the total funds available taken up by the States under the matching provisions.

Senator MURRAY. Very well; it will be made a part of the record.

(The charts referred to were filed with the committee, and are printed as charts 1 and 2, on the following pages:)

CHART 1

PERCENTAGES OF ANNUAL FEDERAL ALLOTMENTS OF MATERNAL AND CHILD-HEALTH FUNDS MATCHED BY STATES IN THE FISCAL YEARS 1937 AND 1939
SOCIAL SECURITY ACT, SECTION 502A



BARS EXTENDING TO 100 PERCENT ON SCALE INDICATE THAT STATES REPRESENTED SUPPLIED MATCHING FUNDS IN THE AMOUNT OF 100 PERCENT OR MORE OF ANNUAL FEDERAL ALLOTMENTS

CHART 2

PERCENTAGES OF ANNUAL FEDERAL ALLOTMENTS OF FUNDS FOR SERVICES FOR CRIPPLED CHILDREN, MATCHED BY STATES IN THE FISCAL YEARS 1937 AND 1939
SOCIAL SECURITY ACT, SECTION 512 A



BARs EXTENDING TO 100 PERCENT ON SCALE INDICATE THAT STATES REPRESENTED SUPPLIED MATCHING FUNDS IN THE AMOUNT OF 100 PERCENT OR MORE OF ANNUAL FEDERAL ALLOTMENTS

CHILDREN'S BUREAU
UNITED STATES DEPARTMENT OF LABOR

Miss LENROOT (continuing):

4. Federal, State, and local governments have had full cooperation from the medical and other professions, and from private hospitals and other private agencies whose resources have been widely used.

5. Extension of public-health nursing and prenatal and child health conference service to rural areas not previously served has been rapid, but still one-fourth of the rural counties are without pub-

lic-health nursing service; only one-seventh of the rural counties have prenatal clinics, and one-fourth child-health conference service.

6. The most urgent need in the field of maternal care is for professional attendance at time of childbirth. The funds authorized under the present act are not sufficient to permit development of this phase of the program. One-eighth of the babies in the United States are born without medical attendance, and many thousands of ill children do not receive medical care when needed.

7. Waiting lists of crippled children in need of care are long in many States, and many types of physical handicap are not covered by the present program.

8. The program has emphasized maintenance of high standards of professional service. This has been accomplished through recommendations of advisory committees and the State and provincial health authorities, and the use of standards of professional associations and specialty boards. Strengthening of the provisions to insure appointments and tenure based on merit would enable the State agencies to maintain and extend the gains made in the direction of sound and competent administration.

9. The rule-making power of the Secretary of Labor has been used sparingly, for the purpose of establishing basic policies only. The general approach has been to emphasize flexibility of program to meet varying conditions and differing administrative problems within the States.

10. The present program has contributed to substantial gains in maternal and child health, as indicated by various indices, to some of which Dr. Eliot will refer.

11. There is great variation in resources and need among the States and in different sections of the same State.

With reference to Federal administration research and demonstration, I have already referred to the staff of the Children's Bureau carrying on administrative and consultative work under the present provisions of title V, parts 1 and 2 of the Social Security Act. Although the present act—section 541—directs the Children's Bureau to make such studies and investigations as will promote the efficient administration of title V, funds have been made available for such research only to a very limited extent.

Increased staff for administrative work and consultation service, and for studies, investigations, and demonstrations is essential if an expanded program of Federal and State cooperation is authorized. Moreover, immediate increase in trained personnel in the States will be necessary, and this demands expansion and improvement in training programs.

Of course, we all feel and realize that the problem of the health of mothers and children goes to the root of national vitality and well-being. Possibilities of great advance await only the provisions of expanded resources for service.

Senator MURRAY. Thank you, Miss Lenroot.

**STATEMENT OF DR. MARTHA M. ELIOT, ASSISTANT CHIEF,
CHILDREN'S BUREAU, DEPARTMENT OF LABOR—Resumed**

Dr. ELIOT. Mr. Chairman and members of the committee, I have prepared a statement giving information with regard to progress and

experience in the administration of the Maternal and Child Health and Crippled Children's programs under the Social Security Act, and evidence of need for expansion of these programs, as proposed in S. 1620. I would like to ask permission to insert this statement in the record, including tables and charts which give data regarding the program and need for expansion, and to summarize briefly some of the important facts brought out in this statement for you at this time.

Senator MUMFAY. The statement will be filed with the clerk and made a part of the record.

(The statement referred to was filed with the committee and is printed at the end of Dr. Eliot's testimony.)

Dr. ELIOT. The programs referred to for Maternal and Child Health and Crippled Children have been in operation for 3 years and 4 months. At this time all States and Territories are cooperating under both programs. Each year the States have prepared and submitted plans which have been approved by the Chief of the Children's Bureau. All of the States have sought consultation and advice from the technical staff of the Children's Bureau. Many more requests for such consultation have been received by the Children's Bureau from the State agencies than it has been possible for the Children's Bureau staff to fulfill.

I would like to refer briefly to certain aspects of the administration of these two programs as they have been developed by the States during the past 3 years, because it is on the basis of this experience and the needs demonstrated that an expansion of program as contemplated in S. 1620 appears justified.

I would like to speak first with respect to the cooperation between the State administrative agencies and the medical profession in the States.

Three devices have been used by the State agencies to establish this type of cooperation.

1. Advisory committees or councils.

All States have established advisory committees on the Maternal and Child Health program, and nearly all advisory committees on the Crippled Children's program. In all cases the medical profession has been represented.

In 28 States special Maternal Child Health advisory committees of physicians have been formed and in 34 States special committees of physicians and surgeons with regard to the Crippled Children's program have been formed. These committees have considered problems of standards of service, qualifications of personnel, and content of programs.

In 25 States, State health officers have appointed as one of their advisory committees the Maternal and Child Health committees of State medical associations.

2. Cooperative studies by the State health agencies with State and local medical associations.

3. Organization of postgraduate education facilities for general practitioners who live in areas remote from medical centers.

During the past 3 years all States have offered courses in obstetrics and pediatrics. In each case this has been done in cooperation with State and local medical societies.

The cost of these postgraduate courses has been borne in whole or in large part by Federal Maternal and Child Health funds.

In 1938, \$146,000 was spent from Maternal and Child Health funds. Ten thousand general practitioners attended these courses in 1938.

Cooperation with dental profession by the State administrative agencies through advisory committees in 29 States have appointed dentists to general advisory committees.

A few States have given postgraduate courses in children's dentistry in cooperation with State dental associations.

Special projects have been undertaken in which State dental associations have cooperated.

COOPERATION WITH NONPROFESSIONAL GROUPS

State administrative agencies have appointed to their general advisory committees representatives from the State farm groups, parent-teacher associations, State federations of women's clubs, service clubs, American Legion, State crippled-children's societies, and so forth.

STATE ADMINISTRATION

In all States Maternal and Child Health programs are administered by the State health departments. Crippled Children's programs are administered by State health agencies in 25 States; State welfare agencies in 15 States; Crippled Children's commissions in 5 States; departments of education in 4 States; an interdepartmental committee in 1 State; and State university hospital in 1 State.

I refer to this because of the clause included in the pending bill that would require the transfer of this program from these agencies to State health agencies at the end of 5 years.

Senator ELLENDER. Dr. Eliot, do you think that that ought to be done?

Dr. ELIOT. The tendency during the last 3 years has been for the State health agencies to assume the responsibility for the crippled children's programs. I have included in my statement the exact number of transfers of the Crippled Children's program that have been made from some other State agency to the State health agency. Also, of the number of new State agencies that have been established by State legislatures to administer the Crippled Children's program, a majority have been the State health agency. The Crippled Children's program is primarily a medical-care program. It is, in fact, one of the few, if not the only program of Federal grants-in-aid to the States for a strictly medical-care program.

Senator ELLENDER. Dr. Eliot, you mentioned a while ago the cooperation that existed between the State agencies with the medical profession and the dental profession. Is there anything in the present bill that would prevent a continuation of that cooperation?

Dr. ELIOT. Nothing, Senator.

Medical participation in these programs: All of the Maternal and Child Health programs are directed by a physician. Thirty-two Crippled Children's programs are directed by a physician. In 18 States technical advisory committees of orthopedic surgeons give medical advice and assistance to the nonmedical directors.

In the Maternal and Child Health program, the medical administrative staff consists of 191 full-time or part-time physicians. Then, to assist them, they have consultants who are paid on a fee basis. The State programs for Maternal and Child Health have employed local practicing physicians paid for conference and clinic work in the number of 3,000 or more.

Under the Crippled Children's program, there are 82 physicians on the administrative staff. Practicing surgeons assist with this program. They are either paid on a fee basis or they are paid on a salary basis. There are 700 such surgeons employed under this program. Other consultants, that is, specialists and practicing physicians, are paid on a fee basis. There are 655 such other consultants employed by the States in this program.

The total number of practicing physicians and surgeons in the Crippled Children's program in 1,355.

Standards of care: I would like to say something with regard to the standards of care.

In order to promote high quality of service, conferences of State and Territorial health officers and Children's Bureau advisory committees have made recommendations with respect to qualifications for personnel to be employed in the Maternal and Child Health and Crippled Children's programs. At a recent conference, in April 1939, the State and Territorial health officers recommended that after June 30, 1939, all new personnel employed should meet the standards laid down by them in these recommendations with regard to qualifications.

State agencies have found these recommendations useful in raising standards of work and in establishing bases for selection of personnel.

Progress in establishing services: I would like to refer to the progress that has been made in establishing services under Maternal and Child Health and the Crippled Children's programs in the States. A report of the actual services rendered in the years 1937 and 1938 under the Maternal and Child Health program will be found in table 1 that I have submitted to you, and a similar one for services for Crippled Children in table 10.

I have asked to have inserted also in the record in connection with this statement, a statement describing certain examples of local Maternal and Child Health services which give a picture of the different types of work that are being carried on in the States. They include projects involving typical prenatal and child-health conferences, maternal nursing projects, care of premature infants, or as in the State of Oklahoma, a complete maternity service including medical care, nursing care, and prenatal and child-health conferences. These are included to indicate that the States have real experience which will be useful to them in administering an expanding program.

I would like to point out that since the Social Security funds have been made available for the Maternal and Child Health program, the number of child-health conferences have increased 60 percent, but in spite of this, only 26 percent of rural counties have such service.

The number of prenatal clinics under State Maternal and Child Health programs has increased 69 percent, but only 14 percent of rural counties have such clinics.

Nursing care for women at delivery is provided by 29 States in very limited areas (a county or part of a county as a rule) to demon-

strate method and feasibility of rendering care. The programs have been very successful and acceptable to patients and physicians.

To provide adequately for all these services four to five times as many nurses as are now available are needed for rural areas, two to three times as many for cities; there should be a great increase in prenatal clinics and child-health conferences, especially in smaller cities and rural areas.

The most apparent needs are listed in full in my statement, and indicate a great lack of resources to provide:

Medical and nursing care for maternity patients and for infants and children in families who cannot provide for them from their own resources.

Hospitalization costs—in existing hospitals which meet standards set by States.

New hospital and health and diagnostic center facilities where needed.

Consultation service of specialists in pediatrics and obstetrics, either practicing physicians or full- or part-time physicians employed by State or local area in areas where there are none today.

That the State health officers themselves recognize their needs in these fields of service is quite clear. Last year 28 health officers estimated the cost of providing personnel and services to meet the most immediate needs at \$22,000,000, including \$14,000,000 for public-health nurses and \$2,500,000 for medical services in clinics, conferences, and in a few States, cost of maternity delivery care. I have asked to have included in the record excerpts from their statements of need, describing in their own language their most pressing needs. These have also been submitted with my statement. Because of certain statements that have been made by witnesses at these hearings regarding infant and maternal mortality rates, I have included in my statement information from the Bureau of the Census and from other sources in the form of tables and charts. I have asked to have them inserted in the record as part of my general statement. The tables give the trend in infant mortality and maternal mortality since 1915, and the trends in the deaths of infants under 1 month—deaths often associated with maternal mortality.

I have prepared some charts which I have included in the statement that you have before you, but I have them here because I thought they would be of interest to you at this time.

The charts give graphically the facts which are the basic evidence of need for expansion of the Maternal and Child Health program.

The first two charts, Miss Lenroot has referred to. The next four relate to infant mortality; the next three to maternal mortality. They show that there has been little decrease in maternal mortality until recently, and but slight decrease in infant mortality in the first month of life. The range in rates by States is very great as can be seen on the maps. The range by counties is even greater.

Approximately 14,000 women die each year, from causes associated with childbirth, and 70,000 newborn infants. Seventy-five thousand infants are still-born.

With expert care, from one-half to two-thirds of the women's lives and at least one-half of the infants' lives and an appreciable number of still-births could be saved. In 1937, only 10,769 women died from

conditions directly due to pregnancy and childbirth. The rate is 14 percent lower than in 1936, representing a saving of approximately 1,750 lives. The interrelation of place of birth, whether urban or rural, of attendant at birth, and the financial resources of the State, as indicated by per capita income is shown in the next five charts.

In connection with the next three charts, I would like to point out that there are nearly one-quarter of a million women delivered each year without a physician in attendance—this means also a quarter of a million infants with no medical attention at the most critical period of their lives. In rural areas, only 16 percent of livebirths occur in hospitals; in cities, 75 percent occur in hospitals.

With reference to the chart showing rural counties with no births in hospitals. I would call your attention to the fact that these are not counties in which only a few births occur. Actually, nearly 200,000 births took place in these counties; in 397 counties, more than 200 births took place in each; in 36 counties, 600 or more births. Obviously in emergencies women must seek hospital care outside their own communities if they are to get it at all.

The last three charts give data on the relative distribution of births and number of children and the distribution of national income among the States grouped according to their income per capita. The discrepancies are obvious and offer basic evidence for the need for some method of equalizing resources to provide for care.

I would like to refer to the data in the statement that I have submitted on economic status, its relation to maternity care and medical care of children, which reads as follows:

"It is estimated that of the 2,000,000 births each year, 1,100,000 occur in families who have incomes of less than \$1,000 or are on relief; approximately 900,000 are in families with incomes of less than \$800 or are on relief. For families with incomes at this level the cost of maternity care must be rated in the category of major medical expenditures. To the Nation the outcome of the 2,000,000 births in terms of the survival and health of the mother and child is of sufficient significance to warrant the provision by Government of facilities to insure the best possible care for all who are unable to provide it from their own resources.

"Data have been cited to show inadequacy of facilities in rural areas and to show that among women who die prenatal care is most inadequately received. A recent study of maternal care made by the Children's Bureau in a New England city has shown that the best type of prenatal care was received by 73 percent of the women who were private patients but by only 15 percent of the women who received free care. Prenatal care was given early in pregnancy to 84 percent of the private patients, but to only 35 percent of the free patients. That the adequacy of prenatal care received is related not only to the income of the family but to the size of place in which they live has been recently reported by the United States Public Health Service from a study of maternal care in which it cooperated with the Michigan State Medical Society. Prenatal care was received by all but 8 percent of women in so-called comfortable circumstances—that is, incomes of about \$2,000 or more—whereas 43 percent of women on relief received no prenatal care. Women living in rural areas, especially those women who were classified as poor (incomes less than

\$1,000 a year) or on relief, had much less prenatal care than women living in large cities. Women living in rural areas will twice as likely get hospital care at delivery when they were in comfortable circumstances as when they were poor or on relief.

"Women in large cities were three times as likely to get hospital care as poor rural women. The same was true for care following delivery; more than twice as large a proportion of women who were poor received no follow-up examination than of women who were in comfortable circumstances; more than twice as large a proportion of poor rural women received no such examination than of city women. The data reported corroborates facts that have been commonly believed for many years.

"Women with low incomes cannot obtain adequate maternity care unaided."

With respect to medical care of children as related to the economic status of the families, I have stated: "Of the 43,000,000 children under 18 years of age in the United States, approximately 16,000,000 are in families with incomes of less than \$800 a year or on relief. Some 700,000 dependent children are now receiving aid under title IV of the Social Security Act, and it is estimated by the Social Security Board that there are probably twice as many additional children who should be getting similar aid. There is no adequate provision for medical care for this group of children, though in one way or another some care is provided in many areas, especially where clinics exist. Some better provision should be made."

The part of my statement on the Maternal and Child Health program concludes with data showing the need for expanding the program for medical care for children beyond the limits of the present child health supervisory type of service and the program of medical care of crippled children to a broader field of medical care of children with defects in need of correction or other types of illness occurring in families that cannot pay the costs of needed care. Special needs of children with defective vision or hearing, with tuberculosis, or other communicable diseases are discussed briefly in the main report; also the needs of children receiving aid under title IV that I have referred to.

The futility of going through a careful physical examination and making a diagnosis of conditions requiring treatment when nothing can be done about treatment is apparent. I would like to draw the committee's attention to the fact included in the report of the technical committee on medical care that in only 2 percent of communities with less than 10,000 population are there out-patient diagnostic and treatment clinics such as are found attached to hospitals in every city of 250,000 population or over, and in half of the cities with 50,000. And yet about 50 percent of families live in these smallest cities and in rural areas.

Finally, I want to refer to statements made regarding certain aspects of administration of the Crippled Children's program. I have already referred to the medical direction and staff, and to cooperation of members of the medical profession through advisory technical committees.

With respect to diagnostic clinics—all States have organized diagnostic clinics, some in hospitals, some as itinerant clinics held at

strategic points throughout the States to serve small cities and rural areas. In all cases diagnostic clinics are in charge of orthopedic surgeons—in 1938, 206 permanent clinics in hospitals in 35 States; 572 itinerant clinics in 38 States.

Eligibility for care is determined on policies laid down by each State agency. As a rule, acceptance of children for whom care is sought by the parents has been limited only by the State definition of type of case to be accepted and by the medical need of the child. Many local medical men have referred their patients to these diagnostic clinics. Acceptance for care in hospitals is, as a rule, authorized by the State agency or by duly authorized local representatives, but only after examination by an orthopedic or plastic surgeon.

With respect to hospital care, I have asked to have inserted in the record a table (No. 9) showing types of hospitals used by each State. Of 601 hospitals approved for use, 15 percent are governmental, 79 percent voluntary nonprofit (including church and fraternal hospitals), and 6 percent are proprietary.

In all cases, whether Government or voluntary hospitals are used, the State agencies purchase care on a per diem basis under contract or agreement with the individual hospital.

Standards of care of crippled children in hospitals have been given careful consideration by State agencies.

Of the 601 hospitals approved for use, 529, or 88 percent, have been approved by the American College of Surgeons or meet the requirements of the American College of Surgeons. In 32 States all hospitals must be so approved. This insures basic standards of care.

In addition, many States are voluntarily adopting minimum standards for a hospital in which crippled children are cared for, which have been recommended by the Children's Bureau advisory committee on crippled children. These are given in my prepared statement.

Expansion of the Crippled Children's program to include other physically handicapping conditions is greatly needed, and possible under the provisions of S. 1620. The funds available do not suffice to care for the known number of orthopedically crippled children or children with conditions that require plastic operations, such as harelip and contractions from burns. I might point out, however, that all States but one accept for care children with harelip and cleft palate. I refer to that because one of the witnesses indicated that children with harelip needed attention in the States. Under this program that type of care is being given by all States except one.

I have asked to have inserted a table showing the number of children on waiting lists for hospital care as of May 15, 1939. There is a total of 14,573 of these children, of which 12,918 are waiting because of lack of funds, and 1,258 because of lack of hospital beds.

I would like to call your attention to the fact that there were 280 children on the waiting list in New Mexico. I refer to that also because of some testimony given by one of the witnesses heretofore.

The number of children awaiting hospitalization does not, however, represent all of the children in need of care. When submitting plans for the fiscal year 1939, State administrative agencies reported that there were 160,000 crippled children in need of care, for

which funds were not available. Many of these have been cared for during the past year, but there still remains a large number of children not yet registered with the State agencies.

In his testimony before the committee on May 12, Dr. Clifford Gruleo, executive secretary of the American Academy of Pediatrics, stressed the need for expansion of the Crippled Children's program to include care for children with heart disease. I have included in my statement details with respect to the need for care of this group of children. The care of children with heart disease is long and costly. In 1936, 3,333 children under 15 years of age died from heart disease. It is conservatively estimated that there are more than 200,000 children with rheumatic heart disease. Many adults are crippled from heart disease because proper care is not given in childhood. To provide funds for this special group of children is an urgent need. The administrative procedures for care of physically handicapped children have been worked out by the States in their programs for care of crippled children. They could be readily expanded to include other groups of physically handicapped children. The proposals under S. 1620 would make this expansion possible.

I am also submitting a statement on need for the development of postgraduate centers for the training of physicians, nurses, and medical social workers in the field of obstetrics and pediatrics, and a statement of needs for studies, investigations, and demonstrations in the fields of Maternal and Child Health and Crippled Children.

The basis of all progress in this whole field of health and medical care is the fundamental knowledge we have of causes and methods of prevention and cure. Without research to find the causes and demonstrations to prove the cures and how best treatment may be applied, progress will not be made.

Thank you.

Senator MURRAY. Thank you, Dr. Eliot. I believe we have provided for having printed all of the different exhibits that you have submitted here. You have made a very comprehensive statement, and it will take us some time to digest it.

Dr. ELIOT. The full statement gives you all the data you may need.

Senator MURRAY. I think it is very proper that we should have the full statement to show the real need for the bill, and we are trying to have it perfected and enacted. Thank you very much.

(The statement, referred to at the beginning of Dr. Eliot's testimony, was inserted at this point, and is as follows:)

STATEMENT PRESENTED BEFORE SUBCOMMITTEE OF COMMITTEE ON EDUCATION AND LABOR NATIONAL HEALTH BILL (S. 1620) AMENDMENTS TO SOCIAL SECURITY ACT, TITLE V, PARTS 1 AND 2

During the 3½ years since funds were made available for grants-in-aid under the Social Security Act for Maternal and Child Health and Crippled Children, rapid progress has been made by the States in the extension of health services and in making the Crippled Children's service available on a State-wide basis. Today 51 States and Territories are cooperating with the Federal Government in both programs.

PROGRESS IN MATERNAL AND CHILD HEALTH PROGRAM UNDER SOCIAL SECURITY ACT

Under the Maternal and Child Health programs in nearly all States progress has been made in providing health supervision for mothers and children, including medical, nursing, nutrition, and dental services. Experience in administration of State and local service has broadened to include provision of and remuneration for medical service in the maternity prenatal clinics and in child-health conferences, and in a few projects medical service at delivery has been paid for from health or welfare funds. The nursing service has also been broadened and a considerable experience in maternity nursing at delivery has been built up. A nutrition program has been developed in about half of the States, a dental program in nearly all. Table No. 1, which follows, shows the total amounts spent from State and local funds and from Federal funds and amounts spent for the various aspects of the program in the fiscal year 1938.

TABLE No. 1.—Total amounts budgeted from Federal, State, and local funds for Maternal and Child-Health services for the fiscal year ending June 30, 1939, in plans approved by the Children's Bureau (as of Nov. 1, 1938)

Grand total.....	\$7, 270, 003. 10
Professional personnel and services:	
Total.....	5, 859, 058. 41
Salaries and travel for 2,822 public-health nurses.....	3, 806, 382. 29
Fees to local practicing nurses for home delivery service.....	21, 254. 51
Salaries and travel for 456 State and local staff physicians.....	1, 034, 480. 70
Fees to local practicing physicians for conferences, school medical examinations, and home-delivery service and consultation.....	316, 014. 14
Salaries and travel for 67 dentists, 52 dental hygienists, and 2 dental-health educators on State and local staffs.....	305, 341. 50
Fees to local dentists.....	88, 249. 04
Salaries and travel for 34 health educators.....	101, 081. 00
Salaries and travel for 43 nutritionists.....	120, 245. 15
Postgraduate education:	
Total.....	243, 338. 14
Medical.....	146, 836. 14
Nursing.....	88, 951. 99
Dental.....	8, 765. 00
Health education.....	3, 115. 01
Nutrition.....	670. 00
Total for clerks, stenographers, and other nonprofessional staff, scientific supplies, equipment, publications, communications, etc.....	1, 168, 566. 55

Cooperation with the medical profession.—Cooperation between the State health department and the medical profession in connection with Maternal and Child Health programs has been worked out in nearly all States, through the device of advisory committees or councils appointed by the State health officer to assist and advise the Maternal and Child Health Divisions. In addition in many States other less formal cooperative activities have been developed providing opportunity for contacts between State officials and specially selected advisors.

In 39 States obstetricians are members of State advisory committees; in 33 States pediatricians who are certified by the American Board of Pediatrics or are members of the Academy of Pediatrics are members of special professional or general advisory committees. In 25 States the maternal or child welfare committees of the State medical associations have been appointed by the State health officer as one of his official advisory committees; in the other 26 States advisory committees have included representation from the medical profession and many have cooperated with the State health agencies in making studies of infant or maternal mortality.

In all 48 States, Alaska, and Hawaii, programs of postgraduate education in obstetrics and pediatrics for general practitioners living at a distance from medical centers have been organized during the past 3 years by the State health agency in all cases in cooperation with the State or local medical association. Federal Maternal and Child Health Service funds have in all States been used to pay a large portion, if not all, of the cost of these programs. In 1938, \$146,000 was spent by the State health agencies from Maternal and Child Health funds for this purpose. The postgraduate courses have been greatly appreciated by the local physicians. In 1938 more than 10,000 physicians attended such courses.

Cooperation with the dental profession has been likewise developed largely through membership on the State maternal and child-health advisory committees or through individual advisory service. Members of the dental profession are members of these advisory committees in 29 States, and in 22 States there is a separate dental advisory committee.

Cooperation with nonprofessional groups.—Many nonprofessional groups and organizations such as the American Legion and its women's auxiliary, parent-teachers associations, State federation of women's clubs, the Associated Women of the American Farm Bureau Federation, the State leagues of women voters, various service clubs, chapters of the American Red Cross, chambers of commerce, serve on the general maternal and child-health advisory committees.

STATE ADMINISTRATION

Medical direction of State programs.—With the use of Social Security funds the State health agencies have materially strengthened the Maternal and Child Health program, placing it in all cases under a medical director in charge of a Maternal and Child Health Division. Prior to the Social Security program only 22 States had such medical direction and only 31 State health agencies had active maternal and child-health divisions rendering service. In a very large majority of the States the medical directors are well qualified for their work. In addition to these 51 medical directors 75 physicians are now serving full-time on State staffs as assistant directors or clinical consultants, and 65 physicians are giving part time for consultation service in maternity or child care. Three-fifths of these physicians, whether in administrative or clinical positions have had special training in pediatrics or obstetrics; others have been trained in public-health administration or devote a major portion of their time to obstetrics or pediatrics.

Medical clinics and conferences.—In 1938 prenatal clinics in charge of a physician were conducted in 511 counties in 33 States under the auspices of State and local health departments as part of the maternal and child-health program; child-health conferences were conducted by physicians under similar auspices in 924 counties in 45 States. Reports from the States show that only 14 percent of all rural counties (with no city as large as 10,000 population) had prenatal clinics, and only 26 percent had child-health conferences.

More than 3,000 practicing physicians were employed in 1938 by State and county health departments of 40 States and paid to render clinical service in prenatal clinics, child-health conferences, and examination of school children (see table 7). In a few areas in a few States funds have been made available to pay for medical or hospital care, or both, for maternity patients. Some experience with payment of fees for delivery or for prenatal care in the physicians' offices is accumulating.

The number of centers providing this type of clinic and medical conference service has increased rapidly since the Social Security funds have been made available.

On January 1, 1939, there were 3,735 permanent centers for child-health conferences supervised by State or county health agencies; of this number, 2,270, or 61 per cent, have been established in the previous 3 years.

On January 1, 1939, there were 1,207 prenatal clinic centers supervised by State or county health authorities; of this number, 827, or 69 percent, had been established in the previous 3 years.

The value of these conferences and clinics as consultation centers to which pregnant women, unable to pay for such care from their own resources, may go for medical advice, and to which mothers may take infants and young children has been established by long experience in larger cities. The need to extend this type of service to all smaller cities and rural communities is recognized. To develop this service effectively and improve the standards of care, further consultation and advisory service of obstetricians and pediatricians is necessary. A beginning has been made on this program, but expansion to all areas without the service is needed.

Clinical consultation service.—A clinical consultation service by obstetricians and pediatricians to aid general practitioners with their more difficult cases has been established in 14 States; in 4 on a State-wide basis; in 10 in a circumscribed area, usually a county or a group of counties. In 5 other States health departments employ obstetricians or pediatricians who are occasionally called on for case consultation. In 1938, 116 specialists in obstetrics and pediatrics were paid to render clinical consultation service to general practitioners. This is a most important development, since it is a move toward establishment of procedures which will raise the standards of care. This part of the program has been organized largely during the past 2 years.

Public-health nursing service.—On January 1, 1939, there were 1,984 counties in which public-health nurses were rendering maternal and child-health services under the general supervision of the State health department or one of the local health departments cooperating with the State health department. Of these, 756 counties, or 38 percent, had had this service established since Social Security funds were made

available. On January 1, 1939, there were still 780 counties in which there was no public-health nurse serving rural areas. To provide adequately for nursing care for maternity patients and for health supervision and other nursing services to infants and children it is estimated that at least 5 times as many public-health nurses are needed in rural areas as are now available and at least 2 or 3 times as many in cities.

The State plans for the current year provided for 2,822 public-health nurses to be paid in whole or in part from Maternal and Child Health funds; 541 serving in an administrative consultant or supervisory capacity. In 29 States special projects to demonstrate the feasibility of providing nursing care to women at delivery in their homes are in progress in limited areas. This care is given usually by public-health nurses, but in the fiscal year 1938 some 340 local practicing nurses also gave maternity nursing service to women at delivery. This nursing care at delivery is a relatively new service for nurses working in rural areas and small cities and has been developed almost entirely since Social Security funds have been available.

Training in the field of public-health nursing or in special maternity work during the first 3 years of the program was provided for 516 nurses with the aid of stipends from Maternal and Child Health funds, but opportunities and resources to provide training for an additional large number of nurses in these special fields are still greatly needed.

Nutrition program.—Before the Social Security funds became available only 10 States health agencies employed nutritionists to aid the State-wide program of maternal and child health; today 24 States employ 43 nutritionists. The program could be further expanded to great advantage to children were funds available to provide competent personnel and to train additional workers. Courses for the training of nutritionists to aid in community health work need to be more extensively developed.

Dental program.—A program of dental service to children has been begun in 40 States. Twenty-nine States employ dentists on the staff of the State health department, and 22 States pay local dentists for service in the Maternal and Child Health programs. With a few exceptions the programs have been limited to educational and prophylactic activities. In 13 States corrective work has been undertaken in limited areas. Funds have not been sufficient to provide adequately for corrective work. Some State dental groups have felt that the relatively small amount of money available would be better spent in developing the nutrition program because of its probable significance in the control of dental caries and have urged that it be so spent. The very great cost of a complete dental program which would include repair of carious teeth and orthodontia and the inability of States and communities to begin to finance it indicates again and again the urgent need to concentrate attention and effort on research to find the cause of dental caries and methods of prevention. Funds are needed for such research.

Health education.—Before Social Security funds became available very few States had definite programs of school-health education. In the maternal- and child-health plans for 1939, 20 States

included staff to develop programs of general health education or special school-health education. There is increasing evidence that the States are assuming responsibility for health education both in the schools and among the public generally.

Mental hygiene.—Very few States have felt that it was possible to begin a program in this field because of the great cost of the work and the limitation of funds for the basic medical, public-health nursing, and nutrition program. A few States have, however, included mental hygiene as a part of the general Maternal and Child Health program. The need for a child-guidance program is widely recognized.

Qualifications for personnel rendering services in the Maternal and Child Health program.—Qualifications for personnel rendering services in the Maternal and Child Health program have been adopted at a series of annual conferences of State and Territorial health officers called by the Chief of the Children's Bureau, and also by the Advisory Committee on Maternal and Child Health Services appointed by the Secretary of Labor. The recommendations of both bodies cover qualifications for medical, nursing, nutrition, and dental personnel to be employed by State health departments.

The qualifications have been widely accepted by State health agencies, though never promulgated as regulations by the Secretary of Labor. (The qualifications for public-health nurses and for nutritionists follow closely the standards set up by the national agencies in these fields; i. e., the National Organization for Public Health Nurses, the American Home Economics Association and the American Dietetics Association. In establishing the highest qualifications for clinical consultants the Conference of State Health Officers accepted certification by the American boards of the various specialties.) In 1939 the Conference of State and Territorial Health Officers recommended that after June 30, 1939, all personnel newly employed by the States or localities and paid in whole or in part from Maternal and Child Health funds must meet the minimum qualifications recommended by the conference.

Attached (exhibit A) are the detailed statements of qualifications adopted by the Conference of State Health Officers and by the Advisory Committee on Maternal and Child Health.

EXHIBIT A.—QUALIFICATIONS FOR PERSONNEL RENDERING SERVICES IN MATERNAL AND CHILD HEALTH PROGRAMS

(Adopted by conferences of the State and Territorial health officers,¹ 1935, 1936, 1937, 1938, 1939)

GENERAL RECOMMENDATIONS REGARDING QUALIFICATIONS TO BE MET AND TRAINING OF PERSONNEL NOT SO QUALIFIED

It is recommended that State or local personnel newly employed after June 30, 1939, paid in whole or in part from maternal and child health or crippled children's funds, must meet the minimum qualifications recommended by the conferences of State and Territorial officers. (Adopted 1939.)

It is recommended that the employment of personnel meeting the minimum requirements recommended by the conference of the State and Territorial health officers be considered essential to efficient administration of the plan. Personnel

¹Unless otherwise noted qualifications were adopted by conference of State and Territorial health officers called by Chief of the Children's Bureau.

at present on the State and local staffs who do not meet these qualification requirements should be given the necessary training and experience at the earliest opportunity. (Adopted 1938.)

MEDICAL PERSONNEL OF DIVISION OF MATERNAL AND CHILD HEALTH (ADOPTED 1936)

1. A full-time director with qualifications, as follows:

- (a) Graduation from a recognized school of medicine.
- (b) Thorough training in pediatrics or obstetrics, or both, and preferably administrative experience in the field of maternal and child health.
- (c) Eligibility for examination for medical licensure in the State in which service is to be rendered.
- (d) Preferably, training in the fundamentals of public health.

2. Additional medical staff for consultation and advisory service composed of full-time or part-time physicians with training and experience in either child or maternal health, the size of the staff to depend on the needs of the individual States. To this medical staff a full-time dentist should be added. The medical staff of the division shall be graduates of recognized schools of medicine, trained in pediatrics or obstetrics, experienced in the field of maternal and child health, and eligible to examination for medical licensure in the State where service is to be rendered.

3. Part-time regional consultants in the field of pediatrics, obstetrics, and dentistry.

PHYSICIANS (ADOPTED 1938)

Clinical consultants.—That it is desirable that the State health agency, in selecting specialists to be paid from maternal and child-health funds for clinical consultation services, should consider those candidates who qualify under one of the following headings, and a list of these specialists should be made available to every physician in the State:

- (a) Diplomate of the American Board of their respective specialties.
- (b) Physicians eligible for the American Board of their respective specialties as far as training and experience are concerned.
- (c) Physicians who limit their practice exclusively to the specialty concerned and who are considered competent by the State health agency after consultation with a committee from groups (a) and (b) (if there are such specialists within the State).
- (d) Physicians who are considered best qualified by a committee of the State medical society appointed or designated for that purpose.

Local practicing physicians paid from maternal and child-health funds for their services in child-health or prenatal clinics and conferences should meet all of the following minimum qualifications:

- (a) They should be licensed to practice in the State.
- (b) They should be graduates of medical schools approved by the council of medical education and hospitals of the American Medical Association.
- (c) A considerable proportion of their practice should be devoted to pediatrics or obstetrics.

These physicians should be considered the outstanding practitioners of obstetrics or pediatrics in their communities.

MINIMUM QUALIFICATIONS FOR THOSE APPOINTED TO PUBLIC HEALTH NURSING POSITIONS (ADOPTED 1936 AND AMENDED 1939 AT CONFERENCES OF STATE AND TERRITORIAL HEALTH OFFICERS, CALLED BY SURGEON GENERAL OF THE U. S. PUBLIC HEALTH SERVICE)

A. *Staff positions.*—1. For the nurse working on a staff under a nursing supervisor who meets the qualifications set forth in section B.

(a) General education: High-school graduation or its equivalent as determined by State department of education.

(b) Professional preparation: (1) Graduation from an accredited school of nursing connected with a general hospital having a daily average of 100 patients or a minimum of 50 patients with one or more affiliations affording supplementary preparation; (2) emphasis throughout the curriculum and in all services on the mental aspects of nursing; (3) instruction and experience in the public health aspects of acute communicable diseases, tuberculosis, syphilis, and gonorrhea, maternity and pediatrics nursing.

(c) State registration.

(d) Personal qualifications: Good physical and mental health.

2. For the nurse working alone or without the guidance of a nursing supervisor who meets the qualifications set forth in section B.

(a) General education: Same as 1 (a).

(b) Professional preparation: (1) Fundamental nursing education same as under 1 (b); (2) a program of study in public-health nursing which meets the requirements recommended by the National Organization for Public Health Nursing and extends throughout at least 1 academic year.

(c) State registration.

(d) Personal qualifications: Same as 1 (d).

B. *Supervisory and executive positions*.—1. Supervisors:

(a) General education: Same as A, 1 (a).

(b) Professional preparation: Basic nursing education same as under A. Special preparation in public-health nursing shall include: (1) A program of study meeting requirements as recommended by the National Organization for Public Health Nursing and covering at least 1 academic year; (2) at least 2 years' experience in a general health agency which provides a nursing supervisor who meets the qualifications set forth in section B.

(c) State registration.

(d) Personal qualifications: (1) Good physical and mental health; (2) Ability to—

(a) Win the confidence of the staff.

(b) Inspire voluntary requests for help.

(c) Delegate work with a fair balance in responsibilities.

(d) Stimulate initiative on the part of the staff.

2. Directors of State public health nursing services.

(a) General education: A college degree or its equivalent is required.

(b) Professional preparation: In addition to the basic and special public-health preparation recommended for supervisors, a director or chief of a State public-health nursing service should have had at least 2 years of experience as a supervisor.

(c) State registration.

(d) Personal qualifications: In addition to the qualities essential to the success of a supervisor, the director or chief of a State nursing service must have administrative ability together with qualities of leadership and balanced judgment.

C. *Supplementary statement*.—Qualifications relating to professional personnel can never be static; therefore the requirements need to be reviewed periodically and revised in accordance with current standards.

The preceding qualifications are considered minimum at the present time. A large number of the public-health nurses now employed have qualifications which far exceed these requirements. Therefore certain additional requirements are listed as desirable at the present time, but within a short period will be considered essential.

1. General education: Advanced education leading to a college degree is desirable for all public-health nurses. Other qualifications being equal, in the appointment of nursing directors and supervisors, preference should be given to those nurses who have college degrees.

2. Professional education:

(a) Preference should be given to those nurses whose basic nursing education has been secured in a school of nursing which is an integral part of an educational institution. The program of study should include in addition to theory and clinical experience in medical, surgical, obstetrical, communicable diseases, and pediatric nursing, experience in: (1) Out-patient clinics; (2) psychiatric nursing; (3) family health work with a community health agency.

(b) At least 1 year of experience on a staff which provides adequate public health nursing supervision is desirable before a nurse is assigned to an agency which furnishes little or no nursing supervision. An "Internship" of 1 year on the staff of an agency which offers close supervision after completing a public-health nursing course of study would appear to be a desirable "first step" for every public health nurse.

(c) Advanced training in public-health nursing which includes courses in supervision is desirable for all public health nursing supervisors and directors.

MINIMUM QUALIFICATIONS FOR NURSE SERVING IN A MATERNAL AND CHILD-HEALTH DEMONSTRATION (ADOPTED 1938)

The qualifications of the public-health nursing staff in a maternal and child-health demonstration should be as follows:

A. STAFF POSITIONS

1. General education:
 - (a) High-school graduation.
 - (b) More advanced preparation on college level desirable.
2. Professional education:
 - (a) Graduation from an accredited school of nursing, including sound preparation in maternity and pediatric nursing.
 - (b) State registration.
 - (c) Completion of a program of study in public-health nursing meeting the National Organization for Public Health Nursing requirements and covering at least 1 academic year, or if to be employed under the direct supervision of a public-health nurse, in lieu of the above training under (c), completion of at least 1 year's specialized preparation in obstetric or pediatric nursing.

B. SUPERVISORS

1. General education:
 - (a) College degree desirable.
2. Professional preparation:
 - (a) Graduation from an accredited school of nursing.
 - (b) Advanced preparation in maternity nursing.
 - (c) State registration.
 - (d) Completion of program of study in public-health nursing meeting the National Organization for Public Health Nursing requirements—preparation in theory and practice of supervision.
 - (e) Two years' field experience under qualified nursing supervision in a public health nursing service.

QUALIFICATIONS FOR PUBLIC HEALTH DENTISTS (ADOPTED 1938)

I. *Basic educational requirements shall be:*

A. The degree of doctor of dental surgery (or equivalent dental degree) from a reputable dental school and eligibility to examination for dental licensure in the State where service is to be rendered.

B. Not less than 3 years of clinical experience in the general practice of dentistry or in a hospital of acceptable standards. Preference shall be given to candidates who have had training and experience in children's dentistry and oral hygiene.

II. *Special qualifications:*

A. Pending the development of a reserve of personnel having graduate training in public-health work, the following minimum qualifications shall apply as a standard in the selection of public-health dentists for jurisdictions of less than 150,000 population, or those in subordinate positions in larger jurisdictions.

1. Candidates for appointment shall be not more than 35 years of age when first specializing in public-health work.

Preference shall be given to candidates in the following order:

- (a) Those who have had training and experience in children's dentistry.
- (b) Those who have had 3 or more years' experience in the general practice of dentistry.

2. Personnel selected shall already have had or shall agree to take before assuming duty not less than the first-semester course in a recognized school of public health.

B. For public health dentists of jurisdictions having populations of more than 150,000, for staff positions with State health departments, and for positions having the responsibility of supervisory and consultant service—the following standard of qualifications shall apply:

1. Not less than 1 year in residence at a recognized university school of public health and the satisfactory completion of a course of study in the fundamental subjects in preventive medicine and dentistry:

(a) Such knowledge of biostatistics as will give the individual a sound conception of the mass phenomena of disease, familiarity with the methods of

collecting, recording, and studying statistics on vital phenomena, and ability to interpret the results of the analysis of such material.

(b) Some knowledge of general or theoretical epidemiology and training in the collection, recording, analysis, and interpretation of epidemiological information regarding the commoner diseases.

(c) Familiarity with the general historical background of health administration, a general knowledge of the forms and methods of operation of health departments of the National Government and of the States and local units, and acquaintance with the standard procedures of health administration.

(d) General knowledge of the usual methods of water purifications and sewage disposal.

(e) Familiarity with the dangers from, and the general methods of securing protection against, diseases transmitted by foods.

(f) Familiarity with the clinical aspects of the commoner communicable diseases.

(g) Familiarity with the principles of nutrition. He should possess a knowledge of basic food requirements, not only those that are necessary to life but those which represent optimum conditions for production of the greater vigor and stamina. He should have sufficient knowledge to recognize those actual clinical entities that may be produced by a faulty diet.

(h) Familiarity with all the techniques of health education, their applicability, and limitations. This includes such techniques as news releases, radio broadcasts, pamphlets, correspondence, group meetings, individual conferences, and home visiting. He should also possess a knowledge of the basic principles controlling human behavior and the manner of applying them to health education programs.

(i) Familiarity with the various dental-hygiene programs being conducted and knowledge of the application of principles and practices that can be applied to the organization and administration of dental health services.

(j) Sufficient knowledge of oral pathology and oral manifestations of communicable diseases to perform personally simple diagnostic procedures for the recognition of symptoms of the diseases of the mouth and the oral manifestations of the commoner communicable diseases.

(k) Familiarity with the management of children in dental practice and the clinical procedures used in the correction of dental defects of children of all ages.

2. Not less than 6 weeks of field experience under proper supervision in a suitable health organization.

III. Exceptions to the foregoing standards for public-health dentists may be made only when candidates for positions have, through experience and practical training, proved ability to perform successfully the duties of the position for which application is made.

NUTRITIONISTS (ADOPTED 1937¹)

MINIMUM QUALIFICATIONS FOR NUTRITIONISTS IN HEALTH AGENCIES

Training and experience.—The minimum educational requirement for any of the positions outlined below is a bachelor's degree in home economics from a college of recognized standing or a bachelor's degree in other subjects with additional courses in nutrition and allied subjects equivalent to the requirements for a major in those fields for a bachelor's degree in home economics. Nutrition should be the subject of major interest in either the undergraduate or the graduate curriculum. The content and extent of graduate study required will vary according to the nature of the position to be filled. Likewise the kind and amount of experience required will vary with the duties and responsibility of the position.

MINIMUM QUALIFICATIONS FOR POSITIONS OF VARYING DEGREES OF RESPONSIBILITY

A. *Nutrition director.*—A person directing a nutrition service in a State or large local agency.

1. Qualifications:

(a) Education:²

¹ Also adopted 1937 by Conference of State and Territorial Health Officers called by Surgeon General of the United States Public Health Service.

² Candidate should have had part of training and experience indicated within 4 years of the time of her application.

(1) B. S. or B. A. degree in home economics with major in foods and nutrition, or B. S. or B. A. degree with major in other subjects *plus* additional courses in nutrition and allied subjects equivalent to the requirements for a major in these fields for a B. S. or a B. A. degree in home economics.

(2) Satisfactory completion of at least 1 year of graduate work so chosen in relation to the undergraduate work as to make the worker specially qualified for the public-health field. An accredited course as student dietitian is a desirable addition to, but not a substitute for, the graduate work outlined above.

Either graduate or undergraduate study should include supervised practice in the health or welfare field.

(b) Experience:⁸ A minimum of 4 years in—

(1) Public-health and social-welfare agencies, or agricultural extension service; or

(2) Two years in either of the above plus 2 years in any of the following:

(a) Hospital dietitian; (b) dietitian or nutritionist in a food clinic; (c) teacher of home economics (including nutrition); (d) teacher, dietitian, or nutritionist in a child-development institute or nursery school.

(3) In 2 of the 4 years to have had experience in administration and organization of nutrition or home-economics programs.

(c) Personal qualifications:

(1) Good health and vitality—emotional stability and poise.

(2) Executive and organizing ability.

(3) Ability to gain confidence and cooperation of fellow workers and public.

(4) Skill in analysis of situations and in presentation of material.

(5) Understanding and tolerance.

(6) Imagination, initiative, and resourcefulness.

B. Assistant or associate nutrition director, or consultant on the staff of a State or large local agency.

1. Qualifications:

(a) Education:⁹ A. B. S. or B. A. degrees as outlined under A 1 (a) (1). Satisfactory completion of at least one semester of graduate work leading to specialized ability for the public-health field as outlined under A 1 (a) (2). Either graduate or undergraduate study should include supervised practice in the health or welfare field.

(b) Experience:⁸ Minimum of 2 years in—

(1) Social-welfare and health agencies or agricultural extension service; or

(2) One year in the above plus 1 year as any of the following: (a) Hospital dietitian; (b) dietitian or nutritionist in a food clinic; (c) teacher of home economics (including nutrition); (d) teacher, dietitian, or nutritionist in a child-development institute or nursery school.

(c) Personal qualifications: Same as A 1 (c).

Candidate may have had less opportunity to develop administrative skills, but she should have at least potential ability along those lines.

C. Nutritionist.—A person: (1) Working under the supervision of a director qualified as in A 1; or (2) working alone on the staff of a small local agency.

1. Qualifications:

(a) Education:⁹

(1) A B. S. or B. A. degree as outlined under A 1 (a) (1). Some opportunity for supervised field work in the health or welfare field is desirable in connection with undergraduate study.

(b) Experience:⁸ Minimum of 1 year⁴ in one or more of the following fields:

(1) Social-welfare and health agencies.

(2) Agricultural extension service.

(3) Hospital dietetics.

(4) Hospital food clinic.

(5) Teaching home economics (including nutrition).

(6) Child-development institute or nursery school.

(c) Personal qualifications: Same as B 1 (c).

⁸ Candidate should have had part of training or experience indicated within 4 years of the time of her application.

⁴ If the agency is prepared to give systematic in-service training to appointees, the requirement of 1 year's experience may be waived for candidates who have done supervised field work in nutrition in the health or welfare field in connection with undergraduate study.

Reports of Maternal and Child Health services.—Table 2, which follows, shows the maternal and child-health services for the calendar years 1937 and 1938 reported by the State as conducted by the State and local health agencies in carrying out the maternal and child-health plans under the Social Security Act. Comparison of the 2 years shows an increase in nearly all activities.

TABLE No. 2.—*Maternal and Child Health Services, calendar years 1937 and 1938, reported by State health agencies administering State plans under the Social Security Act, title V, part 1*

[U. S. Department of Labor, Children's Bureau, Division of Statistical Research, Washington]

Type of service	Number reported ¹		Percent change from 1937 to 1938
	1938	1937	
Medical services:			
Maternity service:			
Cases admitted to antepartum medical service.....	119, 022	75, 193	+58
Visits by antepartum cases to medical conferences.....	313, 426	169, 482	+103
Cases given postpartum medical examination.....	22, 620	15, 189	+49
Infant hygiene:			
Individuals admitted to medical service.....	164, 820	127, 365	+29
Visits to medical conferences.....	563, 008	380, 155	+48
Preschool hygiene:			
Individuals admitted to medical service.....	266, 895	200, 210	+33
Visits to medical conferences.....	501, 981	384, 675	+30
School hygiene:			
Examinations by physicians.....	1, 853, 196	1, 734, 088	+7
Public health nursing service:			
Maternity service:			
Cases admitted to antepartum nursing service.....	236, 324	171, 151	+38
Field and office visits to and by antepartum cases.....	671, 790	502, 693	+34
Cases given nursing service at delivery.....	19, 222	11, 355	+69
Cases admitted to postpartum nursing service.....	162, 782	114, 015	+43
Nursing visits to postpartum cases.....	522, 406	362, 049	+44
Infant hygiene:			
Individuals admitted to nursing service.....	431, 168	297, 929	+45
Field and office nursing visits.....	1, 444, 950	1, 089, 142	+33
Preschool hygiene:			
Individuals admitted to nursing service.....	450, 638	323, 981	+39
Field and office nursing visits.....	1, 130, 262	944, 274	+20
School hygiene:			
Field and office nursing visits.....	3, 364, 328	2, 979, 144	+13
Immunizations:			
Smallpox.....	1, 090, 232	1, 097, 311	+54
Diphtheria.....	1, 172, 604	897, 218	+31
Dental inspections:			
Inspections by dentists or dental hygienists:			
Preschool children.....	141, 101	69, 273	+104
School children.....	1, 640, 007	1, 313, 729	+25
Midwife supervision:			
Visits for midwife supervision.....	38, 934	42, 204	-8
Midwives under planned instruction.....	11, 817	13, 018	-9
Midwife meetings.....	11, 743	10, 460	+12
Attendance at midwife meetings.....	71, 931	62, 140	+16

¹ Reports were received from 48 States, Alaska, Hawaii, and the District of Columbia.

² Includes only figures reported for quarter ended Dec. 31.

NOTE.—These figures are preliminary and incomplete; they include all corrections received through Apr. 18, 1939. Apparent changes may be due to a real change in the amount of service provided, to a change in the number of health jurisdictions included, to more accurate or complete reporting, to statistical errors due to variations in interpretation of terms, or to other factors. The figures on admissions and visits are fairly dependable as an indication of services provided but on account of inconsistencies in the methods used by the States in reporting, these figures should not be used for computing average visits per admission. These figures represent primarily the services provided by the State health agencies but include some services provided by other public and by private agencies.

Value of local Maternal and Child Health services.—As evidence of what the Maternal and Child Health programs may mean to a local community, the following examples of local services (exhibit B) are cited. I would like to insert these for the record:

EXHIBIT B.—EXAMPLES OF LOCAL MATERNAL AND CHILD HEALTH SERVICES

VIRGINIA PRENATAL CARE PROGRAM

The State medical society in October 1936 approved the plan for a prenatal program developed by the bureau of maternal and child health of the Virginia Department of Health.

Sixty-seven prenatal clinics have been organized with local physicians in charge in counties with full-time health departments after the approval of the local medical society has been given. Patients referred by physicians, social agencies, or midwives are admitted to the clinic by appointment only. Quality of work rather than number of patients seen is stressed. The physician conducting the clinic is paid an honorarium of \$7.50 per clinic session.

Midwives are encouraged to attend the clinics with the women under their care in order that the midwife may learn what supervision is necessary.

The local health officer, who is the administrator of the program, becomes acquainted with the general plan and watches the development of each prenatal clinic. He must know the routine of the clinic, so that in rural areas he may be able to substitute for the clinician in emergency. The public-health nurse must know the clinic set-up and routine and how to make the clinic run smoothly. She is responsible for getting patients to come to the clinic and arranges for them to return to the clinic. Nurses give groups instruction at the clinic prior to the arrival of the clinician and make home visits.

The attempt is made to render efficient prenatal service and to follow this up with post-partum examination of the mother and with supervision of the infant during the first critical months. Frequently, in rural areas, it has been found desirable to combine the prenatal clinic and the infant or child-health clinic.

Clinics are first established on a once-a-month basis, and the schedule is increased within a few months, if conditions permit, to a once-a-week basis. The clinics are held in a variety of places, but the advantages of operating in a health center or in especially prepared clinic rooms has led to the holding of clinics in quarters arranged and set aside for them in the majority of cases.

Physicians who have not previously conducted prenatal clinics are given professional assistance from the State bureau of maternal and child health in starting and establishing the routine of the clinics. A standardized routine based on experience in conducting clinics is recommended. Charts outlining essential pelvic measurements and other a'l, including demonstrations of the actual procedures involved in examining a prenatal patient, have been enthusiastically received.

Postgraduate instruction in obstetrics and gynecology and in pediatrics for physicians of the State is carried on by a full-time obstetrician and a full-time pediatrician on the staff of the bureau of maternal and child health with the approval and active support of the Medical Society of Virginia and the two medical colleges. By June 30, 1938, postgraduate institutes of obstetrics had been held in practically all areas of the State. Since then the obstetrician on the State staff has been visiting the maternal and child-health clinics in the State at regular intervals to give instruction through the clinic to the physician acting as clinician and to invited physicians in each area. Special lecturers in obstetrics give talks before medical societies and refresher courses are given at the two medical colleges and at central points in the State.

IOWA MATERNITY DEMONSTRATION IN WASHINGTON COUNTY

Washington County is a rural county with a population of 10,822 (1930). It was selected for the maternity demonstration because all local practicing physicians are members of the county medical society, the society has a contract with the county board of supervisors for the medical care of indigents, there is a county hospital with facilities for laboratory examinations, there is a whole-time county health unit, and the median maternal mortality for the 5-year period 1930-34 was 64 per 10,000 live births, exceeded by only 14 of Iowa's 99 counties.

The county health department has arranged to pay the medical practitioners in the county doing obstetrical work for the prenatal medical care and supervision to all expectant mothers certified as indigent or border line by the county welfare department. Delivery care by the physician is provided under the contract for medical care of indigents which the county board of supervisors has made with the county medical society. Dr. E. D. Plass, professor of obstetrics, University of Iowa, is available for case consultation service and renders specialized supervision of the medical aspects of the program.

The participating physician agrees to give each mother a complete examination on the first visit, including blood Wassermann and regular subsequent examinations, including blood pressure readings and urinalysis.

The division of maternal and child health of the State department of health has placed two maternal and child-health nurses on the staff of the Washington County health unit. These nurses (1) make home visits to expectant mothers, (2) organize and conduct classes in motherhood, and (3) give delivery nursing service and postpartum care. In the home-delivery service, a nurse assists the physician on eligible cases. The Iowa nurses are equipped with fully fitted bags of supplies to give the best service during confinement and in postpartum care. The packets furnished are made up by nurses and are sterilized at the Washington County Hospital for the use of the doctors at all home deliveries. They contain all supplies essential for an aseptic delivery, including the doctor's gown and gloves. In addition, the packets contain pads that are used during the mother's lying-in period.

As the service is continued it is accepted as a community health service rather than as a charity or relief service. The nurses make greater efforts to find pregnant women early and more women seek medical and nursing care early in pregnancy, more Wassermann tests are being taken by physicians, and more persons are being reached through group instruction and talks at clubs. The time is still too short to draw conclusions on the effect of the demonstration on maternal and infant mortality and morbidity.

Dr. C. A. Boice, of Washington, Iowa, county health officer, and counsellor of the eighth district of the Iowa State Medical Society, wrote on May 26, 1930, "Our board of supervisors is quite thoroughly convinced that the health unit, including maternity, tubercular work, and syphilis control, is saving the county money in addition to the humanitarian work."

KENTUCKY OBSTETRICAL NURSING SERVICE

In each of nine counties, in addition to the usual prenatal and postnatal public-health nursing service, an additional public-health nurse has been placed on the county health-department staff to give nursing service at delivery to mothers who cannot afford to pay for this service. These demonstrations are being conducted for the following purposes:

1. To give adequate nursing care through the prenatal, parturition, and postnatal periods.
2. To assist the attending physician by providing nursing service not otherwise available.
3. To safeguard the health of the mother and child through intensive nursing care in the home.
4. To supply the attending physicians with sterile supplies and equipment and emergency therapeutic agents.
5. To educate the public to a better understanding of what constitutes adequate maternal care.

The objectives sought are the lowering of maternal and infant morbidity and mortality.

The home-delivery nursing service is greatly appreciated by the physicians in the counties where it is available and physicians in other counties are asking for similar nursing service.

MICHIGAN OBSTETRICAL CONSULTATION SERVICE

The bureau of maternal and child health of the Michigan Department of Health employs a full-time obstetrician to give talks to county and district medical societies and to give consultation service to local practicing physicians on their private cases. It was planned originally for him to give 2-months' service during the current year 1938-39 to the Upper Peninsula of Michigan but so many county and district medical societies in the Upper Peninsula re-

requested the service that it was necessary to extend the period of service for that area.

The following excerpts from a report of 1 week of the consultant's trip in eastern Michigan shows the character of his work:

July 11, 1938:

Discussion at hospital with group of physicians on an expected difficult delivery to occur that week. Fifteen-minute discussion after lunch with medical-society group.

Discussion with one physician of thyroid states in pregnancy.

July 12, 1938:

Call at office of Dr. L. and discussion of forceps deliveries.

Requested by Dr. L. to see emergency case, patient examined and advice given on care.

Dr. P. requested consultant to see two of his patients in hospital, one 8-months' pregnant had been severely injured in auto accident. Consultant concurred with Dr. P. that therapeutic abortion was not indicated; the other a postoperative case.

Discussed with Dr. N. ectopic gestation; asks to see suspected case; discussed histories of eight patients coming to clinic Thursday.

Interview half the afternoon with Dr. O.

Dinner, Rotary Club.

July 13, 1938:

Conversation with Dr. N. from angle of diagnostic methods.

Discussion with Dr. P. on eyeground changes in early cases of toxemias of pregnancy.

Interviewed Dr. M.—does not practice obstetrics—interested in project.

Interviewed Dr. R. and discussed vomiting during pregnancy.

Talked with Dr. I., best-qualified obstetrician in county on various gynecologic disorders.

July 14, 1938:

At hospital entered into round table about various techniques in operative deliveries and especially the use of forceps in posterior positions. Drs. N., I., and P and others present.

Afternoon at Dr. N.'s office. Doctor had collected more puzzling cases for this clinic. In 6-hour session discussed, examined, and advised on 13 patients.

Long-distance call from Dr. I. of D. asking consultant to see 25-year-old girl with tumor, on Saturday.

July 15, 1938:

Called at office of Dr. N., very progressive—father confessor of local medical group.

A visit with Dr. L. checking up on patient seen Tuesday.

Local doctor's wife called Dr. L. and asked to have consultant see her. At hospital discussed care of infected, incomplete abortions, etc.; present Drs. P., N., S., and P., and others.

Interviewed Dr. U. of G. ———. Does 8-10 gynecological operations a year.

Interviewed Dr. M. decreasing practice. Wife graduate nurse runs small maternity home.

Interviewed Dr. U. who asked consultant to look up data upon Mrs. T. and mail information. Discussed post-radiation morbidity.

Interviewed Dr. T. of C. ———. Volunteered that he had never used gloves in obstetrical cases. Long talk about dangers of delivering cases without gloves. Doctor admits he is cause of much maternal morbidity—should be encouraged to have 2 weeks at Ann Arbor for safety of future patients.

July 16, 1938:

Examined doctor's wife in Dr. L.'s office and advised on care.

Assisted Dr. N. in doing a subtotal hysterectomy at hospital. Drs. S., N., P., I., N., N., and P. present. Long discussion of hemorrhaging before, during, and after menopause.

Patient of Dr. I. admitted to hospital as emergency case.

Examined two patients of Dr. I. Advised tumor operation for first, for second further conservative therapy for residual breast abscess.

Interviewed Dr. N. in same building and saw patient—agreed on diagnosis of congenital heart disease.

The work of this full-time obstetric consultant serving the general practitioners in areas without specialists in obstetrics has been so successful that a second full-time consultant has now been employed. Both consultants are fully qualified in their specialty who command the respect of the physicians they work with and are rendering a splendid service in improving the quality of obstetric practice in the State.

OKLAHOMA: MATERNITY PROGRAM IN CHEROKEE COUNTY

In 1936 with Federal and State aid, a 5-county district health unit was established in the northeast section of the State because of the needs of a largely rural population spread over 3,388 square miles whose economic status and living conditions were below normal. In the 5 counties the hospital facilities consist of a few proprietary clinics, a small proprietary hospital in Tahlequah, and a new 78-bed hospital opened in Tahlequah by the Indian Service.

The district health unit, including on its staff the director, a pediatrician, an obstetrician, two sanitary engineers, a maternal and child-health nurse supervisor, two public-health nurses in each of the five counties, and three additional nurses for the maternity program in Cherokee County, provides a well-rounded public-health program for the five counties.

When Cherokee County was chosen for the maternity program a survey revealed that 90 percent of the deliveries each year were done in the home, 25 percent to 50 percent were performed by persons other than physicians, the maternal-mortality rate for 1937 was 62 per 10,000 live births, and the infant mortality was 62 per 1,000 live births. In this county there were from 50 to 75 percent of the people who could not pay for medical, nursing, or hospital care.

The maternity program, started in April 1938, is carried on by the staff obstetrician with the aid of three maternity nurses. The nurses urge expectant mothers to visit the nearest maternity clinic, conducted usually by the staff obstetrician. The patient is given a complete examination, including laboratory procedures. Any corrections necessary are advised and if she has a private physician he is sent a copy of all findings. If she has no physician and cannot afford one, a social-welfare worker works out a budget with the patient and if she can pay an appreciable part of the doctor's fee a doctor is engaged. If she cannot pay, she chooses her physician and is given a letter at the prenatal clinic authorizing payment of the doctor's fee from Maternal and Child Health funds. For prenatal care beginning at or before the fifth month, delivery care, and postpartum care, the doctor receives \$25. The fee is \$20 if the patient receives care after the fifth month and before the seventh month, \$17.50 if care starts during the last 3 months, and \$15 for delivery and postpartum care only. A fee of \$5 is added for travel of 10 miles or more at the time of the delivery.

After acceptance of the case the patient is instructed to visit her physician regularly and the public-health nurse visits the mother at home once a month. When the mother goes into labor, she calls her physician, who requests the attendance of the nurse and they attend the patient together. The nurse works under the direction of the physician but she follows a set technique in regard to the preparation of the patient, the materials used, and the use of solutions. The physician, with the aid of the nurse, is better able to carry out good technique.

Following the delivery the nurse visits the patient on the third, sixth, and ninth day, and unless she lives in an isolated section she is also visited by the physician. If the nurse reports any abnormality the patient is visited by the physician regardless of her locality. The patient is visited by the nurse during the fifth postpartum week and she is urged to visit her physician. He makes the postpartum examination, treats any abnormality, and when the patient is discharged he is eligible for the payment of his fee.

Maternity clinics were being held regularly each month in eight centers. By October 1, 1938 the staff obstetrician had been called at the private physician's request for 85 consultations.

In the other 4 counties in the health district prenatal clinics are held monthly in 10 centers and obstetric consultation service is being given to the physicians.

MASSACHUSETTS CARE FOR PREMATURE INFANTS

A law passed in 1937 provides for the reporting of premature births to local boards of health, for the transportation of the baby by the board of health to a

hospital equipped for his care, and for hospitalization at the expense of the local board of public welfare if the parents are unable to pay. The State department of health administers the law.

Forty-two hospitals (June 1938) are centers for the care of premature infants recognized by the State department of health as meeting standards necessary for the care of such infants.

Special beds for the transportation of premature infants are prescribed to insure keeping the baby warm during the trip to the hospital.

When a hospital becomes a center the physicians in the community are notified and with the notification goes a pamphlet on the care of the premature infant. In the postgraduate medical education, provided through the State medical society, one lecture in the pediatric groups is devoted to the care of the premature infant.

After each hospital was satisfactorily equipped as a premature center, its nursery supervisor was given a graduate course in the care of prematurely born infants at the Boston Lying-In Hospital.

A State supervising nurse visits the hospitals with premature centers and assists the nursery supervisors in adapting the nurseries to the principles learned in the Boston Lying-In Hospital.

Each nursery supervisor who takes the special course is thereafter better equipped to teach the care of the premature infant. Instruction through demonstration and group discussion on the care of the premature infant is also given to groups of public-health nurses.

Talks are given to groups of women on the premature baby, and a leaflet has been issued for their use. The care of the premature baby is included in the Outlines for Mothers' Club Instruction.

A subcommittee of the State advisory committee on maternal and child hygiene advises on the program for the care of premature infants.

CONNECTICUT WELL-CHILD CONFERENCES IN RURAL AREAS

There are 105 well-child conferences in rural areas under the supervision of the bureau of child hygiene of the State department of health. With rare exceptions, these conferences are held in towns where there is no resident physician.

The medical examinations of infants and preschool children in newly organized conferences is supervised by a physician from the bureau of child hygiene until the local physicians are fully prepared to take over this activity. Appointment of local physicians for this service depends on the recommendation by the county medical association and upon training at demonstration child-health conferences, including attendance at six conference sessions and the conduct of the conference under supervision at the sixth session. After appointment, the doctor is paid \$5 for each conference session.

One of the purposes of the conference is to teach parents the importance of regular medical examination for their children and the need for routine medical supervision and how to keep their children healthy. All children are weighed and measured at each visit. The mother is taught to weigh her baby and young child regularly and to keep a record of growth and gain in weight. Each child is given a complete physical examination on his first visit and thereafter infants under 1 year are examined every 4 months and children over 1 year every 6 months. An interview with the doctor every month is recommended for mothers with infants, once in 2 months for children between 1 and 2, and when necessary between examinations for children over 2.

All pertinent medical data and physical findings are recorded on the child's record card. The degree of any defect found is recorded so that the physician may watch changes in the defect and know whether the child is receiving as much medical attention as necessary.

All mothers are advised to have their children immunized against diphtheria and vaccinated against smallpox.

All conditions needing medical or surgical treatment are referred to the family physician by written report within 24 hours.

Well-child conferences are conducted in towns where a local organization sponsors this activity. The public-health nurse carries equipment in her car for conducting a well-child conference held in a room arranged for by the local organization. Usually the local public-health nurse assumes the responsibility for nursing follow-up of children attending the conference. If there is no local nurse one of the regional maternal and child-health nurses carries on this part of the work.

Well-child conferences are sponsored by local organizations that are responsible for providing an adequate building with light and heat, clerical helpers, transportation for mothers and children, and publicity. When a conference is started a schedule of helpers is made for the year under the leadership of the local chairman. Often these organizations furnish funds for necessary treatment of indigent cases.

During 1938 Connecticut reported that 1,683 infants made 4,432 visits and 2,896 preschool children made 8,480 visits to medical conferences or well-child conferences held under public auspices.

CALIFORNIA MATERNAL AND CHILD HEALTH SERVICES FOR MIGRATORY CROP WORKERS

In July 1936, with the help of Federal grants for maternal and child-health services, the bureau of child hygiene of the California Department of Health began to supply medical and nursing supervision for the mothers and children among migratory workers in the two central valleys of California. During the second year these services were limited to five counties in order to carry on a more effective program.

The migrant crop workers in California include men, women, and children who migrate up and down the valleys of the Pacific coast to engage in agricultural labor. They include refugees from drouth and "dust bowl" areas, "State homeless" workers who follow the crops—lettuce, peas, and early vegetables, deciduous fruits and hops, grapes, and cotton—and workers who may own a small home or farm who go into adjoining counties for seasonal agricultural work.

Among the factors contributing to the health defects of mothers and children are the limited supplies of milk and the limited use of milk because of its expense; the restricted diet consisting principally of gravy, biscuits, beans, and potatoes, with little meat, fruit, or vegetables; the poor, overcrowded housing facilities in the camps with inadequate provision for sewage and garbage disposal; and the use of children to help with the crops.

A pediatrician, two public-health nurses, and two nutrition teachers were assigned to this service. Prenatal and child-health conferences are held at which the mothers and children are examined by the physician, and the mothers are instructed by the physician and the public-health nurses in the care of themselves and their children. A medical trailer was put in operation for this service in January 1938. The trailer was divided into medical and nursing rooms equipped with desks, a sterilizer, running water, and an ice box for pharmaceuticals and with an awning and camp chairs for an outdoor waiting room. The Farm Security Administration is providing funds for medical care and food among migratory workers.

The two nutritionists conduct nutrition classes and cooking demonstrations in the migratory camps and cooperate with school authorities in an effort to supply hot milk, cocoa, or soup to malnourished children in the migratory schools. They cooperate also with those in charge of school lunchrooms or cafeterias in an attempt to adjust the menus to the needs of migratory children.

During the first year that the maternal and child-health program for migratory workers was under way (July 1936 through June 1937) 1,002 children of agricultural workers in 598 families were served.

During the year ended June 30, 1938, 173 health conferences were held and 8,083 children were examined. Of these, 2,459 were examined for the first time. A total of 185 prenatal patients were seen and of these 100 were examined by a physician, and there were 61 prenatal hygiene discussions with expectant mothers.

EVIDENCE OF NEED FOR EXPANSION OF MATERNAL AND CHILD-HEALTH PROGRAM

The report of the technical committee on medical care pointed out many of the special needs of maternity and infancy and of children.

The experience under the Social Security Act has brought to light the many gaps that exist in the Maternal and Child-Health program and has indicated the direction in which the program should advance if obvious needs are to be met.

The most apparent needs are the lack of resources to provide:

1. (a) Medical and nursing care throughout the maternity cycle, especially at delivery in home or hospital, and (b) medical and nursing care for children.

2. Hospitalization costs, including transportation, for care in existing facilities.

3. New hospital facilities for maternity care and care of children, as needed, especially in rural areas.

4. Diagnostic clinics in areas where there is no out-patient service in obstetrics, pediatrics, and other special services in connection with a general hospital.

5. Consultation service by obstetric, pediatric, and other specialists either through employment of practicing physicians (specialists) on a case basis, or employment of part-time or full-time specialists as members of State or local staff to serve areas where there are now none.

6. Increase in number of public-health nurses and other special workers.

7. Training centers for postgraduate education of physicians, nurses, medical-social workers, using existing facilities in medical centers and amplifying with staff and cost of patient care.

It is the consensus of opinion of obstetricians and pediatricians that these needs must be met if maternity care and care of new-born infants and care of older children is to be adequate and the lives of mothers, infants, and children now needlessly lost are to be saved and the health of children conserved. It is the opinion of medical experts who have studied the problem that from one-half to two-thirds of maternal deaths and at least half the deaths of infants under 1 month of age are preventable. Many deaths of children from communicable diseases and from other causes may be prevented. The knowledge of how to save the lives of the women and children is at hand; the resources to provide services and facilities are not adequate. Many of the States do not have the financial resources to provide the necessary care in maternity or medical services for children.

The State health officers when submitting their plans for maternal and child-health services under the Social Security Act for the fiscal year 1939 made statements regarding the immediate needs of their respective States in this field. They estimated the number of new personnel, such as public-health nurses, nutritionists, etc., that could be effectively used at once and the cost of increased medical service in child-health and prenatal conferences and in a few States the cost of some other medical service, such as care of women at delivery. Twenty-eight State health officers reported their needs in such a way that the cost could be accurately estimated. The total sum for these 28 States amounted to an annual increase of \$22,000,000. Except in a few instances the figures included only types of service that the States had been rendering during the 3 previous years. The cost of increased number of public-health nurses amounted to \$14,000,000; the cost of the services of physicians at clinics or conferences or for delivery care to \$2,500,000. I cite these figures to indicate that the State health officers realize that the present pro-

grams are not adequately meeting the needs. That was a year ago. I would like to submit excerpts (exhibit C) from the original statements for the record.

EXHIBIT C.—EXCERPTS FROM MATERIAL SUBMITTED BY STATE HEALTH OFFICERS
SHOWING NEEDS OF STATES

ALABAMA

Twelve and eight-tenths percent of white mothers were attended by midwives and others not physicians in 1936.

Seventy-five and six-tenths percent of colored mothers were attended by midwives and others not physicians in 1936.

Only 11 percent of mothers were hospitalized at time of delivery.

Estimating that there should be at least 1 public health nurse for every 10,000 of the population, there should be 122 additional public health nurses (at \$2,000 each), \$244,000.

State staff nurses:

0 advisory nurses (at \$3,180)-----	\$10,080
1 auxilliary nurse-----	2,280
2 obstetric nurses (at \$2,100)-----	4,200
0 tuberculosis nurses (at \$2,100)-----	12,000
Medical service at maternal conferences in 9 counties-----	15,080
Medical service at 60 child-health conferences-----	15,000

Total ----- 312,840

In 1937:

Maternal deaths-----	390
Maternal death rate-----	63
Infant deaths-----	3,844
Infant death rate-----	62

ALASKA

Alaska has an area of 586,400 square miles, one-third of which is above the Arctic Circle. The population of Alaska is approximately 62,000, one-half white and one-half native, Indian, Eskimo, and other races. Alaska is almost entirely rural. The white population of Alaska is centered in the larger towns, none of these, however, larger than 7,000. The native population is scattered in villages and small settlements, the largest village having a population of about 500. During the summer the native population is even more scattered; most of the inhabitants go out fishing and working in the canneries. These summer earnings constitute their entire income for the year.

There are 48 doctors in the Territory. They are located in 25 communities. This number includes 8 doctors under contract with the Office of Indian Affairs for the care of natives. The Office of Indian Affairs also maintains a staff of 41 nurses for medical and nursing care of the natives. Of these, 24 are field nurses and 17 are connected with hospitals.

There are 19 hospitals in the Territory, with a total bed capacity of 505. Six of these are maintained by the Bureau of Indian Affairs for natives only, with a total bed capacity of 131. All of the hospitals admit obstetrical patients and have a total number of 78 bassinets.

During the year 1937 there were 1,229 births reported in the Territory. Four hundred and forty-seven were whites, and of these 413 were delivered by doctors and 34 by others, such as nurses, midwives, and neighbors. Of the total 882 native births, only 242 were delivered by doctors and 640 delivered by others, such as nurses, midwives, and neighbors. There were 18 white infant deaths reported during the year 1937. The infant death rate of the natives is appallingly high. One hundred and ninety-three infant deaths were reported for the above number of infant native births for 1937. This year the maternal mortality rate was also lower among the white mothers than among the natives. There were 2 white maternal deaths for the 447 births, which gives an average of 4.5 deaths per thousand live births; and there were 9 maternal deaths for the 882 native births, which makes an average of 11.8 maternal deaths per thousand live births.

From personal contact with preschool and school children in Alaska, a large number of physical defects were observed. A great number of young children show evidence of rickets. Fatigue, poor muscle tone, and poor nutrition are also very common. Dental caries is the most prevalent defect. A large number of children are suffering from eye defects. Some of these defects might possibly have been the result of faulty nutrition, and many undoubtedly are caused by congenital lues. A number of school children are in need of corrections of refraction errors. The returns from this year's school health examination, although not completed as yet, show that there was a total of 3,858 physical defects found for a total number of 3,972 children examined.

This year's budget provides for an increased staff of field nurses who are being charged with maternal and child-health supervision as one of their chief services in the community. This year's budget will also permit the purchasing and publication of more health-educational material for free distribution to parents, whose acquaintance and appreciation for child hygiene has heretofore been very meager.

ARKANSAS

Alternating flood and drought have brought much suffering to the State. A large amount of preventable illness exists, especially with reference to faulty nutrition and communicable diseases. Arkansas still has a high incidence of diphtheria, smallpox, and typhoid fever. Malaria fever constitutes a major problem. A high proportion of tenant farmers and a heavy Negro population, both with poor living conditions, present special health needs. Medical facilities and hospitalization are often unavailable due to poverty and lack of physicians in rural areas. Arkansas has an unnecessarily high maternal-mortality rate—62 per 10,000 live births in 1936.

The State needs approximately 300 additional public-health nurses at \$1,800 per annum salary and travel or a total of \$540,000 in order to approach generally accepted standards, and approximately 20 additional medical directors at \$3,000, or \$78,000.

In 1937:

Maternal deaths	240
Maternal death rate	68
Infant deaths	1,919
Infant death rate	54

CALIFORNIA

There is 1 public-health nurse to 6,000 population throughout the State. Nine counties have no public-health nurses except those supplied by Federal Maternal and Child Health funds. In 33 counties there is no organized provision for education of expectant mothers.

Specific needs:

1,802 additional public-health nurses (at \$2,400)	\$4,540,800
1 monthly prenatal conference in 20 counties, medical services	1,740

Total

4,542,540

In 1937:

Maternal deaths	385
Maternal death rate	41
Infant deaths	5,070
Infant death rate	54

COLORADO

At the present time one of the greatest needs of the State of Colorado is increased trained personnel to be placed in several counties of the State. Only 33 counties out of 63 have public-health nursing service, and in many of these 33 counties only 1 public-health nurse is stationed where there should be at least 2 and in many cases 3. It is estimated that at least 40 additional public-health nurses would be needed to provide an adequate generalized public-health nursing program in Colorado.

It is believed at this time that the best program that the Division of Maternal and Child Health can inaugurate to lower the high maternal and infant mortality rate in Colorado is the extension of Maternal and Child Health units,

providing nursing assistance in home deliveries in those areas of the State where adequate hospital facilities do not exist. A conservative estimate would be that there are at least 10 sections of the State where such Maternal and Child Health Units could be advantageously established.

The establishment of full-time county or district health units is a necessity in any program designed to lower the maternal and infant mortality rate. Before such units can be established, a great deal of educational work is necessary. This can best be inaugurated by the placing of public-health nurses in various counties.

Professional services.—The great need of the practicing physicians in the rural areas of Colorado is increased hospital facilities, especially for deliveries and the care of sick children. In a majority of the rural areas of Colorado, the building of hospitals is for the present, and for a long time in the future, an economic and political impossibility. If such institutions could be constructed, it is doubtful if the necessary funds for their maintenance could be secured.

In many areas there is a need for prenatal, postnatal, and infant clinics for indigent patients. A consulting service is needed badly in many localities. Approximately 80 counties of the State have a real need for these services.

Corrective dental care.—There are several areas of the State wherein no dental care is available. A program of dental correction such as described under "Dental Program" in this narrative is needed in these areas. About 10 such areas are known.

In 1937:

Maternal deaths.....	105
Maternal death rate.....	54
Infant deaths.....	1,441
Infant death rate.....	73

DISTRICT OF COLUMBIA

More adequate provision is needed for the hospitalization of maternity cases, particularly those requiring public care, and improved facilities for the care of the newborn, especially the premature.

Additional maternal and child health conferences are needed on the basis of the number of patients registered for care in the health department clinics for the 5-months period, January to May 1938. It is estimated that 3,338 will register for care in the Health Department prenatal clinics during the year. At an average of 6 visits per case—5 prenatal and 1 postpartum—35 2-hour clinic sessions a week are needed to care for these patients. One hundred and ten infant and preschool child-health conferences are needed a week in order to give reasonably adequate infant and preschool health supervision. This number is greatly in excess of the number available or possible with present appropriations.

From 130 to 150 additional public-health nurses are needed.

Additional clinic space is needed, and finally clerical service for these clinics, of which none is at present available, is an urgent need in order to conserve nursing time and to improve the record keeping at the clinic.

In 1937:

Maternal deaths.....	71
Maternal death rate.....	58
Infant deaths.....	751
Infant death rate.....	61

GEORGIA

Disease costs Georgia an estimated \$155,302,763 annually. Much of this is unavoidable, yet with the application of known preventive measures, a tremendous reduction can be made. While specific preventives for many diseases are lacking, most illness is amenable in some degree to public-health measures.

Need for more local health departments and personnel.—About 40 percent of our population, in 105 counties, have no health protection other than what the State department can provide by its staff members, itinerant nurses, and district sanitariums. Because this very large territory is thinly populated, service is far below the needed minimum.

The establishment of local health departments has been and will continue to be hindered by lack of local appropriations and properly trained personnel.

The 20 itinerant nurses are attempting to carry a restricted generalized public-health nursing program in the above 94 counties, with a population of over a million.

Most Georgia counties that can afford public-health service, as now financed, have it at least in minimum. If the other 105 counties are to have this protection, some other plan for financing it must be found.

If disease and death rates are to be lowered, thereby conserving human resources, health protection must be secured for all sections of our State, as well as improvements made in the more fortunate areas. Results will depend upon efficient, continuous, simultaneous service in each section.

To do this on a minimum scale will require more than twice the number of qualified medical, nursing, and sanitary workers than are now engaged in local health activities.

Mortality.—About one-fifth of all the deaths in Georgia occur in individuals who have not reached the end of school age. Most of these are preventable.

An average of 66,260 births occur annually. Here is what becomes of these babies: 9,520 (1 out of 7) never reach age of 5, 8,155 (1 out of 8) never see a birthday, 3,816 are born dead, 1,082 die the day they are born.

On an average, 475 Georgia mothers die each year from childbirth. These deaths, plus stillbirths and practically all deaths of infants less than a week old, are ascribable to causes connected with the prenatal period or the act of birth. Thus we annually lose 6,200 lives from childbearing (over 17 deaths daily). Two-thirds of these are preventable.

Midwives.—There are over 3,000 midwives practicing in Georgia. They attend more than 20,000 births each year (2 out of every 5 births in the State). These women should be better taught and more closely supervised than it is possible now to do it in many areas.

There should be maternal and infant health centers in each county. Only 51 counties at present have both types of service. Funds are needed to compensate practicing physicians serving in centers.

During 1937, 847 cases of pellagra and 370 deaths were reported. Not a single case need have occurred. Pellagra is preventable.

In more than one-third of the counties young children and expectant mothers are receiving specific dietary advice. However, in approximately 100 counties such service cannot be rendered because no local health department exists. Until funds sufficient to finance a State-wide program are appropriated, the nutritional problem cannot be eradicated.

In 1937:

Maternal deaths.....	472
Maternal death rate.....	74
Infant deaths.....	3,952
Infant death rate.....	62

INDIANA

The outstanding health problems of the mothers and children of Indiana have been the need for additional generalized public-health nursing services in organized and unorganized counties; more home-nursing delivery demonstrations throughout the State; further expansion of the child mental-hygiene program now being carried out by the Bureau of Maternal and Child Health; more child-health conferences especially in the rural areas; and for improvement and extension to all parts of the State of the school health services.

The needs for extension of maternal and child-health services in the State of Indiana are great. As indicated in the following paragraphs there is an urgent need for more generalized public-health nurses in the rural population in Indiana.

There exists further need for making available biologicals, such as toxoid vaccine, smallpox virus, etc., to all people.

There exists a great need for medical inspection of county hospitals, especially with the idea of promoting stations for the care of premature babies in each county of the State.

One of the chief difficulties in conducting the program as above outlined, and the foregoing suggestions for expansion, is due to lack of funds.

In the 1930 annual plan it is impossible to take advantage of all Federal funds offered, and hence the activities of the Bureau of Maternal and Child Health cannot be extended to meet some of the minimal demands, because of insufficient matching funds.

To maintain the ideal of 1 public-health nurse to every 2,000 people, Indiana needs 1,714 public-health nurses in the State, or 1,261 more than the 444 which are now available. When the rural population is considered and a goal of 1 public-health nurse to 5,000 people is set, it is found that 230 public-health nurses or 126 more than the 104 now in this group are needed.

At present in the 18 counties which have Maternal and Child Health public-health nursing services (1937) there is 1 public-health nurse to a ratio of 1 Maternal and Child Health nurse to around 23,000 people.

Prenatal and postpartum clinics.—There exists in Indiana comparatively few prenatal and postpartum clinics. For the most part these clinics are held in connection with the State hospitals, and local boards of health in the larger cities. In developing the Maternal and Child Health program for Indiana, the State director has been aware of a need for this type of clinic in the rural areas. However, due to lack of response on the part of the medical profession and the lack of facilities and personnel for establishing such clinics, the Maternal and Child Health Bureau has been unable to set up this much needed type of service.

School health services.—There is great need in Indiana for the provision of full-time school physicians. At the present time there are only two cities in the State of Indiana which have services of full-time school physicians.

In 1937:

Maternal deaths.....	195.
Maternal death rate.....	35
Infant deaths.....	2,789
Infant death rate.....	50.

IOWA

Stated briefly, the outstanding needs include: Development and maintenance of prenatal service; classes in motherhood, including care of mothers before baby comes and care of infant after birth; liberal provision for field service and supervision by representatives of division of child health and health education; development and maintenance of local health administration, either more satisfactorily on a part-time basis or through the medium of the whole time health district, county health unit, or detached county public health nursing services.

Under present conditions the State and local political subdivisions are not ready to assume the entire financial responsibility for a Maternal and Child Health program which meets the major needs. They are able to meet a part of the cost and favorable sentiment and support is certainly being developed and secured.

In 1937:

Maternal deaths.....	190.
Maternal death rate.....	45.
Infant deaths.....	1,862
Infant death rate.....	44

KANSAS

A total of 56 of the 105 counties in the State are without any type of health service, save the part-time county health officer required by statute. In many counties where health work is carried on, only a small proportion of the population is reached. From funds found at the present time, we find it necessary to drop 7 of the counties where nursing service has been started. It is evident from these facts that there is a definite need in Kansas for increasing public-health service to the citizens.

There are no prenatal or child-health conferences carried on regularly except in some of the larger cities of the State. An attempt will be made during the coming year to organize such clinics in the full-time unit counties and in coun-

ties with public-health nursing, but this service will be a very small part compared to the needs of the State.

In 1937:

Maternal deaths.....	127
Maternal death rate.....	43
Infant deaths.....	1,302
Infant death rate.....	44

KENTUCKY

Approximately one-sixth of the 120 counties of the State are classed as pauper ones. The income of these counties for general purposes is practically all required for meeting interest charges on bonded and floating indebtedness. In these counties the health needs are great, the local resources limited. The 20 counties referred to are ones having inadequate supply of physicians; no hospitals; few, if any, natural resources except the soil, and much of the land is submarginal or nearly so.

In these counties 393,880 people exist; annually there are 11,642 infants born, and 720 die before reaching 1 year of age. The perils and health hazards to which the surviving infants will be subjected can be entirely prevented, or, if not, so ameliorated that a healthier child will survive.

The request for additional funds for expenditure is based upon health needs of these and other counties whose economic status is not quite so serious as the 20 counties that have been described.

In 1937:

Maternal deaths.....	263
Maternal death rate.....	47
Infant deaths.....	3,321
Infant death rate.....	59

LOUISIANA

State and local funds are inadequate to maintain existing activities or for expansion proposed.

According to best public-health practice it is estimated that Louisiana (exclusive of New Orleans) would need an additional 600 nurses to attain the required basis of 1 nurse to every 2,000 population.

It is estimated that each of the 63 parishes should be served by not less than 5 prenatal and 5 child-health conference centers per parish. The cost of medical service for such service in any one parish would, at \$5 per clinic session, approximate \$700 per year based on conference frequency, prenatal twice monthly per center, and child-health quarterly per center.

For prenatal and child-health conferences in all of the 63 parishes....	\$44,100
For 600 public-health nurses (\$2,000 each).....	1,260,000

Total..... 1,304,100

Of the total 25,010 deaths in Louisiana in 1937, 3,020 were infants under 1 year and 330 were attributed to puerperal causes.

In summarizing our inadequacies, we find 98 percent of all State births and 52 percent of all rural births are attended by midwives, which facts indicate that there is general lack of appreciation of medical care at delivery and inadequate understanding of prenatal care. We know, too, that obstetric consultation to physicians in rural areas is practically nil except in the environs of two city areas, New Orleans and Shreveport; that hospital facilities are inadequate and too inaccessible to the majority of rural patients. Tuberculosis, syphilis, and malnutrition are factors contributing to maternal and infant mortality.

Only 30 of Louisiana's 63 parishes were organized health units.

In 1937:

Maternal deaths.....	330
Maternal death rate.....	72
Infant deaths.....	3,020
Infant death rate.....	66

MAINE

There are needed additional qualified workers in the fields of public-health nursing, dental hygiene, nutrition, and so forth.

Some nurses are serving populations of from 25,000 to 30,000 people, and to meet the usually estimated number of nurses needed for a given population the present force of 22 should be multiplied by 10.

Medical facilities in the State are adequate as to the number of physicians, but the disinclination of physicians in general to settle in rural communities leaves a serious problem in supplying medical care to the people of low incomes and the indigent who cannot afford to pay fees necessary to secure medical aid from a distance.

Such physicians as are located in small communities can hardly find the time or afford the expense of postgraduate work away from home, and thus some means such as proposed in the present plan is needed to bring something of the newer knowledge of obstetrics and pediatrics to these men.

Because of the financial status in many Maine communities, it is impossible for such communities to provide the sorely needed services. It is only from outside sources that any nursing service and, in many instances, necessary medical service, can be supplied.

A recent survey indicates that Maine is included in the area where 45 percent of the diets are inadequate, showing the desperate need for public education in matters pertaining to selection of diets. While it is practically impossible to provide expert nutritionists to reach this large percentage of the population, at the same time, the need for such instruction as the public-health nurse can offer is apparent.

An outstanding problem in Maine is the rural, scattered population, complicated by really long distances. Prenatal care and follow-up, dental corrections, and, many times, necessary medical emergency care is difficult to obtain.

In 1937:

Maternal deaths.....	100
Maternal death rate.....	63
Infant deaths.....	998
Infant death rate.....	65

MARYLAND

Specific needs for additions to the staff of the State department of health amount to \$20,300. There are approximately 86 nurses attempting a generalized service in a population, largely rural, of 915,000. An equal number of additional nurses is required to meet the minimum requirement of 1 nurse to 5,000 population, set by public-health experts.

Unfortunately, no funds are available to pay physicians or midwives for the delivery of indigent cases. Comparatively few of the rural hospitals accept uncomplicated free cases and the county commissioners defray the expenses of only a few of these women of the low-income groups.

One thousand one hundred and six infants died in their first year in the counties, a rate of 67.1 per 1,000 live births. Many of these deaths were from causes which are largely preventable. The 155 deaths in the counties from diarrhea and enteritis surely can be reduced. Only 63 deaths from this cause occurred during the year in Baltimore City. The counties are at a disadvantage and in many cases the lack of an adequate supply of pure milk, a much greater prevalence of flies, infrequent nursing visits, and the small number attending child-hygiene conferences are factors in the unfavorable results.

In 1937:

Maternal deaths.....	117
Maternal death rate.....	42
Infant deaths.....	1,705
Infant death rate.....	61

MICHIGAN

Among the outstanding health problems of mothers and children in Michigan are the many preventable deaths of mothers and babies. Contributing to these deaths are: (1) Need for more adequate medical and nursing care for mothers during pregnancy and at childbirth, and for the children especially during early

infancy; (2) the need for continued postgraduate education in obstetrics and pediatrics for general practitioners; (3) in many areas the absence of consultant obstetric and pediatric services is a very definite factor.

A demonstration home-delivery nursing service was begun in Cass County January 1, 1938, by three nurses who give prenatal instruction to all mothers in the county, and assist the attending physician with home deliveries in homes where nursing service would otherwise not be available. This service is needed in many other areas, but funds are inadequate to finance the same.

The school health program in the State is undeveloped. Lack of local funds for this purpose and lack of health training of educators in health programs are factors in bringing about this condition.

There are 25 counties having no organized health service and for which assistance should be provided. There are 36 units of 58 counties in organized areas to each of which a minimum of one MCH nurse should be added at the approximate cost of \$52,800.

Additional nurses are needed on the staff of the State department of health to work with staff physicians in special programs for the control of tuberculosis, venereal disease, typhoid fever, diphtheria, and smallpox. A minimum of four nurses would require approximately \$10,400; total, \$63,200.

There is also need for better medical and nursing care for mothers at the time of delivery and for babies during the first weeks of life—no estimate of cost.

In 1937:

Maternal deaths.....	334
Maternal death rate.....	30
Infant deaths.....	4,380
Infant death rate.....	48

Maternal Care in Michigan, a Study of Obstetric Practice.—This publication constitutes the report of the committee on maternal health of the Michigan State Medical Society of a study on obstetric practices which was carried out by the committee with the assistance of the United States Public Health Service.

During 3-month period January–March 1936, a total of 21,508 births were registered in Michigan. By questionnaires, 48 percent of the births and 52 percent of the attendants of the births registered January–March 1936 were secured for study (10,205 questionnaires returned by 1,687 attendants).

Studies reveal that 85 percent of the births are attended by less than one-fourth of the total number of doctors in the State.

Maternal care given by obstetric specialists tends to be concentrated in the large cities; in rural areas this service is mostly in the hands of the general practitioners, especially those graduated prior to 1915.

A very small proportion of women living in rural districts have the services of obstetric specialists.

Prenatal care attaining the level of completeness which is advocated as an ideal standard is received by very few women. Classification of prenatal care in broad groups with respect to its relative completeness and adequacy reveals that one-fifth of the women receive what may be termed satisfactory care from a practical viewpoint, while one-fifth receive wholly inadequate or essentially no professional prenatal service.

Study of the distribution of this care shows a very marked correlation between the level of adequacy of prenatal service and economic status, size of city in which the mother lived, and her parity. In general, women who are poor or on relief, women who live in rural areas, and multiparous women bear the brunt of the widespread deficiency in prenatal services.

Nearly 60 percent of the mothers living in the larger cities while less than 28 percent of the rural women are delivered in hospitals.

According to economic status, hospitalization varies from 65 percent among the comfortable, 50 percent among the moderate, 33 percent among the poor to 28 percent among those on relief.

Techniques employed in the handling of labor and delivery were found to vary widely and to be related to certain characteristics of the birth attendant, to place of delivery (home or hospital), to size of city, and to economic status of the family.

Although questionable, and even dangerous, procedures are spread widely over the total group of parturient women, a relatively large share of the most serious defects in practice fall upon poor women, those delivered at home, and those living in rural communities.

MISSISSIPPI

Mississippi is the only State in the Union in which the Negro (50.2 percent) exceeds the white (49.8 percent) population. During 1930 certain diseases peculiar to the Maternal and Child Health program were at least 100 percent greater among the colored than the white (malaria; diseases of pregnancy, childbirth, and the puerperal state; tuberculosis).

The minimum sanitarium requirements for tuberculosis control is considered one bed per death. Mississippi has approximately one bed for each three deaths.

In order to determine the lack of medical service to people within the State according to death certificates submitted for 1930, it is found that 14.8 percent of all deaths reported did not have medical attention. Of this number 4.6 were white and 22.2 were colored. The figures quoted do not include sudden deaths. Many other deaths occurred where only one call had been made by the physician.

Hospital care: Mississippi has approximately 1 bed to 250 population. The United States average is approximately 1 bed to 130 people.

In 1937:

Maternal deaths.....	368
Maternal death rate.....	71
Infant deaths.....	3,066
Infant death rate.....	59

MISSOURI

Missouri is facing several rather serious problems.

The increasing scarcity of medical practitioners in rural areas and extremely high maternal and infant mortality rates in certain sections may be counted as the most pressing.

A crying need is funds with which to subsidize physicians for delivery service to women of the low-income groups.

Droughts, depressions, etc., have reduced many very worth-while rural families to a very insecure economic position.

In 1937:

Maternal deaths.....	203
Maternal death rate.....	51
Infant deaths.....	3,219
Infant death rate.....	57

MONTANA

Montana is the third largest State in point of area and two-thirds percent of the half million population live in rural areas. The effects of the economic depression have been exaggerated by a long period of drought in the eastern two-thirds of the State. In 1937, 30,433 individuals in Montana submitted Federal income-tax reports. This would indicate roughly that about five-sixths of those of wage-earning age have incomes of less than \$1,000 if single or \$2,500 if married. The problem of providing medical care for this large group on low incomes is apparent.

The need for preventive medical measures is indicated by the fact that in 1937 there were 898 cases of smallpox reported, 62 cases of diphtheria with 8 deaths, and 96 cases of typhoid fever with 11 deaths. The maternal mortality rate was materially reduced in 1937—35 maternal deaths per 10,000 live births—but a study of maternal deaths indicates that there are still many preventable deaths. The infant mortality rate remains high, 51 per 1,000 live births, and is extremely high in some areas in the State. There are available for general medical care only 2,800 hospital beds for a population of over 500,000. Of the 46 general hospitals, there are only 6 maintained by city or city-county governments.

The fact that only 4 of the 56 counties have full-time organized health departments and that there is not an out-patient department associated with any of the hospitals or a free dispensary in the State, and no organized prenatal, infant, or preschool medical conferences indicate there is great need for

the development of public-health service in the field of maternal and child health.

In 1937:

Maternal deaths.....	38
Maternal death rate.....	37
Infant deaths.....	517
Infant death rate.....	51

NEBRASKA

Nebraska has no local provision for health service outside of the metropolitan centers, nor is there any legal authority for same. This situation is well known and need not be dilated upon. On the other hand, distance is so great and population so sparse through the greater part of the State that a large central organization will be entirely impracticable. Local resources have been so depleted by the recent years of drought that even though legal authority were provided many counties would be reluctant to commit themselves for any considerable sum of money for health service.

In 1937:

Maternal deaths.....	92
Maternal death rate.....	41
Infant deaths.....	937
Infant death rate.....	42

NEW JERSEY

From a general standpoint there is need for improvement in the social and economic status of many families of the State. This is the basis of much inadequate feeding, medical care, and bad housing. More specifically in the field that relates immediately to the work of this Bureau there is need for additional prenatal clinics, baby-keep-well stations, and public-health nurses placing special emphasis on maternal and child health; training and education of physicians in better preventive pediatrics and maternal welfare; more adequate education of parents in child nurture particularly in reference to preventive mental hygiene.

Finances obtained from the State legislature are not adequate to carry out this type of program.

In 1937:

Maternal deaths.....	207
Maternal-death rate.....	38
Infant deaths.....	2,154
Infant-death rate.....	39

NEW MEXICO

Our infant-death rate—twice that of the United States registration area—and our high maternal-death rate indicate the seriousness of the maternal- and child-health problems in the State. The situation has not changed essentially in the past year.

We recognize these further needs in New Mexico: Free hospital beds with adequate equipment and staff; qualified obstetricians to serve as consultants; more qualified pediatricians to serve as consultants; nurses to assist in home deliveries; doctors willing to answer calls when the midwife finds the case beyond her competence and sends for help as we have been at pains to teach her to do; younger and more intelligent midwives.

The medical and nursing resources are inadequate—both as to number and distribution. About one-fourth of the 400 doctors of medicine in the State are practicing in the 4 largest communities. There are no doctors in New Mexico who have passed the examination of the American Board of Obstetrics. Quacks and cultists flourish since there is no law requiring the practitioners of the healing arts to pass an examination in the basic sciences before being licensed.

To meet the standard of 1 nurse to every 2,000 of population, over 160 addi-

tional nurses are needed. More clinics are needed—at least 1 in each of the 31 counties of the State, and several in the larger centers of population.

In 1937:

Maternal deaths.....	60
Maternal-death rate.....	50
Infant deaths.....	1,711
Infant-death rate.....	124

NEW YORK

Probably the outstanding need is for more public-health nurses for county work. State-aid, while available to any county, must be matched with an equal amount of county funds. Many counties cannot meet this requirement for health services, particularly rural counties where there has been a drift of the taxable population toward the urban areas, and also where the Federal Government has taken up considerable marginal land, from which no taxes are derived. The great emphasis on different phases of public health such as syphilis and pneumonia control, tuberculosis, and maternal and child health together with a subsequent increase of clinic activity, has taxed to the utmost the existing nursing service.

Corrective work of a preventive character should be more available for needy young children. There is no agency through which this can be secured, to any great extent, as welfare funds are needed for acute conditions.

Dental work is a crying need, and while funds have been provided for work of this character in the more rural areas, there is a wide zone between what is needed and what is possible.

Small ruralized hospital units of 12 to 20 beds, where any physician may deliver his maternity cases under favorable conditions, and at small cost, would serve to prevent some of the fatalities caused by taking serious cases to distant city hospitals, the mortality of cases so handled being extremely high as shown by department studies. (St. Lawrence and Clinton Counties infant-welfare surveys showed mortality of hospital cases where hospitals were in same locality as residence, 38 as compared with 88, where location of hospital and residence was different.)

In 1937:

Maternal deaths.....	749
Maternal death rate.....	40
Infant deaths.....	8,369
Infant death rate.....	45

NORTH CAROLINA

Seventy-six of one hundred counties are cooperating with the State board of health in providing some type of full-time organized local public-health service. Six cities have departments of public health.

The two largest classes of population are rural and industrial—meaning employees of tobacco factories and textile mills for the most part, most of them being workers in the lower-paid brackets and not rated as skilled labor. Of the rural population the majority of births occur among the tenant or sharecropper groups. The per capita and per family wealth of the State is low.

In the State in rural districts there were many areas in which people live too far from a physician to obtain the services needed. In such areas and in many others not only syphilis, hookworm, and malaria are likely to prevail, tuberculosis is a problem in such districts as well as in the congested industrial areas; 16,000 colored women and 5,000 white women each year depend solely on midwives for care at delivery.

In spite of low per capita wealth, legislative appropriations and county and city tax levies provide approximately \$1,000,000 in this current year (1939) for public-health work, State and local.

North Carolina has 100 counties with a population of 3,407,000. Two hundred and seven local public-health nurses are employed by State, counties, and cities. One public health nurse for each 5,000 population would require 500 additional public-health nurses.

To place a maternal and child-health center within reach of every expectant mother of the poorer classes who have no method of transportation would require 600 such centers.

In 1937 there were 420 maternal deaths, in 1938 there were 440. In 1937 there were 5,180 infant deaths, and in 1938 there were 5,474. There was not a sufficient difference in the number of births to account for the slight rise in the number of deaths. Proposed remedies: Careful medical supervision during pregnancy, competent obstetric service at birth by physicians or thoroughly trained midwives, public hospitals in every county to take care of deliveries when prenatal service shows variation in prospect for normal delivery. Encouragement to mothers to seek medical supervision early in pregnancy, public-health nurses to attend births with midwives. Poverty and ignorance cause more deaths among mothers and babies than anything else. Better housing, increase in income, steady employment, and practical education for children will reduce hazards.

In 1937:

Maternal deaths	420
Maternal death rate	54
Infant deaths	5,180
Infant death rate	66

NORTH DAKOTA

There has not been one good crop since 1930. In 1936 there was a complete crop failure in the western two-thirds of the State. It was the first year on record when people did not have even potatoes. In 1937 the rains came too late to save the grain in the western two-thirds of the State. Late gardens helped some but did not provide any ready cash. The relief load was heavier than ever before in this part of the State during the winter of 1938, and has given plenty of cause for worry. There has been a noticeable migration from the farms to the small villages and cities in order to be closer to the relief sources.

It has been difficult to collect taxes and large areas have gone back to the State, thus decreasing the expected taxes. Since there are no industries to tax and income tax is very limited, the public funds have been more than exhausted in meeting the extra relief burdens. To March 1938, 33 percent of the total population were on relief and another 33 percent did not have funds for medical or dental care.

There are very few physicians left in the rural areas, and those who are left find it difficult to eke out a living and keep up to date. Some counties do not have physicians and others have very few. This situation complicates public-health administration.

The public-welfare board provides emergency medical care for indigents, and the Farm Security Administration provides emergency medical care through loans to a certain group of farm families. This medical care is limited to emergency care and does not include anything nearly adequate in medical care for maternity cases or for correction of defects in children.

Twenty-seven counties do not have public-health nurses, and since the counties in the western half of the State are not in a position to pay even 50 percent of the cost of public-health nursing service at the present time, and since it was not deemed wise to ask the eastern counties who have had only 1 year of prosperity, to shoulder more than 50 percent of the cost, this year many of our counties will have to go without even a public-health nursing service, the lowest level of maternal and child-health service we have to offer. This also means that 27 counties will not have preschool conferences.

Thirty public-health nurses could be used if funds were available. Our one great need, however, is more adequate provision for medical care for mothers and babies.

In 1937:

Maternal deaths	50
Maternal death rate	47
Infant deaths	662
Infant death rate	52

OHIO

That well-qualified public-health administrators are rare, especially in local health districts, is an accepted fact. The Ohio Department of Health has no share in insisting in naming the various health officers except in cases of Federal salary allocated toward their salaries.

Much of the southern half of the State is rural and many of the homes are inaccessible. During the floods which invade the Ohio River and its tributaries urgent action is demanded of all health authorities. Much more is to be desired in public-health nursing than is now possible. We shall have to begin serious consideration of the establishment of regional consulting services to local physicians by highly qualified specialists in problems of maternity and child health.

Because of the large industrial centers the industries of which are now operating at approximately 25 percent of capacity, we have great numbers of families who when not "relief indigent" are "medically indigent" and are not receiving even an approach to adequate medical care.

In 1937:

Maternal deaths.....	403
Maternal death rate.....	46
Infant deaths.....	5,332
Infant death rate.....	50

OKLAHOMA

We are presenting figures on the State showing the total population per county, number of physicians per county, total tax assessments in dollars, total number of persons on relief calls, and the percent of population on direct relief in each county. This does not include those working in governmental projects, such as Works Progress Administration, Public Works Administration, or National Youth Administration.

On examination of our figures it appears that the counties with the smallest per capita assessed valuation have the largest number of people on relief and the smallest number of physicians.

The percentage of people unable to purchase adequate medical care (in certain counties), and this includes a large number of those doing Works Progress Administration and Public Works Administration work, runs close to 50 percent. Therefore the number of people able to purchase adequate obstetric care is probably less than 50 percent; in 11 counties from 10 to 30 percent (average 14 percent) of the population are on relief; in 15 more counties from 5 to 10 percent (average 7 percent) of the population are on relief.

In other words, in over one-third of the counties of the State, an average of 10 percent of the people, are on relief.

In 1937:

Maternal deaths.....	214
Maternal death rate.....	52
Infant deaths.....	2,345
Infant death rate.....	57

OREGON

With the demands coming so rapidly from counties, other than the 14 having full-time health units, for public-health service on a full-time health-unit basis, it becomes impossible to furnish the service as requested without the continuation of the present financial assistance. As the program sells itself to the communities the people request and the county officials approve increased expenditure for health activities.

The assistance needed is greatest in the rural areas of particularly central and eastern Oregon, and it will probably be necessary in the establishment of full-time services in these counties to at least participate with outside assistance to the extent of 50 percent of the cost.

Without the financial assistance of Federal funds, it would not be possible to maintain the State office staff on the State appropriation. The amount which the State will appropriate in 1939 is not known, but a request is anticipated to the extent that State participation plus the usual Federal fund allotments will not necessitate retraction in the present State activity and assistance to the counties.

With the establishment of child-guidance clinics, and crippled children's services, with new emphasis on maternal, infant, and preschool-age groups, with the continued requirements of the school personnel in many areas for service to the school-age group, with the development of the dental-health and hearing programs, and with the development of interest in the child as a unit, promoted to a great extent by the handicapped children's survey, there has been

a great demand upon the services of existing health personnel. It is estimated that 15 additional health nurses are now needed to begin to make effective in a large section of the State the present maternal and child-health plan.

No estimate is available for the number of prenatal and child-health conferences needed on a State-wide basis, but it is estimated, providing the rural demonstration program and the Malheur County program are established, that these areas will need at least 25 infant and preschool medical conferences, which in certain instances will also include maternal health. Provided suitable plans may be developed for the establishment of the maternal and child-health plan in Umatilla, Clatsop, Jackson, and Klamath Counties, there will be an additional need for at least 20 infant and preschool medical conferences.

In 1937:

Maternal deaths.....	62
Maternal death rate.....	40
Infant deaths.....	642
Infant death rate.....	42

RHODE ISLAND

As practically all of the cities and towns had never made any provision in their local budget for the hospital care of the indigent because there were such great demands made upon them to find money enough to care for their unemployed, it is becoming increasingly evident that this State will soon reach a crisis where some arrangement must be made with the respective hospitals to compensate them for the medical care of the indigent.

In regard to delivery service, we believe that there are approximately 2,000 deliveries per year in the homes that would, and should, take place in the hospitals had the State the funds for such delivery service.

This State needs 10 additional public-health nurses and 5 well-baby conferences; \$720 to pay for medical services at these conferences; and a minimum of \$100,000 to start a program for hospitalization of the indigent at time of delivery.

In 1937:

Maternal deaths.....	39
Maternal death rate.....	38
Infant deaths.....	487
Infant death rate.....	48

SOUTH DAKOTA

From a recent communication (apparently from a county official) to this office we quote: "We have outstanding obligations amounting to more than \$250,000. If this condition continues for any length of time we will have reached the maximum indebtedness under the constitution which is 5 percent of the assessed valuation. Our income the past few years has been considerably less than the amount we have been forced to spend. It is for this reason that at the present time we are unable to continue the program (public-health nursing) even though we appreciate the value of the service rendered by the public-health nurse."

From another letter we quote: "Last year's tax payment dropped to 57 percent. The county indebtedness is rather heavy. If it is possible for the United States Children's Bureau to continue this nursing service it will be greatly appreciated by the board and the entire county, but financial conditions really make it almost impossible to continue this if same is to be paid by our county."

South Dakota receives the largest allotment of Farm Security funds of any State in this region.

In 1937:

Maternal deaths.....	48
Maternal death rate.....	40
Infant deaths.....	608
Infant death rate.....	51

[Excerpts from report of public health committee of the South Dakota State Planning Board (most of the data covers year 1935)]

The provision of adequate medical care is a serious problem especially in the sparsely settled areas of the State.

The problem of adequate medical care is greatest in that portion of the State lying west of the Missouri River. This portion of the State represents roughly one-half of the total area. Counties which are without the services of one or more of the professional groups are as follows:

Armstrong, population 59; no physician, dentist, or nurse.

Buffalo, population 1,811; no dentist.

Campbell, population 5,634; no physician.

Harding, population 3,467; no dentist.

Lyman, population 5,720; no dentist.

Shannon, population 3,290; no physician, dentist, or nurse.

Stanley, population 2,559; no dentist.

Todd, population 6,463; no dentist.

Washabaugh, population 2,782; no physician, dentist, or nurse.

Washington, population 1,824; no physician, dentist, or nurse.

Zelbach, population 3,702; no dentist.

The large majority of our physicians are not making a living and some are in actual want.

Physicians

Percentage	Gross Income	Overhead	Net Income
1 to 25 percent.....	\$10, 134	\$4, 646	\$5, 488
26 to 50 percent.....	4, 280	1, 843	2, 437
51 to 75 percent.....	2, 292	1, 117	1, 175
76 to 100 percent.....	1, 194	629	665

In other words, 50 percent of our doctors are not earning as much as the average stenographer, and 25 percent more than the average Works Progress Administration worker or relief client.

It is our recommendation that some form of medical relief be inaugurated to insure the people of this State of competent medical care and to adequately compensate the physician for the medical services rendered. This will help both the laity and the profession. It will equalize the incomes of doctors who are located in the drought-stricken area with those who are more fortunately situated in the eastern part of the State. The physicians in this State have carried the burden of medical care long enough and cannot carry on much longer if something of this nature is not done. From the foregoing it must be apparent that there are not too many doctors in the State as it is, that the majority of our physicians are well along in years, and that South Dakota is not attracting the younger men of the profession.

There are not sufficient dentists in the State to provide adequate dental care and the large percentage who are practicing are not making a living.

Dentists

Percentage	Income	Overhead	Net Income
1 to 25 percent.....	\$4, 177	\$1, 927	\$2, 250
25 to 50 percent.....	2, 252	1, 208	1, 044
50 to 75 percent.....	1, 611	709	902
75 to 100 percent.....	761	348	413

From the above it can be seen that approximately 45 percent of a dentist's income goes to pay his business overhead, that 75 percent of the dentists are not making a living and are in need of some type of relief which will increase their cash income, and that even in the highest income bracket our dentists are making little more than is the superintendent of schools of our rural towns. When one considers the large amount of money a dentist has invested in instruments, equipment, and materials it makes his income look still smaller.

Recommendations.—The dentists should be included in the same set-up of medical relief as prescribed for the physicians for exactly the same reasons as previously discussed. Everything possible should be done to encourage the location of dentists in the counties that are now without dental service.

There are a large number of nurses in the State who do not have sufficient employment to enable them to earn a living practicing their profession.

Hospitals.—(1) The distribution of hospitals throughout the State is not uniform; (2) each day a hospital operates increases its deficit.

At the present time this deficit is being absorbed by delay in payments of principal, interest, and taxes, in cutting down necessary personnel, in delaying the purchase of needed equipment, and in foregoing any permanent improvements which can be put off. These measures are only temporary and will soon break down. Some plan of increasing the annual income of our hospitals must be effected soon.

Recommendations.—(1) The people and their boards of county commissioners living in the area described above should take advantage of the liberal building policy of the Federal Government and construct what hospitals they need; (2) hospitalization should be included in the cooperative medical set-up as prescribed for physicians.

TEXAS

There is a tremendous need for expansion of services within this State so that every county and community may have public-health service.

Only 12 counties have full-time county health units and only 20 have nursing services. These local services serve approximately 18 percent of the people. There is only 1 nurse for each 40,000 of the State's population.

Considering, then, the minimum service such as now exists in counties now organized throughout the State, there are urgently needed 75 nursing services in counties of less than 10,000 population; 40 district units combining two or more counties of from 10,000-20,000 population; 87 health units in counties of 20,000 or more population.

Based on the population of 1930, it is conservatively estimated that \$10,000,000 would be required for a fairly adequate health protection, of which \$3,000,000 might eventually be contributed from local sources. The present total funds available from Federal, State, and local sources is about 15 percent of the amount needed.

Texas, with its population of 6,000,000, represents 4.7 percent of the population of the United States.

Between 110,000 and 120,000 births occur in this State each year; of these births approximately 20,000 are attended by totally untrained, ignorant "granules."

Four thousand stillbirths occur each year and approximately 8,000 children die in the first year of life.

Texas, 254 counties in State.

In 1937:

Maternal deaths.....	666
Maternal death rate.....	57
Infant deaths.....	8,575
Infant death rate.....	74

UTAH

In order to provide 1 public-health nurse for every 2,000 population in the rural section of Utah, we would need approximately 140 nurses, whereas at present we have approximately 50 nurses.

To estimate the number of prenatal and child-health conferences is impossible because even in areas where good hospitals exist, health supervision of children is exceedingly inadequate. We may safely say that child-health and prenatal conferences are needed in every part of the State where people reside.

In recent surveys of Iron County, which has a good hospital, and excluding the isolated part of the county, it was shown that only 8 percent of the children under school age had had examinations and health supervision through personal contact with a physician in the past year.

For this fiscal year we have stated in our plan to limit the number of child-health conferences. This limitation is necessary because of insufficient funds with which to establish permanent monthly conferences in meeting the expense of physician's fees and travel.

One of the great needs in the State is delivery care. In Duchesne County in 1937 there were 47 of the 87 deliveries by midwives. In Garfield County there were 60 of the 138 deliveries by midwives. In San Juan County there were 21 of the 46 deliveries by midwives, and this year there is no physician in this county, so all of the deliveries will be conducted by midwives unless provision is made for a physician to manage these deliveries. In other counties of our

State midwives deliver considerable number of cases with none getting supervision in the prenatal stage.

In San Juan County alone last year one midwife lost three babies, which gave the appearance of asphyxia pallida. Many peculiar stories could be told yearly of unnecessary deaths of both mother and child because of supervision of delivery by untrained midwives instead of physicians.

These counties mentioned have no hospitals and deliveries are all in the home, and it is impossible to get a physician to travel in many of these instances more than a hundred miles to care for these patients.

In 1937:

Maternal deaths	42
Maternal death rate	33
Infant deaths	520
Infant death rate	41

VERMONT

Physicians are very often unpaid, or not paid at all for maternity care given to needy cases. Many take their pay in produce from the farm and are glad to get anything from wood to maple sirup, poultry, etc., but, unfortunately, all needy cases are not in a position to contribute in this manner. In that case, either the town must pay or the physician writes it in red on his ledger. Necessarily, adequate prenatal care is lacking in many cases.

The estimated number of public-health nurses needed, on the basis of 1 public-health nurse for every 2,000 population, excluding the city of Burlington, which is over 20,000, the rural population of Vermont would be estimated at approximately 340,000, and therefore 100 public-health nurses would be needed. At the present time there are 60 nurses, including Red Cross, private organizations, school, and State public-health nurses. On the assumption that each public-health nurse would conduct, during the year, 12 medical conferences for infant and preschool children, there would be a need for 1,200 conferences at an average of \$10 per conference, or at an approximate cost of \$12,000.

To conduct an adequate prenatal service, it also would be assumed that 1,200 prenatal clinics would be needed, with an average cost of \$15 per clinic, or an approximate cost of \$18,000.

A low estimate of 33 $\frac{1}{4}$ percent of obstetric cases might well be estimated in the low-income and needy families. In the course of a year, a little over 6,000 babies are born in Vermont, making about 2,000 cases in the low-income group which would need obstetrical care at the time of delivery, either in the home or in the hospital. Medical fees for this type of service for the attending physician would average \$25, making an estimated need of \$50,000. This is assuming that on the basis of 2,000 deliveries in the low-income group, 50 percent of these are now being hospitalized, which may be considered a careful estimate, with an average stay for each case of 10 days in the hospital. This would be at an average rate of \$3 per day, which makes a total of 10,000 days of hospital care at an approximate cost of \$30,000.

To carry on an adequate nutritional program to meet the needs for proper instructions for the low-income group, as suggested in foregoing statements, 14 nutritionists, one for each county in the State, would be a conservative estimate with the necessary equipment, travel, and salaries. This would amount to about \$38,000.

The dental needs in many of the smaller communities where there are no dentists, and the dental conditions being found at our preschool conferences, are astonishing. On the same basis as each nurse conducting a preschool medical conference, the need would be approximately 1,200 dental conferences, with a dentist in attendance, at an average cost of \$10 per conference for examinations and talks to mothers. The cost of these conferences would be \$12,000. For corrective work done for these preschool children, the estimate of \$75,000 would certainly be low, as in some places where dental corrective work has been carried on over the period of years the average amount of money being spent for dental care averages between \$18 and \$25.

To pay for necessary corrective work, such as the removal of tonsils, fitting of glasses, and the fees to be paid to physicians and the hospital care, the conservative estimate of \$100,000 might be said to be comparatively low.

This outline is a brief picture of what could be done for the low-income group of Vermont if there were sufficient funds to carry on such a program.

In 1937:

Maternal deaths.....	86
Maternal death rate.....	57
Infant deaths.....	818
Infant death rate.....	49

WASHINGTON

In cities of over 10,000 the population is 792,000, or roughly 50 percent of the population.

Without making allowance for the difference in the age groups of the rural and urban population, then about 12½ percent of the population is rural and under 15 years of age, or about 195,824.

The only well-child and infant clinics are in Seattle, Spokane, and Tacoma. These three cities include roughly one-third of the population of the State (1930). The remaining two-thirds of the population is not served by clinics or (on the same basis as above two-thirds of 25 percent or 17 percent) 265,777 children under 15 years of age are not served by preventive clinical facilities.

At present there is no nursing delivery service. A complete survey of the necessities of the State in this field has not been made. Roughly 30 percent of the deliveries in the State occur in the homes. In the rural districts about 60 percent are in the homes. One obstacle at the present time to the development of a nursing delivery service is the lack of nursing facilities. If our average county health nurse were called upon to assist at delivery some of her efforts at promoting preventive medicine would have to suffer.

In 1937:

Maternal deaths.....	114
Maternal death rate.....	46
Infant deaths.....	998
Infant death rate.....	40

WEST VIRGINIA

Resources are inadequate to meet the need for extension of health services. Many of our counties are so rural, and tax valuations of property are so very low that it is practically impossible for these counties to support a public-health service. Even the services that are already established are not adequately staffed. For example, a public-health nurse located in one of our counties is endeavoring to carry on a program for a population of 14,555 scattered over an area of 904 square miles.

There are 18 counties at this period (May 1938) without any supervised health service.

If a minimum of 2 maternal health conferences and 2 infant bureau conferences were maintained in each county, it would require the maintenance of 220 such conferences a month, or 2,640 a year. With a minimum of \$6 per conference it would require \$15,840 for such services alone. When it is considered that West Virginia has over 40,000 births a year, even such a service would be very inadequate.

West Virginia lacks proper distribution of physicians. For example, one county with a population of 6,358 over an area of 218 square miles, has only 1 active practicing physician. This county cannot support physicians, let alone a health service. A county such as the above cannot even match funds for health services. When it is considered that even in metropolitan centers there is inadequate maternal and child-health care, it further emphasizes the need in such rural areas as are found in West Virginia.

In 1937:

Maternal deaths.....	218
Maternal death rate.....	50
Infant deaths.....	2,610
Infant death rate.....	62

WISCONSIN

The outstanding need at the present time in Wisconsin is for an increase in the number of adequately trained public-health nurses in rural areas. The ratio of public-health nurses to population in November 1937 was: Rural areas of county with nursing service, 1 nurse to 18,013 population; cities with nursing service (excluding Milwaukee), 1 nurse to 5,858 population; Milwaukee City, 1 nurse to 4,044 population.

In addition to this, a number of counties still have no nursing service of any type. These were not included in determining the ratios given. With more public-health nursing, educational programs could be extended and more service could be rendered in the homes, especially in the rural areas where the need is tremendous.

There is need to build stronger local health units in order to plan programs adapted to individual communities and to give closer supervision to all public-health work.

In 1937:

Maternal deaths.....	195
Maternal death rate.....	36
Infant deaths.....	2,324
Infant death rate.....	43

The facts concerning infant mortality, maternal mortality, attendants at births, and place of birth, whether in home or hospital, deaths among children of all ages from various causes are available from the United States Bureau of the Census. Data on each item are available by race and by whether birth occurred in urban or rural areas.

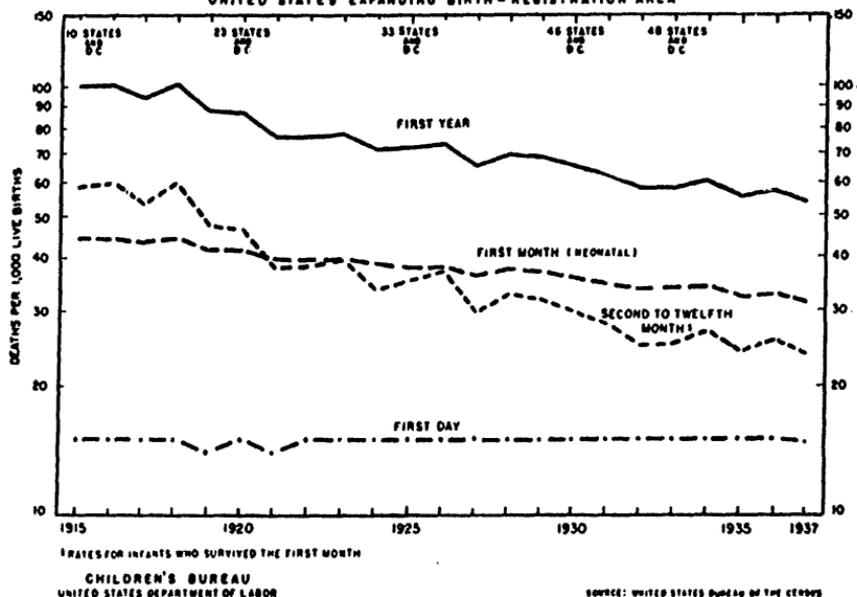
Data are available from which estimates may be made showing relation of the per capita income of the States to such factors as infant mortality, number of births, and number of children in the United States and in various sections of the country. The number of births and number of children in families with incomes of certain levels or on relief have been estimated for the country as a whole and may be used as a basis of calculation of need on a national basis, but no satisfactory way has been found to estimate the number in each of the several States. The geographic conditions under which families must live also affect the availability of medical and hospital services and the cost of health services. Some data are available showing the need for preventive medical services to conserve hearing or vision among children. These data would all appear to be pertinent to the problem of providing adequately for maternity care and medical care and health supervision of infants and children.

INFANT MORTALITY

Infant mortality rates have decreased strikingly during the past 23 years. (See chart 3, Infant Mortality 1915-37, by Age at Death), but the decrease has occurred almost entirely in the age group from the second to the 12th months of life and very little during the first month of life. Deaths during the first weeks of life are largely of prenatal and natal origin and are largely associated with maternal conditions. Almost one-half of the deaths in the first month are due to premature birth.

CHART 3

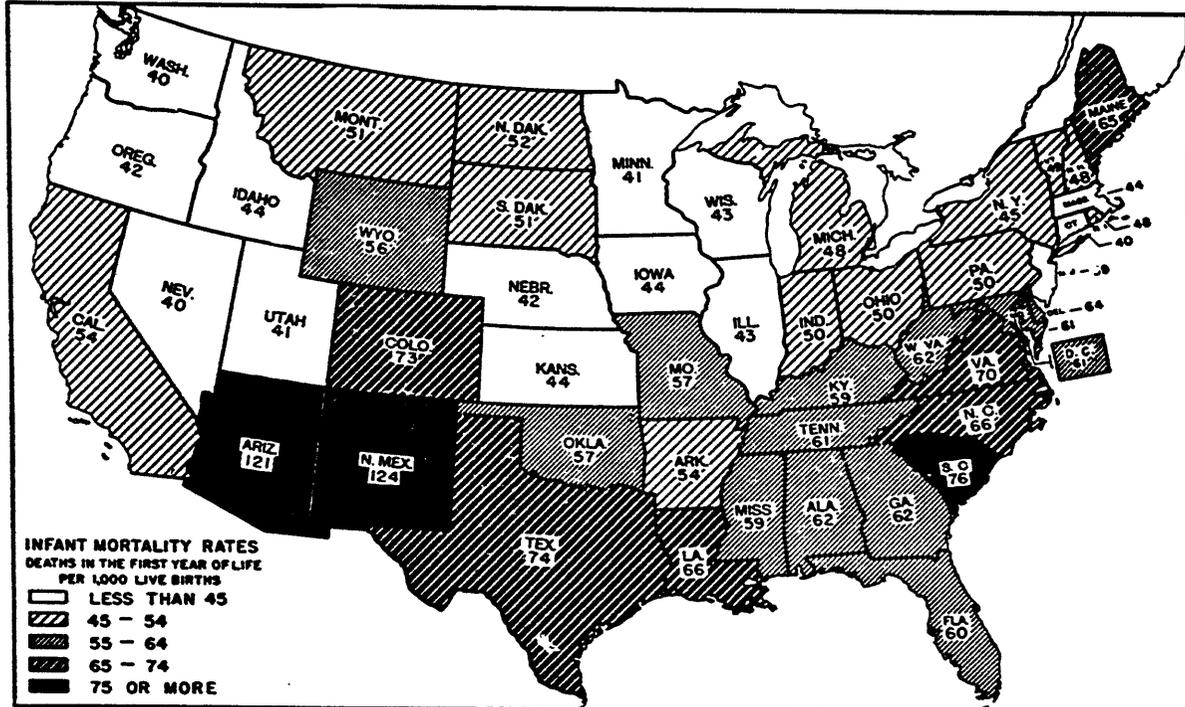
INFANT MORTALITY—
CERTAIN PERIODS OF THE FIRST YEAR OF LIFE, 1915-37
UNITED STATES EXPANDING BIRTH-REGISTRATION AREA



The infant mortality rates for 1937 are seen on chart 4, Infant Mortality in the United States 1937, for Each State.

CHART 4

INFANT MORTALITY IN THE UNITED STATES, 1937



CHILDREN'S BUREAU
UNITED STATES DEPARTMENT OF LABOR

SOURCE: UNITED STATES BUREAU OF THE CENSUS

The great variation in rates is clear. In individual counties infant mortality rates vary still more from less than 40 to 150 or more per 1,000 live births.

Table 3, Trends in Infant Mortality and table 4, Trends in Neonatal Mortality, which follow, are from special reports of census.

TABLE No. 3.—Trend of infant mortality: United States birth-registration area by States, 1915-38

[From Bureau of the Census: Vital Statistics—Special reports, June 21, 1939, vol. 7, No. 48]

State	Deaths under 1 year per 1,000 live births																							
	1915	1916	1917	1918	1919	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938
Area.....	100	101	94	101	87	86	76	76	77	71	72	73	65	69	68	65	62	58	58	60	56	57	54	51
Alabama.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	64	75	74	72	61	61	65	68	63	67	61
Arizona.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	121	130	142	133	117	110	96	104	112	120	121
Arkansas.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	61	67	58	51	49	45	54	54	47	51	51
California.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	61	67	58	51	49	45	54	54	47	51	51
Colorado.....	(2)	(2)	(2)	(2)	70	74	66	71	73	67	69	63	62	62	63	59	57	53	51	49	52	50	53	54
Connecticut.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	62	62	63	59	57	53	51	49	48	42	40
Delaware.....	107	101	94	107	86	92	73	77	69	73	72	59	59	64	56	54	49	48	48	49	43	42	40	36
District of Columbia.....	111	106	107	112	85	91	83	85	92	76	87	85	85	68	65	71	71	67	67	60	61	66	65	64
Florida.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	67	67	65	64	61	61	63	65	59	72	61
Georgia.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	82	74	75	67	67	65	61	63	68	62	59
Idaho.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	63	50	59	57	57	68	64	67	79	68	70
Illinois.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	62	62	76	64	61	61	63	68	62	59	60
Indiana.....	(2)	(2)	86	87	79	82	71	67	71	65	68	72	59	64	64	55	57	56	43	47	50	51	51	44
Iowa.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	78	82	71	73	69	64	64	61	56	56	43	47	50	51	44
Kansas.....	(2)	(2)	77	80	70	73	63	65	63	59	62	65	55	59	55	53	53	48	48	48	53	57	51	50
Kentucky.....	(2)	(2)	87	93	82	73	62	69	72	65	71	75	61	71	70	70	71	65	65	63	58	58	52	44
Louisiana.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	67	70	70	71	65	65	63	65	59	67	61
Maine.....	105	104	93	101	91	102	88	86	89	81	76	80	80	77	78	74	78	66	65	70	69	69	72	66
Maryland.....	(2)	121	120	104	105	104	94	94	95	86	90	87	81	81	73	77	76	72	63	66	67	63	64	65
Massachusetts.....	101	100	98	113	88	91	76	81	78	68	73	73	65	80	80	80	75	81	69	66	70	62	69	61
Michigan.....	86	96	88	89	92	79	75	80	72	75	77	68	65	64	62	60	55	53	52	49	48	47	44	41
Minnesota.....	70	70	67	71	67	66	59	58	62	57	60	58	52	68	69	66	63	57	54	51	52	48	51	48
Mississippi.....	(2)	(2)	(2)	(2)	(2)	(2)	68	68	68	71	68	70	67	66	62	54	51	52	47	48	47	45	44	41
Missouri.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	60	66	66	62	59	63	57	55	63	57	57
Montana.....	(2)	(2)	(2)	(2)	(2)	(2)	70	71	67	71	77	66	61	61	64	58	60	51	51	53	60	57	51	46
Nebraska.....	(2)	(2)	(2)	(2)	(2)	64	59	57	57	55	58	59	51	51	53	52	52	49	49	43	49	45	41	42
Nevada.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	67	67	68	68	74	70	73	59	71
New Hampshire.....	110	115	110	113	93	88	87	80	83	80	76	79	69	69	69	68	61	57	59	56	61	54	46	48
New Jersey.....	(2)	(2)	(2)	(2)	(2)	(2)	74	79	72	70	69	70	61	61	65	60	61	57	56	49	46	44	44	39
New Mexico.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	65	60	56	57	50	46	49	46	44
New York.....	99	94	91	97	84	86	75	77	72	69	68	71	59	65	61	145	134	119	136	126	129	122	124	109
North Carolina.....	(2)	(2)	100	102	84	85	75	80	81	82	79	82	73	69	69	59	57	53	54	52	48	47	45	41
North Dakota.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	67	69	73	67	66	78	69	69	69	66	68
Ohio.....	(2)	(2)	92	94	90	82	75	72	75	67	70	70	62	62	59	67	62	59	55	60	57	59	50	52
Oklahoma.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	66	66	69	61	60	58	53	54	50	51	50
Oregon.....	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	69	69	70	61	51	50	56	61	55	60	57
Pennsylvania.....	110	114	111	129	100	97	88	88	90	79	82	82	69	48	47	48	44	41	40	40	41	44	42	39

TABLE NO. 4.—Trend of neonatal mortality: United States birth registration area by States, 1915-37

[From Bureau of the Census: Vital Statistics—Special Reports, July 13, 1938, vol. 5, No. 37]

State	Deaths under 1 month per 1,000 live births																						
	1915	1916	1917	1918	1919	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937
Area	44.4	44.1	43.4	44.2	41.5	41.5	39.7	39.7	39.5	38.6	37.8	37.9	36.1	37.2	36.9	35.7	34.6	33.5	34.0	34.1	32.4	32.6	31.3
Alabama	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	36.1	40.4	41.0	40.4	36.0	36.3	39.4	37.0	37.0	39.8	38.3
Arizona	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	41.8	47.3	40.6	47.3	46.1	45.4	41.5	46.3	38.2	42.2	45.7
Arkansas	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	30.0	32.8	31.2	27.8	26.3	24.4	27.5	20.0	20.0	24.5	27.8
California	(C)	(C)	(C)	(C)	35.3	36.1	34.6	35.0	34.9	32.6	33.8	31.7	31.4	30.8	31.7	29.7	30.7	30.0	29.6	28.9	28.9	26.6	28.6
Colorado	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	44.5	44.4	42.3	42.1	37.4	37.3	38.1	39.6	39.6	36.9	37.5
Connecticut	44.7	45.3	42.8	47.6	43.4	44.3	41.2	40.0	41.9	40.2	40.2	39.7	36.7	35.8	33.4	34.0	31.3	31.3	33.7	33.7	30.6	30.3	31.5
Delaware	(C)	(C)	(C)	(C)	(C)	(C)	42.3	44.8	44.5	39.6	36.6	39.3	35.2	37.1	35.7	32.6	34.9	33.3	31.6	30.6	28.9	28.9	28.9
District of Columbia	50.0	43.7	44.5	50.6	40.8	47.7	49.1	46.8	47.1	41.2	42.8	42.3	37.8	34.9	36.1	38.1	34.2	42.9	36.4	36.4	35.0	40.2	40.2
Florida	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	46.2	44.1	42.3	40.2	41.0	41.6	39.4	40.2	38.5	41.7	41.3	38.4	40.4	40.4
Georgia	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	44.8	42.6	43.2	40.8	39.6	43.7	38.4	40.4	36.6
Idaho	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	35.2	30.6	36.9	34.8	38.7	39.5	36.5	43.7	38.4	40.4	36.6
Illinois	(C)	(C)	(C)	(C)	(C)	(C)	40.6	41.4	39.9	36.1	37.7	37.3	36.7	36.9	34.8	34.0	34.9	37.7	33.0	30.3	31.6	31.6	31.6
Indiana	(C)	(C)	43.9	42.8	41.0	42.6	39.4	38.3	38.8	35.0	36.3	36.6	33.2	34.0	35.8	32.0	32.4	31.5	33.0	30.6	28.9	28.9	28.9
Iowa	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	34.6	35.0	34.5	36.0	35.1	33.7	34.9	30.9	30.3	32.1	31.6	28.9	28.9	28.9
Kansas	(C)	(C)	(C)	43.0	43.9	38.9	40.0	38.4	40.4	36.3	36.7	37.2	36.4	34.9	33.8	34.4	33.0	31.1	31.5	32.2	28.9	28.9	28.9
Kentucky	(C)	(C)	(C)	43.3	42.9	38.4	37.0	32.1	36.1	35.4	33.3	35.1	36.9	31.5	36.8	35.2	33.4	33.7	31.6	31.6	31.6	31.6	31.6
Louisiana	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	36.4	38.5	35.8	38.4	34.3	35.9	38.7	36.4	35.9	35.9	35.9
Maine	47.4	42.9	44.1	42.5	38.4	41.3	44.8	44.9	46.4	47.0	45.3	42.8	42.5	41.1	43.0	42.2	44.4	40.7	40.9	37.5	37.5	37.5	37.5
Maryland	(C)	50.5	47.3	50.5	44.9	43.6	43.2	40.9	41.0	39.9	39.2	39.5	38.1	38.7	37.4	36.0	36.6	36.6	36.6	36.6	36.6	36.6	36.6
Massachusetts	42.6	42.1	42.4	44.9	41.2	41.5	40.2	40.0	40.0	38.0	38.9	38.2	36.8	34.5	35.2	35.1	33.2	33.2	33.2	33.2	33.2	33.2	33.2
Michigan	46.9	46.2	44.0	43.5	43.9	45.4	43.7	42.1	42.3	41.9	40.3	41.0	39.2	38.1	37.8	36.4	33.9	33.9	33.9	33.9	33.9	33.9	33.9
Minnesota	41.3	39.9	40.0	39.7	39.7	40.6	37.9	39.2	39.0	36.0	38.3	35.3	34.3	34.5	34.0	34.4	35.1	32.9	31.9	31.9	31.9	31.9	31.9
Mississippi	(C)	(C)	(C)	(C)	(C)	(C)	37.2	35.0	32.8	36.9	34.9	33.8	33.5	37.0	36.8	35.5	29.6	32.7	32.7	32.7	32.7	32.7	32.7
Missouri	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	33.9	35.2	34.7	33.8	34.5	32.6	34.9	32.0	33.3	33.3	33.3
Montana	(C)	(C)	(C)	(C)	(C)	(C)	41.4	44.1	41.8	39.7	43.7	42.9	43.0	43.8	43.6	37.3	34.3	34.3	34.3	34.3	34.3	34.3	34.3
Nebraska	(C)	(C)	(C)	(C)	(C)	35.1	36.8	34.9	34.1	34.9	36.2	36.8	32.8	33.2	31.0	32.3	34.3	33.8	30.5	31.0	31.0	31.0	31.0
Nevada	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	37.5	39.1	31.0	30.0	34.0	30.1	30.7	27.9	27.9
New Hampshire	47.8	52.0	48.2	45.7	44.9	41.6	47.8	41.6	48.9	41.7	43.7	42.5	43.0	43.8	43.6	37.3	49.9	31.7	40.7	30.7	30.7	30.7	30.7
New Jersey	(C)	(C)	(C)	(C)	(C)	(C)	36.3	37.3	35.1	35.8	35.1	35.0	33.9	35.2	38.5	34.3	35.8	35.8	35.8	35.8	35.8	35.8	35.8
New Mexico	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	52.5	55.3	39.4	39.4	27.3	29.8	29.8	29.8	29.8
New York	41.3	40.9	40.7	41.1	39.0	39.6	38.5	37.6	38.9	37.0	35.9	36.5	34.1	34.7	33.8	33.5	32.6	31.8	31.8	31.8	31.8	31.8	31.8
North Carolina	(C)	(C)	43.1	43.8	39.1	40.8	36.7	40.8	39.2	40.6	40.5	39.6	39.6	43.4	39.9	40.8	39.0	38.0	35.2	35.0	35.0	35.0	35.0
North Dakota	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	40.5	39.7	40.9	39.4	35.3	41.6	38.0	35.2	35.0	35.0	35.0	35.0	35.0	35.0
Ohio	(C)	(C)	44.0	43.9	43.4	41.7	40.0	39.8	40.0	39.6	37.1	39.2	37.5	38.3	39.0	35.3	35.2	34.7	34.7	34.7	34.7	34.7	34.7
Oklahoma	(C)	(C)	(C)	36.8	38.5	32.3	36.9	37.4	35.2	32.0	31.9	30.8	30.6	31.9	32.4	32.5	28.5	27.6	28.5	28.5	28.5	28.5	28.5
Oregon	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	36.2	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5
Pennsylvania	47.6	46.9	46.7	49.4	43.3	42.1	41.8	41.5	41.4	39.6	39.1	37.0	37.8	36.9	31.9	30.6	31.9	32.4	29.1	28.0	28.0	28.0	28.0

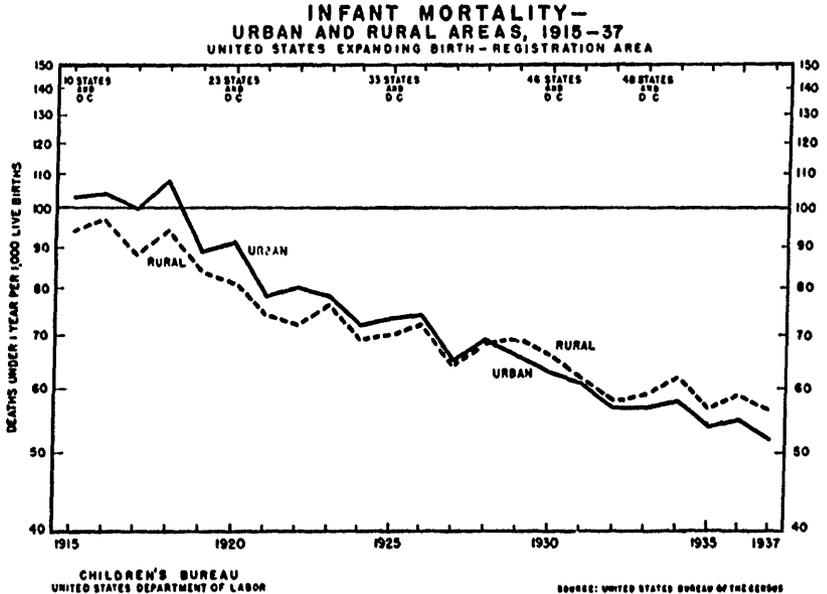
Rhode Island	46.3	45.8	46.3	46.1	(1)	(1)	43.7	43.3	45.1	44.0	39.0	43.1	37.7	34.6	42.6	35.4	36.6	33.3	37.1	35.7	31.1	30.2	29.0
South Carolina	(1)	(1)	(1)	(1)	(1)	54.1	55.8	49.6	47.3	47.5	48.5	(1)	(1)	47.8	46.1	45.2	42.0	42.1	41.3	40.9	39.9	42.2	38.9
South Dakota	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	32.4	33.5	35.0	34.3	27.8	38.9
Tennessee	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	32.4	33.5	35.0	34.3	34.9	32.4
Texas	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	36.8	41.5	40.6	39.2	35.4	35.8	38.8	38.5	34.3	34.9	32.4
Utah	(1)	(1)	40.6	39.2	42.9	39.1	41.7	41.4	39.6	39.8	35.2	40.4	36.4	37.0	34.7	32.4	34.5	36.7	36.7	36.9	34.4	34.9	32.5
Vermont	42.7	47.1	43.3	44.8	45.1	50.7	41.5	39.5	45.2	41.3	45.1	40.7	42.2	41.3	39.5	40.8	37.3	38.3	34.1	30.8	30.6	37.1	31.0
Virginia	(1)	(1)	43.7	44.7	40.8	41.0	39.4	39.5	42.2	39.9	40.2	42.4	39.9	40.7	42.0	40.6	40.8	37.8	34.1	30.8	30.6	35.7	32.5
Washington	(1)	(1)	39.2	40.3	37.9	40.2	36.1	37.4	35.5	34.5	35.1	32.4	31.1	31.4	31.3	30.1	30.0	38.6	38.6	38.6	40.8	32.8	31.0
West Virginia	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	38.2	39.7	38.5	39.0	39.3	41.2	39.5	38.9	38.8	36.0	36.0	32.8	32.8
Wisconsin	(1)	(1)	43.6	41.8	43.6	42.3	43.8	43.8	42.6	40.3	40.4	41.7	37.3	37.8	36.2	34.9	34.0	32.6	32.7	32.1	31.1	32.8	31.0
Wyoming	(1)	(1)	(1)	(1)	(1)	(1)	(1)	49.2	46.9	41.1	39.3	41.9	41.1	36.3	42.5	35.6	40.0	39.3	33.5	33.3	32.1	32.5	32.5

1 Not in birth registration area.

Each year approximately 70,000 infants die in the first month of life, representing more than half of the total deaths under 1 year; each year approximately 75,000 infants are still-born; and yet studies and demonstrations have shown, and competent authorities agree that at least half of the deaths in the first month of life could be prevented if facilities for the best care were made available.

Prior to 1929 the infant mortality rate for the United States was higher in urban areas than in rural areas. Since 1929 the reverse has been true. (See chart 5, Infant Mortality—Urban and Rural Areas, 1915-37.)

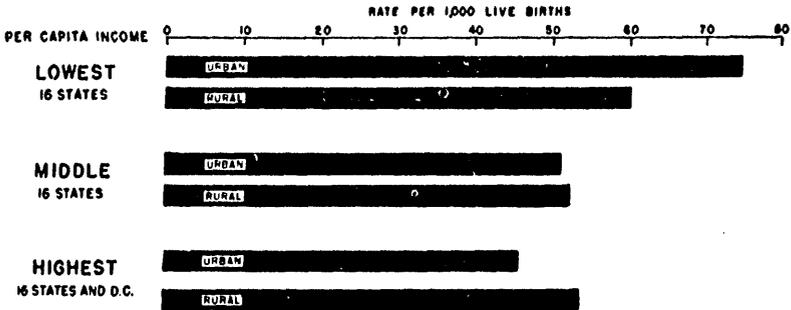
CHART 5



Infant mortality is highest in the 16 States with the lowest per capita incomes. In the low-income States urban infant mortality rates still exceed rural rates. It is in the 16 States with the highest per capita income that urban rates have been reduced most strikingly and are below rural rates. (See chart 6, Infant Mortality in Urban and Rural Areas, by Per Capita Income of States, 1937.) In

CHART 6

INFANT MORTALITY IN URBAN AND RURAL AREAS,
BY PER CAPITA INCOME OF STATES, 1937



CHILDREN'S BUREAU
UNITED STATES DEPARTMENT OF LABOR

SOURCE: UNITED STATES BUREAU OF THE CENSUS
NATIONAL INDUSTRIAL CONFERENCE BOARD INCOME DATA

general, it is in these high-income States (with a few exceptions) that maternal and child-health services have been most highly developed over a long period of years, especially in the cities, as is shown in exhibit D, which follows:

EXHIBIT D.—Per capita income of States, 1937

[Children's Bureau, U. S. Department of Labor]

Lowest 16 States less than \$419	Middle 16 States, \$419 to \$580	Highest 16 States and District of Columbia, \$581 or more
Alabama. Arkansas. Georgia. Kentucky. Louisiana. Mississippi. Nebraska. North Carolina. North Dakota. Oklahoma. South Carolina. South Dakota. Tennessee. Texas. Virginia. West Virginia.	Colorado. Florida. Idaho. Indiana. Iowa. Kansas. Maine. Minnesota. Missouri. New Hampshire. New Mexico. Ohio. Oregon. Utah. Vermont. Washington.	Arizona. California. Connecticut. Delaware. District of Columbia. Illinois. Maryland. Massachusetts. Michigan. Montana. Nevada. New Jersey. New York. Pennsylvania. Rhode Island. Wisconsin. Wyoming.

Source: Per capita income, 1937—National Industrial Conference Board.

MATERNAL MORTALITY

Each year approximately 14,000 women die from causes associated with pregnancy and childbirth and some 35,000 children are left motherless.

Maternal mortality rates have not decreased strikingly as have infant mortality rates in the last 23 years.

Table 5, Trend in Maternal Mortality, from special reports from the Bureau of the Census, follows.

Pennsylvania	64	70	65	105	68	78	68	62	66	63	64	64	61	65	60	65	61	58	58	55	55	46
Rhode Island	66	58	63	98	(3)	(3)	71	55	63	63	52	60	60	79	57	55	60	57	55	57	44	38
South Carolina	(3)	(3)	(3)	(3)	112	122	96	107	97	108	(3)	(3)	109	114	114	102	94	80	85	85	85	40
South Dakota	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	48	51	65	61	77
Tennessee	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	71	89	87	84	74	77	48	51	65	46	40
Texas	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	77	62	57	54	52
Utah	(3)	(3)	59	86	84	79	73	55	50	45	52	49	49	49	42	43	43	45	45	48	49	46
Vermont	61	79	64	80	80	70	73	74	70	81	68	67	73	58	66	76	71	71	71	56	54	57
Virginia	(3)	(3)	82	107	83	86	70	72	74	65	70	80	62	75	71	75	71	64	39	56	57	33
Washington	(3)	(3)	74	99	86	92	78	79	67	71	60	75	66	72	62	64	60	60	49	49	46	46
West Virginia	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	63	71	62	57	58	58	57	57	55	52	50	50
Wisconsin	(3)	(3)	57	60	48	67	58	56	58	60	52	60	53	58	54	45	44	44	49	49	46	38
Wyoming	(3)	(3)	(3)	(3)	(3)	(3)	(3)	71	73	98	95	93	87	65	84	84	66	57	61	41	35	38

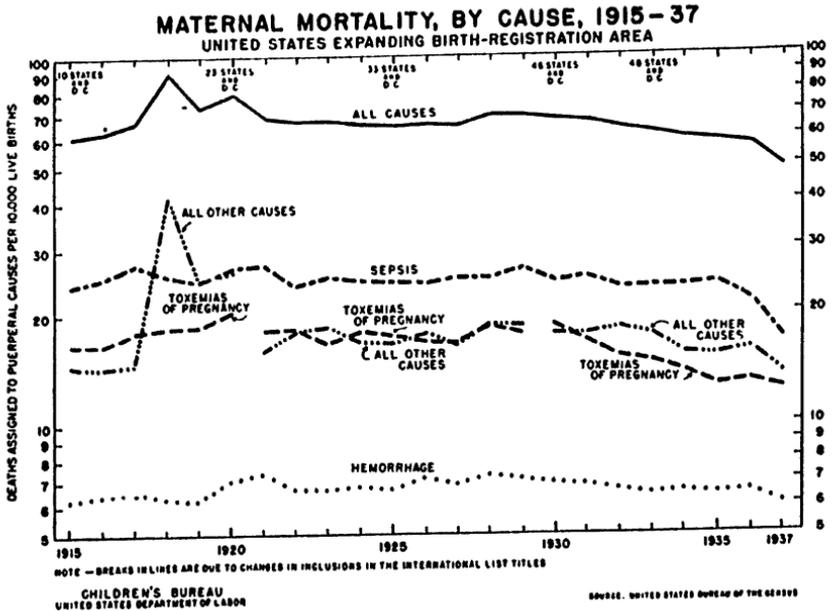
¹ Provisional rates for the first 9 months of 1938, U. S. Public Health Service Report, Feb. 3, 1939.

² Not in birth-registration area.

³ 40 States. Includes all States, except South Carolina, with data for the 9-month period of 1937 and 1938.

Since 1931 there has been a slight but steady decline in the death rate from one cause, toxemia of pregnancy, which is controlled by care during the prenatal period. In 1937 there was a significant decrease in the maternal death rate reflecting decreases in deaths from all major causes including infection. In 1937 only 10,769 women died from conditions directly due to pregnancy and childbirth. The rate was 14 percent lower than in 1936 which represents the saving of the lives of about 1,750 women. Significant decreases occurred in 17 States. Provisional reports for 1938 indicate that the decline in maternal death rates probably continued in that year.

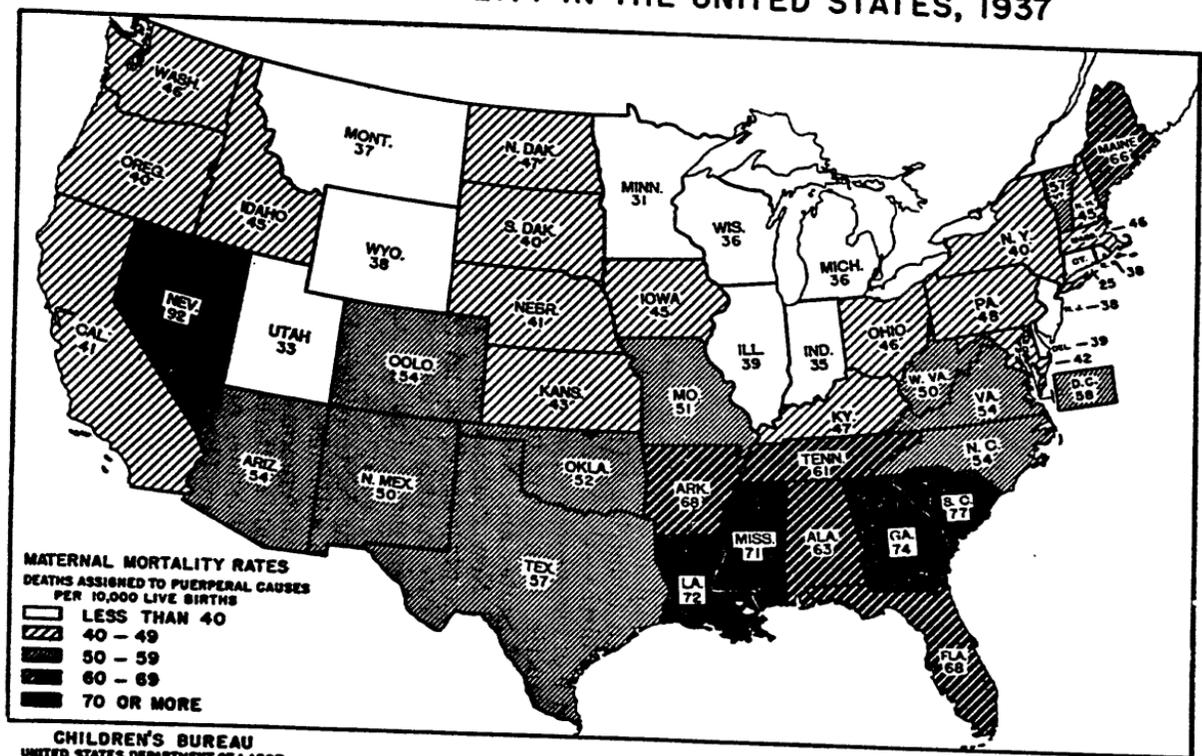
CHART 7



(See chart 7, Maternal Mortality by Cause, 1915-37.) A wide variation exists, however, in the rates for individual States (see chart 8, Maternal Mortality in the United States, 1937), ranging in 1937 from

CHART 8

MATERNAL MORTALITY IN THE UNITED STATES, 1937



CHILDREN'S BUREAU
UNITED STATES DEPARTMENT OF LABOR

SOURCE: UNITED STATES BUREAU OF THE CENSUS

92 deaths per 10,000 live births in Nevada and 77 in South Carolina to 81 in Minnesota and 25 in Connecticut. The variation in county rates is even greater, from no deaths at all over a period of 5 years to more than 200 per 10,000 live births in a few counties.

The decrease in the deaths due to toxemia of pregnancy can reasonably be attributed to a long period of education of professional and lay groups regarding the significance of good prenatal care. The decrease in deaths from infection that has occurred in the past 2 years may be associated primarily with a better understanding and application of good delivery care. In the last 12 years there have been widespread studies of causes of maternal deaths by physicians and today both physicians and the public have a better understanding of what constitutes good maternity care. Knowledge with regard to what to do is not lacking; what is lacking in many areas are the resources and facilities to provide good care and proper distribution of expert professional service. Studies have shown that prenatal care was not given at all or was inadequately given to a great majority of the women whose deaths in childbirth have been analyzed by experts. (See chart 9, Frequency of Prenatal Care and Preventability of Maternal Deaths.) Competent authorities estimate that from one-half to two-thirds of deaths of women in childbirth can be avoided.

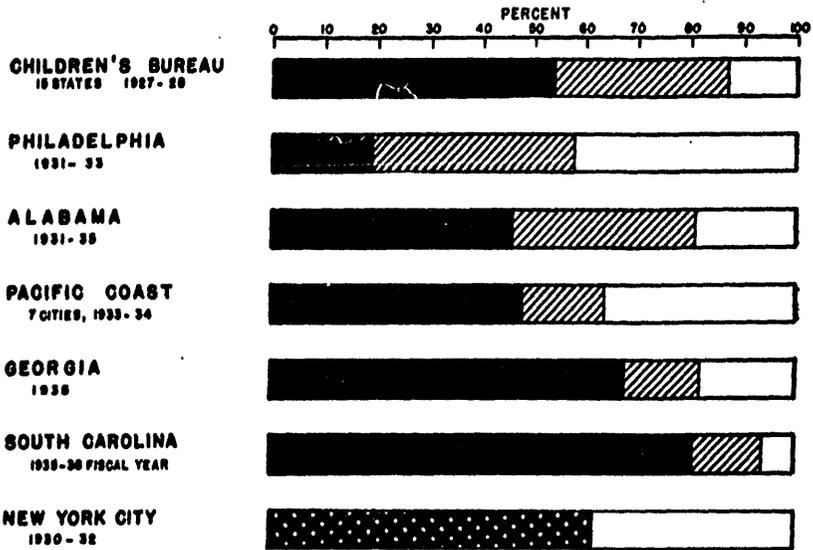
MATERNAL MORTALITY IN THE UNITED STATES AND FOREIGN COUNTRIES

The maternal mortality rate is recognized as high as compared with foreign countries. The United States rate for 1937 (49 per 10,000 live births—the all-time low rate of the United States) exceeds that of 9 of the 12 foreign countries which have issued rates for 1937. The countries with lower rates (final or provisional) for 1937 than the United States are: Netherlands (26), Italy (27), Ireland (32), Uruguay and New Zealand (37), Denmark (38), Switzerland and Czechoslovakia (44), and Scotland (48). The rate for Canada is the same as the rate for the United States. The only countries with higher rates than the United States are Chile (98) and Northern Ireland (50).

The fact that the high maternal mortality rate for the United States as compared with foreign countries is due to excessive maternal losses and not to differences in statistical procedure was definitely established by a study of the comparability of the maternal mortality rates of the United States and certain foreign countries made by the Children's Bureau (Bureau publication No. 229). This study was initiated with the cooperation of the Bureau of the Census by a subcommittee of the White House Conference on Child Health and Protection (1929) of which Dr. F. L. Adair was chairman. The subcommittee included in its membership leaders in the field of obstetrics, public health, and vital statistics. No study has been conducted in the United States or in any foreign country since that study was published that has served to negate the finding—that the United States maternal mortality rate was excessive. The results of this Children's Bureau study have been authoritatively used and referred to in most studies of maternal mortality of broad scope made in this country and abroad since the date of its publication.

CHART 9

FREQUENCY OF PRENATAL CARE
AS SHOWN BY SPECIAL STUDIES OF MATERNAL MORTALITY

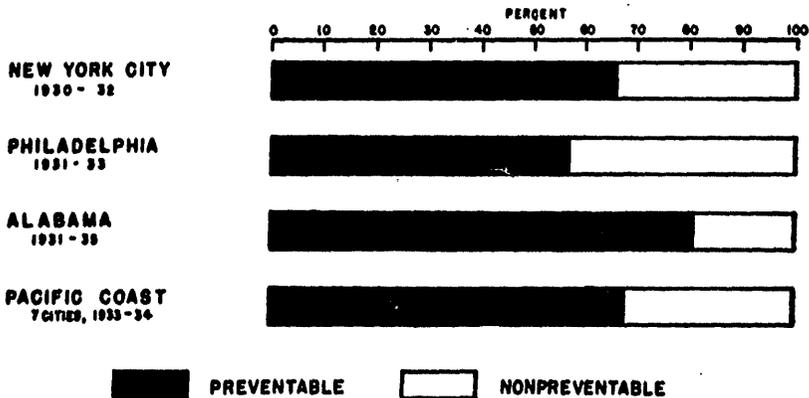


PRENATAL CARE



* IN PACIFIC COAST CITIES, INCLUDES NONE AND UNKNOWN

PREVENTABILITY OF MATERNAL DEATHS



PLACE OF BIRTH (HOSPITAL OR HOME) AND ATTENDANT AT BIRTH

Reports from the United States Bureau of the Census show great variation in the number of births taking place in hospitals in the different States (see chart 10, Place of Birth by State, 1937), and in the births attended by physicians.

CHART 10

PLACE OF BIRTH BY STATE, 1937

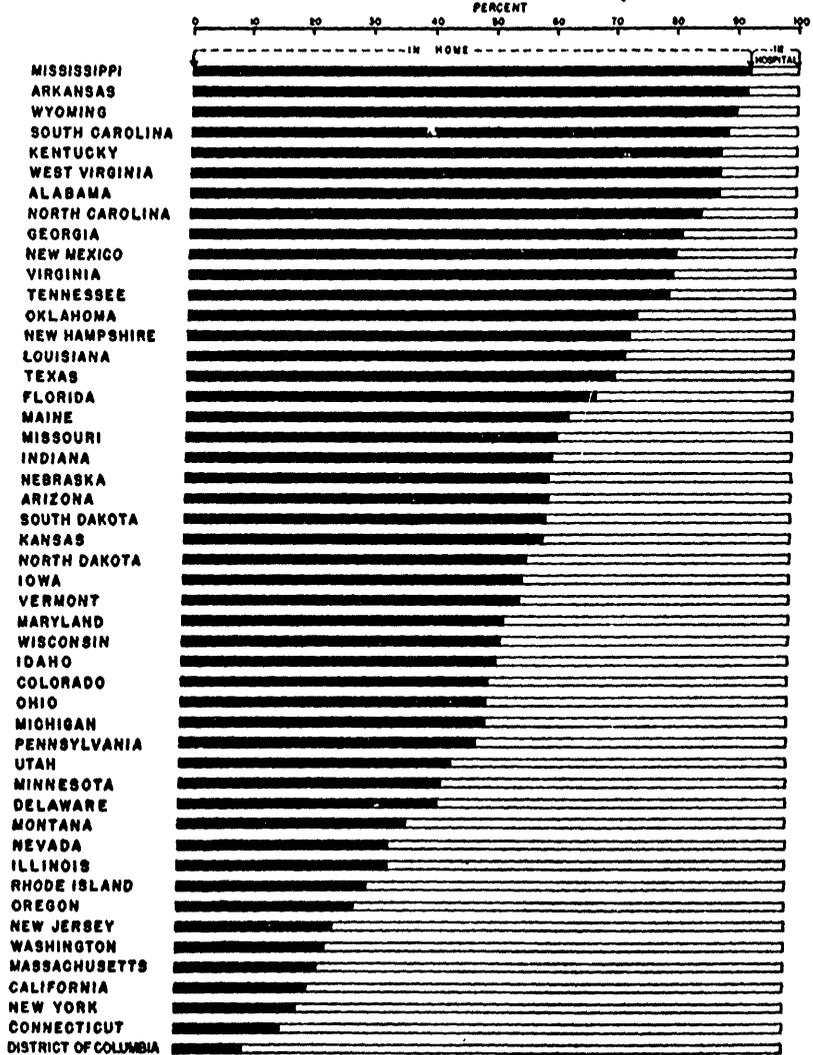


Table No. 6, Special Reports from Bureau of the Census, 1937, showing number of live births and persons in attendance at birth in urban and rural areas, and table No. 7, Special Reports of Bureau

of the Census, showing number of live births and attendant at birth by race, follow:

TABLE No. 6.—Number of live births and percentage distribution, by person in attendance, in urban areas of each State, 1937.

[From Bureau of the Census: Vital Statistics—Special reports, March 7, 1939, vol. 7, No. 17]

Area	Number					Percent				
	Total live births	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified	Total per cent	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified
United States.....	2,203,337	987,032	982,303	220,344	13,658	100	44.8	44.6	10.0	0.6
Urban.....	1,067,239	801,712	236,161	27,683	1,653	100	75.1	22.1	2.6	.2
Rural.....	1,136,098	185,290	746,142	192,661	12,005	100	16.3	65.7	17.0	1.1
Alabama.....	61,611	7,834	32,101	21,406	270	100	12.7	52.1	34.7	.4
Urban.....	12,615	6,805	4,366	1,434	10	100	53.9	34.6	11.4	.1
Rural.....	48,996	1,029	27,735	10,972	260	100	2.1	56.6	40.8	.6
Arizona.....	10,494	4,194	5,156	728	416	100	40.0	49.1	6.9	4.0
Urban.....	3,379	2,160	1,039	146	28	100	64.1	30.7	4.3	.8
Rural.....	7,115	2,028	4,117	582	338	100	28.5	57.9	8.2	5.6
Arkansas.....	35,236	3,016	22,609	8,894	817	100	8.6	63.9	25.2	2.3
Urban.....	4,360	2,105	1,933	305	17	100	48.3	44.3	7.0	.4
Rural.....	30,876	911	20,576	8,589	800	100	3.0	66.6	27.8	6.2
California.....	94,230	73,658	19,069	1,060	443	100	78.2	20.2	1.1	.5
Urban.....	59,675	51,017	7,663	856	139	100	85.5	12.8	1.4	.2
Rural.....	34,555	22,641	11,406	204	304	100	65.5	33.0	.6	.9
Colorado.....	19,610	9,721	9,577	203	104	100	49.6	48.8	1.1	.5
Urban.....	8,919	6,568	2,234	99	18	100	73.6	25.0	1.1	.2
Rural.....	10,691	3,153	7,343	109	86	100	29.5	68.7	1.0	.8
Connecticut.....	22,774	18,836	3,577	336	25	100	82.7	15.7	1.5	.1
Urban.....	19,518	17,054	2,142	300	22	100	87.4	11.0	1.5	.1
Rural.....	3,256	1,782	1,435	36	3	100	54.7	44.1	1.1	.1
Delaware.....	4,355	2,500	1,290	552	13	100	57.4	29.6	12.7	.3
Urban.....	2,497	2,108	246	140	3	100	84.4	9.9	5.6	.1
Rural.....	1,858	392	1,044	412	10	100	21.1	56.2	22.2	.5
Dist. of Columbia.....	12,343	10,935	1,397	8	3	100	88.6	11.3	.1	(1)
Florida.....	29,507	9,521	11,180	8,487	319	100	32.3	37.9	28.8	1.1
Urban.....	11,409	7,391	2,034	1,934	50	100	64.8	17.8	17.0	.4
Rural.....	18,098	2,130	9,146	6,553	269	100	11.8	50.5	36.2	1.5
Georgia.....	64,061	11,992	27,648	24,317	104	100	18.7	43.2	33.0	.2
Urban.....	15,475	9,062	3,739	1,766	8	100	64.4	24.2	11.4	.1
Rural.....	48,586	2,030	23,909	22,551	96	100	4.2	49.2	46.4	.2
Idaho.....	10,369	5,018	5,301	30	20	100	48.4	51.1	.3	.2
Urban.....	1,442	1,295	143	4	1	100	89.8	9.9	.3	.2
Rural.....	8,927	3,723	5,158	26	19	100	41.7	57.8	.3	.2
Illinois.....	115,282	75,467	38,717	1,021	77	100	65.5	33.6	.9	.1
Urban.....	81,330	67,117	13,347	832	34	100	82.5	16.4	1.0	(1)
Rural.....	33,952	8,350	25,370	189	43	100	24.6	74.7	.6	.1
Indiana.....	56,087	22,185	33,658	218	26	100	39.6	60.1	.4	(1)
Urban.....	28,943	17,744	10,989	205	5	100	61.3	38.0	.7	(1)
Rural.....	27,144	4,441	22,669	13	21	100	16.4	83.5	(1)	.1

¹ Less than one-tenth of 1 percent.

TABLE No. 6.—Number of live births and percentage distribution, by person in attendance, in urban areas of each State, 1937—Continued

Area	Number					Percent				
	Total live births	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified	Total percent	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified
Iowa.....	42,105	18,569	23,492	22	22	100	44.1	55.8	0.1	0.1
Urban.....	16,770	13,055	3,708	5	2	100	77.8	22.1	(1)	(1)
Rural.....	25,335	5,514	19,784	17	20	100	21.8	78.1	.1	.1
Kansas.....	29,325	11,981	17,231	65	48	100	40.9	58.8	.2	.2
Urban.....	10,971	7,303	3,675	25	8	100	67.1	32.6	.2	.1
Rural.....	18,354	4,618	13,656	40	40	100	25.2	74.4	.2	.2
Kentucky.....	56,183	6,932	38,092	10,951	188	100	12.3	67.8	19.8	.8
Urban.....	11,191	5,678	5,431	77	5	100	50.7	48.5	.7	(1)
Rural.....	44,972	1,254	32,661	10,874	183	100	2.8	72.6	24.2	.4
Louisiana.....	46,006	12,636	15,891	17,456	23	100	27.5	34.5	37.9	(1)
Urban.....	15,437	11,180	2,629	1,625	8	100	72.4	17.0	10.5	(1)
Rural.....	30,569	1,456	13,262	15,831	20	100	4.8	43.4	61.8	.1
Maine.....	15,246	5,634	9,612	.....	.....	100	37.0	63.0	.....	.....
Urban.....	5,119	3,398	1,721	.....	.....	100	66.4	33.6	.....	.....
Rural.....	10,127	2,236	7,891	.....	.....	100	22.1	77.9	.....	.....
Maryland.....	27,739	13,073	12,145	2,421	100	100	47.1	43.8	8.7	.4
Urban.....	16,892	11,480	4,879	528	5	100	68.0	28.9	3.1	(1)
Rural.....	10,847	1,593	7,266	1,893	95	100	14.7	67.0	17.5	.9
Massachusetts...	61,736	47,311	14,161	22	242	100	76.6	22.9	(1)	.4
Urban.....	55,855	44,739	10,862	18	236	100	80.1	19.4	(1)	.4
Rural.....	5,881	2,572	3,299	4	6	100	43.7	56.1	.1	.1
Michigan.....	91,539	45,692	45,090	552	205	100	49.9	49.3	.6	.2
Urban.....	59,542	39,149	20,108	210	75	100	65.8	33.8	.4	.1
Rural.....	31,997	6,543	24,982	342	130	100	20.4	78.1	1.1	.4
Minnesota.....	48,036	27,354	19,386	503	793	100	56.9	40.4	1.0	1.7
Urban.....	20,316	18,026	2,127	142	21	100	88.7	10.5	.7	.1
Rural.....	27,720	9,328	17,259	361	772	100	33.7	62.3	1.3	2.8
Mississippi.....	52,095	4,219	21,448	26,148	280	100	8.1	41.2	50.2	.5
Urban.....	5,530	2,778	1,434	1,314	4	100	60.2	25.9	23.8	.1
Rural.....	46,565	1,441	20,014	24,834	276	100	3.1	43.0	53.3	.6
Missouri.....	56,951	22,094	32,447	1,409	941	100	38.8	57.0	2.6	1.7
Urban.....	25,591	19,663	5,472	427	29	100	76.8	21.4	1.7	.1
Rural.....	31,360	2,431	26,975	1,042	912	100	7.8	66.0	8.3	2.9
Montana.....	10,248	6,396	3,561	200	91	100	62.4	34.7	2.0	.9
Urban.....	3,511	3,160	845	5	1	100	90.0	9.8	.1	(1)
Rural.....	6,737	3,236	3,216	195	90	100	48.0	47.7	2.9	1.3
Nebraska.....	22,270	8,906	13,331	11	22	100	40.0	59.9	.1	.1
Urban.....	7,562	5,751	1,809	2	2	100	76.1	23.9	(1)	.....
Rural.....	14,708	3,155	11,522	9	22	100	21.5	78.8	.1	.1
Nevada.....	1,742	1,139	555	10	88	100	65.4	31.9	.6	2.2
Urban.....	219	205	12	.....	2	100	93.6	5.5	.....	.9
Rural.....	1,523	934	543	10	86	100	61.3	35.7	.7	2.4

1 Less than one-tenth of 1 percent.

TABLE No. 6.—Number of live births and percentage distribution, by person in attendance, in urban areas of each State, 1937—Continued

Area	Number					Percent				
	Total live births	Physician (In hospital)	Physician (not in hospital)	Mid-wife	Other and not specified	Total per cent	Physician (In hospital)	Physician (not in hospital)	Mid-wife	Other and not specified
New Hampshire.....	7,638	2,048	5,572	4	9	100	26.8	73.0	0.1	0.1
Urban.....	4,854	1,432	2,922	.....	.....	100	32.9	67.1	.....	.....
Rural.....	3,279	616	2,650	4	9	100	18.8	80.8	.1	.3
New Jersey.....	54,607	40,484	11,830	2,578	85	100	74.1	24.1	4.7	.1
Urban.....	44,729	36,789	5,789	2,126	15	100	82.3	12.9	4.8	(1)
Rural.....	9,878	2,685	6,721	452	20	100	37.7	87.9	4.6	.2
New Mexico.....	13,837	2,694	6,605	3,275	1,363	100	19.5	47.0	23.7	9.9
Urban.....	1,619	819	775	201	24	100	45.0	42.1	11.1	1.8
Rural.....	12,018	1,875	5,730	3,074	1,339	100	15.6	47.7	25.6	11.1
New York.....	185,602	147,950	34,185	3,124	237	100	79.8	18.4	1.7	.1
Urban.....	155,154	135,045	17,122	2,930	27	100	87.0	11.0	1.9	(1)
Rural.....	30,348	12,921	17,063	1,194	170	100	49.8	56.2	.8	.6
North Carolina.....	79,080	12,267	48,175	21,484	184	100	15.6	57.1	27.2	.2
Urban.....	14,514	7,670	5,245	1,590	6	100	52.8	36.2	11.0	(1)
Rural.....	64,566	4,697	39,927	19,894	148	100	7.1	61.8	30.8	.2
North Dakota.....	12,637	5,485	6,194	180	508	100	43.4	49.0	3.6	4.0
Urban.....	2,659	2,324	330	3	3	100	87.4	12.4	.1	.1
Rural.....	9,978	3,161	5,864	447	505	100	31.7	58.8	4.5	5.1
Ohio.....	107,576	3,520	53,833	1,000	8	100	49.8	50.0	.2	(1)
Urban.....	69,456	49,183	20,129	181	13	100	70.9	29.0	.....	(1)
Rural.....	38,120	4,343	33,710	82	85	100	11.4	88.4	.....	.1
Oklahoma.....	41,456	10,721	29,722	1,610	400	100	25.9	69.3	1.9	1.0
Urban.....	1,656	7,284	4,100	16	16	100	62.5	35.0	1.4	.1
Rural.....	29,800	3,437	24,622	1,443	384	100	11.5	82.1	4.9	1.3
Oregon.....	15,457	10,956	4,449	21	81	100	70.9	28.8	.1	.2
Urban.....	7,427	6,018	491	9	9	100	83.1	6.6	.1	.1
Rural.....	8,030	4,938	3,088	12	22	100	30.8	49.3	.1	.3
Pennsylvania.....	161,288	82,557	77,127	1,248	256	100	51.2	47.8	.8	.2
Urban.....	94,234	67,884	25,883	731	236	100	72.0	26.9	.8	.8
Rural.....	67,054	14,673	51,744	517	120	100	21.9	77.2	.8	.2
Rhode Island.....	10,240	7,046	3,031	132	31	100	68.8	29.6	1.3	.8
Urban.....	9,532	6,898	2,524	91	19	100	72.4	26.5	1.0	.2
Rural.....	708	148	507	41	12	100	20.9	71.6	5.8	1.7
South Carolina.....	40,643	4,731	16,568	19,328	26	100	11.6	40.7	47.6	.1
Urban.....	5,990	3,123	2,064	782	1	100	52.1	34.8	13.1	(1)
Rural.....	34,653	1,608	14,474	18,546	25	100	4.6	41.8	53.5	.1
South Dakota.....	11,908	4,809	6,681	146	273	100	40.4	56.1	1.2	2.3
Urban.....	2,816	2,151	657	4	4	100	76.4	23.3	.1	.1
Rural.....	9,092	2,658	6,024	142	268	100	29.2	68.3	1.6	2.9
Tennessee.....	51,938	10,591	34,697	6,296	354	100	20.4	66.8	12.1	.7
Urban.....	14,693	9,274	5,102	223	94	100	63.1	34.7	1.5	.6
Rural.....	37,245	1,317	29,595	6,073	260	100	3.5	79.5	16.3	.7

¹ Less than one-tenth of 1 percent.

TABLE NO. 6.—Number of live births and percentage distribution, by person in attendance, in urban areas of each State, 1937—Continued

Area	Number					Percent				
	Total live births	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified	Total percent	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified
Texas.....	116,057	33,975	62,145	17,489	2,448	100	29.3	53.5	15.1	2.1
Urban.....	41,314	25,326	11,027	4,608	353	100	61.3	26.7	11.2	.9
Rural.....	74,743	8,649	51,118	12,881	2,095	100	11.6	68.4	17.2	2.8
Utah.....	12,693	7,037	5,441	161	54	100	55.4	42.9	1.3	.4
Urban.....	5,528	4,605	907	14	2	100	83.3	16.4	.3	(¹)
Rural.....	7,165	2,432	4,534	147	52	100	33.9	63.3	2.1	.7
Vermont.....	6,326	2,816	3,505	3	2	100	44.5	55.4	(¹)	(¹)
Urban.....	1,585	1,278	309	-----	-----	100	80.5	19.5	-----	-----
Rural.....	4,741	1,540	3,196	3	2	100	32.5	67.4	.1	(¹)
Virginia.....	51,950	10,415	27,418	13,437	680	100	20.0	52.8	25.9	1.3
Urban.....	12,634	7,445	3,713	1,448	28	100	59.9	29.4	11.5	.2
Rural.....	39,316	2,970	23,705	11,989	652	100	7.6	60.3	30.5	1.7
Washington.....	25,036	18,918	5,911	112	65	100	75.6	23.7	.4	.3
Urban.....	16,121	14,760	1,214	71	8	100	91.5	8.0	.4	(¹)
Rural.....	8,913	4,158	4,697	41	57	100	46.7	52.2	.5	.6
West Virginia....	42,240	5,292	34,358	1,825	765	100	12.5	81.3	4.3	1.8
Urban.....	7,867	4,112	3,720	23	12	100	52.3	47.3	.3	.2
Rural.....	34,373	1,180	30,638	1,802	753	100	3.4	89.1	5.2	2.2
Wisconsin.....	53,543	25,435	27,591	350	167	100	47.5	51.5	.7	.3
Urban.....	25,999	19,416	6,444	125	14	100	74.7	24.8	.5	.1
Rural.....	27,544	6,019	21,147	225	153	100	21.9	76.8	.8	.6
Wyoming.....	4,530	460	4,037	10	23	100	10.2	89.1	.2	.5
Urban.....	745	116	627	-----	2	100	15.6	84.2	-----	.3
Rural.....	3,785	344	3,410	10	21	100	9.1	90.1	.3	.6

¹ Less than one-tenth of 1 percent.

TABLE NO. 7.—Number of live births and percentage distribution, by race and by person in attendance, in each State, 1937

[From Bureau of the Census: Vital Statistics—Special reports, Mar. 6, 1939, vol. 7, No. 10]

Area and race	Number					Percent				
	Total live births	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified	Total percent	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified
United States.....	2,203,337	987,032	982,303	220,344	13,658	100	44.8	44.6	10.0	0.6
White.....	1,928,437	929,386	912,114	76,384	10,553	100	48.2	47.3	4.0	.5
Negro.....	262,402	31,878	66,102	142,609	1,873	100	19.8	25.2	54.3	.7
Other races.....	12,438	5,768	4,087	1,351	1,232	100	46.4	32.9	10.9	9.9
Alabama.....	61,611	7,834	32,101	21,406	270	100	12.7	52.1	34.7	.4
White.....	33,208	6,506	27,341	4,155	206	100	17.0	71.6	10.9	.5
Negro.....	23,401	1,328	4,758	17,251	64	100	5.7	20.3	73.7	.3
Other races.....	2	-----	2	-----	-----	100	-----	100.0	-----	-----

TABLE No. 7.—Number of live births and percentage distribution, by race and by person in attendance, in each State, 1937—Continued

Area and race	Number					Percent				
	Total live births	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified	Total percent	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified
Arizona.....	10,494	4,194	5,158	728	416	100	40.0	49.1	6.9	4.0
White.....	9,188	3,729	4,640	688	131	100	40.6	50.5	7.5	1.4
Negro.....	190	40	127	19	4	100	21.1	60.8	10.0	2.1
Other races...	1,116	425	389	21	281	100	38.1	34.9	1.9	25.2
Arkansas.....	35,236	3,016	22,569	8,894	817	100	8.6	63.9	25.2	2.3
White.....	26,615	2,968	20,937	2,007	643	100	11.2	78.7	7.8	2.4
Negro.....	8,611	47	1,565	6,825	174	100	.5	18.2	79.3	2.0
Other races...	10	1	7	2		100	10.0	70.0	20.0	
California.....	94,230	73,658	19,069	1,060	443	100	78.2	20.2	1.1	.5
White.....	89,745	71,189	17,637	589	330	100	79.3	19.7	.7	.4
Negro.....	1,665	1,019	530	7	9	100	65.1	33.9	.4	.6
Other races...	2,920	1,450	902	464	104	100	49.7	30.9	15.9	3.6
Colorado.....	19,610	9,721	9,577	208	104	100	49.6	48.8	1.1	.5
White.....	19,324	9,576	9,440	208	100	100	49.6	48.9	1.1	.5
Negro.....	181	102	79			100	56.4	43.6		
Other races...	105	43	58		4	100	41.0	55.2		3.8
Connecticut.....	22,774	18,836	3,577	336	25	100	82.7	15.7	1.5	.1
White.....	22,157	18,383	3,426	326	22	100	83.0	15.5	1.5	.1
Negro.....	614	451	150	10	3	100	73.5	24.4	1.6	.5
Other races...	3	2	1			100	66.7	33.3		
Delaware.....	4,355	2,500	1,290	552	13	100	57.4	29.6	12.7	.8
White.....	3,657	2,311	1,142	198	6	100	63.2	31.2	5.4	.2
Negro.....	697	188	148	354	7	100	27.0	21.2	50.8	1.0
Other races...	1	1				100	100.0			
Dist. of Col.....	12,343	10,935	1,397	8	3	100	88.6	11.3	.1	(1)
White.....	8,274	7,863	403	6	2	100	95.0	4.9	.1	(1)
Negro.....	4,044	3,053	988	2	1	100	75.5	24.4	(1)	(1)
Other races...	25	19	6			100	76.0	24.0		
Florida.....	29,507	9,521	11,180	8,487	319	100	32.3	37.9	28.8	1.1
White.....	20,584	8,771	9,769	1,826	198	100	42.7	47.5	8.9	1.0
Negro.....	8,927	745	1,410	6,660	112	100	8.3	15.8	74.6	1.3
Other races...	16	5	1	1	9	100	31.3	6.3	6.3	56.8
Georgia.....	61,061	11,992	27,648	24,317	104	100	18.7	43.2	38.0	.2
White.....	38,194	9,200	24,202	4,730	62	100	24.1	63.4	12.4	.2
Negro.....	25,857	2,789	3,439	19,687	42	100	10.8	13.3	75.8	.2
Other races...	10	3	7			100	30.0	70.0		
Idaho.....	10,369	5,018	5,301	30	20	100	48.4	51.1	.3	.2
White.....	10,282	4,974	5,260	28	20	100	48.4	51.2	.3	.2
Negro.....	1		1			100		100.0		
Other races...	86	44	40	2		100	51.2	46.5	2.3	
Illinois.....	115,282	75,467	39,717	1,021	77	100	65.5	33.6	.9	.1
White.....	109,422	72,094	36,284	994	50	100	65.9	33.2	.9	(1)
Negro.....	5,785	3,332	2,399	27	27	100	57.6	41.5	.5	.5
Other races...	75	41	34			100	54.7	45.3		
Indiana.....	56,987	22,185	33,658	218	26	100	39.6	60.0	.4	(1)
White.....	54,264	21,673	32,371	198	24	100	39.9	59.7	.4	(1)
Negro.....	1,823	512	1,287	22	2	100	28.1	70.6	1.2	.1

1 Less than one-tenth of 1 percent.

TABLE No. 7.—Number of live births and percentage distribution, by race and by person in attendance, in each State, 1937—Continued

Area and race	Number					Percent				
	Total live births	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified	Total percent	Physician (in hospital)	Physician (not in hospital)	Mid-wife	Other and not specified
Iowa.....	42, 105	18, 569	23, 492	22	22	100	44.1	55.8	0.1	0.1
White.....	41, 801	18, 400	23, 358	21	22	100	44.0	55.9	.1	.1
Negro.....	271	146	124	1		100	53.9	45.8	.4	
Other races.....	33	23	10			100	69.7	30.3		
Kansas.....	29, 325	11, 981	17, 231	65	48	100	40.9	58.8	.2	.2
White.....	28, 330	11, 744	16, 494	60	42	100	41.5	58.2	.2	.1
Negro.....	945	227	699	13	6	100	20.0	74.0	1.4	.6
Other races.....	50	10	38	2		100	20.0	76.0	4.0	
Kentucky.....	56, 163	6, 932	38, 092	10, 951	188	100	12.3	67.8	19.5	.3
White.....	53, 051	6, 367	35, 888	10, 612	184	100	12.0	67.6	20.0	.3
Negro.....	3, 111	665	2, 203	339	4	100	18.2	70.8	10.9	.1
Other races.....	1		1			100	100.0			.8
Louisiana.....	46, 006	12, 636	15, 891	17, 466	23	100	27.5	34.5	37.9	(1)
White.....	26, 534	8, 600	13, 559	4, 360	15	100	32.4	51.1	16.4	.1
Negro.....	19, 384	4, 034	2, 310	13, 024	7	100	20.8	12.0	67.2	(1)
Other races.....	88	2	13	72	1	100	2.3	14.8	81.8	1.1
Maine.....	15, 246	5, 634	9, 612			100	37.0	63.0		
White.....	15, 207	5, 622	9, 585			100	37.0	63.0		
Negro.....	10	7	3			100	70.0	30.0		
Other races.....	29	6	24			100	17.2	82.8		
Maryland.....	27, 739	13, 073	12, 145	2, 421	100	100	47.1	43.8	8.7	.4
White.....	21, 761	11, 051	9, 808	839	63	100	50.8	45.1	3.9	.3
Negro.....	5, 958	2, 010	2, 330	1, 681	37	100	33.7	39.1	26.5	.6
Other races.....	20	12	7	1		100	60.0	35.0	6.0	
Massachusetts.....	61, 736	47, 311	14, 161	22	242	100	76.6	22.9	(1)	.4
White.....	60, 782	46, 676	13, 874	22	210	100	76.8	22.8	(1)	.3
Negro.....	919	616	273		30	100	67.0	29.7		3.3
Other races.....	35	19	14		2	100	54.3	40.0		5.7
Michigan.....	91, 639	45, 692	45, 090	652	205	100	49.9	49.3	.6	.2
White.....	88, 101	43, 920	43, 696	511	164	100	49.8	49.4	.6	.2
Negro.....	3, 166	1, 734	1, 367	27	38	100	54.8	43.2	.9	1.2
Other races.....	182	78	127	14	3	100	20.9	69.8	7.7	1.6
Minnesota.....	48, 036	27, 354	19, 386	503	793	100	56.9	40.4	1.0	1.7
White.....	47, 426	26, 936	19, 268	482	740	100	56.8	40.6	1.0	1.6
Negro.....	105	88	17			100	83.8	16.2		
Other races.....	505	330	101	21	53	100	65.3	20.0	4.2	10.5
Mississippi.....	52, 095	4, 219	21, 448	26, 148	280	100	8.1	41.2	50.2	.5
White.....	23, 248	3, 712	17, 389	2, 011	186	100	16.0	74.8	8.7	.6
Negro.....	28, 763	469	4, 027	24, 184	133	100	1.6	14.0	83.9	.5
Other races.....	84	38	32	3	11	100	45.2	38.1	8.6	13.1
Missouri.....	56, 951	22, 094	32, 447	1, 469	941	100	38.8	57.0	2.6	1.7
White.....	53, 418	19, 974	31, 372	1, 198	874	100	37.4	58.7	2.2	1.6
Negro.....	3, 516	2, 110	1, 072	267	67	100	60.0	30.5	7.6	1.9
Other races.....	17	10	3	4		100	58.8	17.6	23.5	
Montana.....	10, 248	6, 396	3, 661	200	91	100	62.4	34.7	2.0	.9
White.....	9, 598	5, 971	3, 432	159	36	100	62.2	35.8	1.7	.4
Negro.....	14	6	7		1	100	42.9	50.0		7.1
Other races.....	636	419	122	41	54	100	66.9	19.2	6.4	8.5

¹ Less than one-tenth of 1 percent.

TABLE No. 7.—Number of live births and percentage distribution, by race and by person in attendance, in each State, 1937—Continued

Area and race	Number					Percent				
	Total live births	Physician (in hospital)	Physician (not in hospital)	Midwife	Other and not specified	Total percent	Physician (in hospital)	Physician (not in hospital)	Midwife	Other and not specified
Nebraska.....	22,270	8,906	13,331	11	22	100	40.0	59.9	(1)	0.1
White.....	21,979	8,733	13,215	10	21	100	39.7	60.1	(1)	.1
Negro.....	175	100	75	-----	-----	100	57.1	42.9	-----	-----
Other races...	116	73	41	1	1	100	62.9	35.3	0.9	.0
Nevada.....	1,742	1,139	555	10	39	100	65.4	31.9	.6	2.2
White.....	1,572	1,049	513	3	7	100	66.7	32.6	.2	.4
Negro.....	4	2	2	-----	-----	100	50.0	50.0	-----	-----
Other races...	166	88	40	7	31	100	53.0	24.1	4.2	18.7
New Hampshire..	7,033	2,048	5,572	4	9	100	26.8	73.0	.1	.1
White.....	7,028	2,047	5,568	4	9	100	26.8	73.0	.1	.1
Negro.....	3	-----	3	-----	-----	100	-----	100.0	-----	-----
Other races...	2	1	1	-----	-----	100	50.0	50.0	-----	-----
New Jersey.....	54,607	40,484	11,510	2,578	35	100	74.1	21.1	4.7	.1
White.....	50,346	37,433	10,375	2,509	29	100	74.4	20.6	6.0	.1
Negro.....	4,239	3,039	1,125	69	6	100	71.7	28.5	1.6	.1
Other races...	22	12	10	-----	-----	100	54.5	45.5	-----	-----
New Mexico.....	13,837	2,604	6,505	3,275	1,363	100	10.5	47.0	23.7	9.9
White.....	13,210	2,511	6,410	3,269	1,014	100	19.0	48.6	24.7	7.7
Negro.....	32	5	25	1	1	100	15.6	78.1	3.1	3.1
Other races...	595	178	64	5	348	100	29.9	10.8	.8	59.5
New York.....	185,502	147,956	34,185	3,124	237	100	79.8	18.4	1.7	.1
White.....	176,652	140,776	32,723	2,937	216	100	79.7	18.5	1.7	.1
Negro.....	8,491	6,960	1,369	163	3	100	82.0	16.0	1.9	(1)
Other races...	359	214	103	24	18	100	59.6	28.7	6.7	5.0
North Carolina..	79,080	12,267	45,175	21,484	154	100	15.5	57.1	27.2	.2
White.....	53,664	10,796	37,288	5,485	95	100	20.1	69.5	10.2	.2
Negro.....	24,592	1,378	7,522	15,642	50	100	5.6	30.6	63.6	1.1
Other races...	824	93	365	357	9	100	11.3	44.3	43.3	.2
North Dakota....	12,637	5,485	6,104	450	508	100	43.4	49.0	3.6	4.0
White.....	12,165	5,170	6,068	430	467	100	42.5	50.1	3.5	3.8
Negro.....	1	-----	1	-----	-----	100	-----	100.0	-----	-----
Other races...	471	315	95	20	41	100	66.9	20.2	4.2	8.7
Ohio.....	107,576	53,528	53,839	163	48	100	49.8	50.0	.2	(1)
White.....	102,023	50,835	50,986	158	44	100	49.8	50.0	.2	(1)
Negro.....	5,523	2,680	2,335	5	3	100	48.5	51.3	.1	.1
Other races...	30	11	18	-----	-----	100	36.7	60.0	-----	3.3
Oklahoma.....	41,456	10,721	28,722	1,613	400	100	25.9	69.3	3.9	1.0
White.....	37,616	9,766	26,905	731	214	100	26.0	71.5	1.9	.6
Negro.....	2,197	106	1,215	762	114	100	4.8	55.3	34.7	5.2
Other races...	1,643	849	602	120	72	100	51.7	36.6	7.3	4.4
Oregon.....	15,457	10,956	4,449	21	31	100	70.9	28.8	.1	.2
White.....	15,264	10,834	4,389	10	31	100	71.0	28.8	.1	.2
Negro.....	32	27	3	2	-----	100	84.4	9.4	6.3	-----
Other races...	161	95	57	9	-----	100	59.0	35.4	5.6	-----
Pennsylvania....	161,288	82,557	77,127	1,248	356	100	51.2	47.8	.8	.2
White.....	152,631	77,133	74,077	1,207	214	100	50.5	48.5	.8	.1
Negro.....	8,613	5,402	3,029	41	141	100	62.7	35.2	.8	1.6
Other races...	44	22	21	-----	1	100	50.0	47.7	-----	2.3

1 Less than one-tenth of 1 percent.

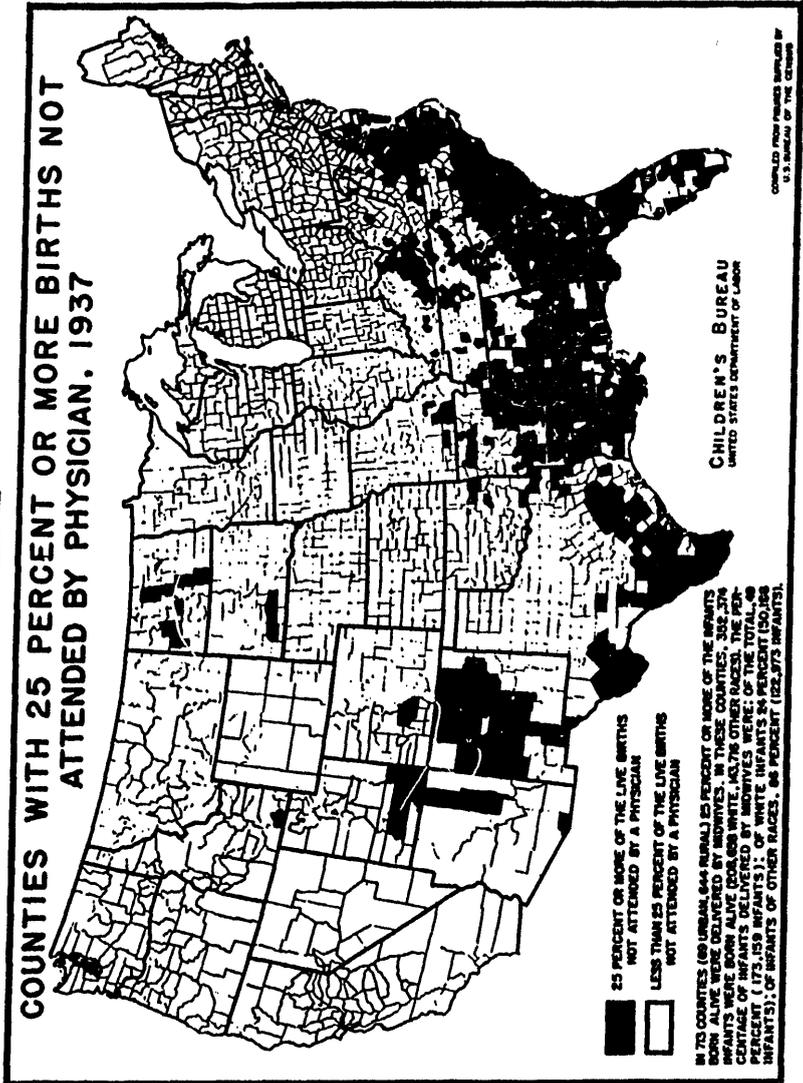
TABLE No. 7.—Number of live births and percentage distribution, by race and by person in attendance, in each State, 1937—Continued

Area and race	Number					Percent				
	Total live births	Physician (in hospital)	Physician (not in hospital)	Mid-wifo	Other and not specified	Total percent	Physician (in hospital)	Physician (not in hospital)	Mid-wifo	Other and not specified
Rhode Island.....	10,240	7,046	3,031	132	31	100	68.8	29.6	1.3	0.3
White.....	9,954	6,827	2,972	127	28	100	68.6	29.9	1.3	.3
Negro.....	280	216	66	6	3	100	77.1	20.0	1.8	1.1
Other races.....	6	3	53	—	—	100	50.0	50.0	—	—
South Carolina.....	40,643	4,731	16,558	19,328	26	100	11.6	40.7	47.6	.1
White.....	19,745	4,066	13,534	2,130	15	100	20.6	68.5	10.8	.1
Negro.....	20,860	662	3,008	17,179	11	100	3.2	14.4	82.4	.1
Other races.....	38	3	16	19	—	100	7.9	42.1	60.0	—
South Dakota.....	11,908	4,809	6,681	146	272	100	40.4	56.1	1.2	2.3
White.....	11,318	4,551	6,493	123	151	100	40.2	57.4	1.1	1.3
Negro.....	6	3	3	—	—	100	50.0	50.0	—	—
Other races.....	684	255	185	23	121	100	43.7	31.7	3.9	20.7
Tennessee.....	51,938	10,591	34,697	6,296	354	100	20.4	66.8	12.1	.7
White.....	43,850	8,665	31,180	3,775	239	100	19.8	71.1	8.6	.5
Negro.....	8,074	1,924	3,515	2,520	115	100	23.8	43.5	31.2	1.4
Other races.....	5	2	2	1	—	100	40.0	40.0	20.0	—
Texas.....	116,057	33,975	62,145	17,489	2,448	100	29.3	53.5	15.1	2.1
White.....	102,129	31,637	57,849	10,627	2,016	100	31.0	56.6	10.4	2.0
Negro.....	13,861	2,327	4,264	6,850	426	100	16.7	30.8	49.4	3.1
Other races.....	67	17	32	12	6	100	25.4	47.8	17.0	9.0
Utah.....	12,693	7,037	5,441	161	54	100	55.4	42.9	1.3	.4
White.....	12,547	6,048	5,393	156	50	100	55.4	43.0	1.2	.4
Negro.....	9	7	2	—	—	100	77.8	22.2	—	—
Other races.....	187	82	46	5	4	100	59.9	33.6	3.6	2.9
Vermont.....	6,326	2,816	3,505	3	2	100	44.5	55.4	(¹)	(¹)
White.....	6,323	2,816	3,502	3	2	100	44.5	55.4	(¹)	(¹)
Negro.....	3	—	3	—	—	100	—	100.0	—	—
Virginia.....	51,950	10,415	27,418	13,437	680	100	20.0	52.8	25.9	1.3
White.....	36,834	9,271	22,864	4,223	476	100	25.2	62.1	11.5	1.3
Negro.....	15,080	1,136	4,544	9,196	204	100	7.5	30.1	61.0	1.4
Other races.....	36	8	10	18	—	100	22.2	27.8	60.0	—
Washington.....	25,036	18,018	5,941	112	65	100	75.6	23.7	.4	.3
White.....	24,370	18,603	5,692	39	31	100	76.4	23.4	.2	.1
Negro.....	69	55	13	—	1	100	79.7	18.8	—	1.4
Other races.....	597	255	236	73	33	100	42.7	39.5	12.2	5.5
West Virginia.....	42,240	5,292	34,358	1,825	765	100	12.5	81.3	4.3	1.8
White.....	39,944	5,167	32,238	1,801	738	100	12.9	80.7	4.5	1.8
Negro.....	2,292	124	2,117	24	27	100	5.4	92.4	1.0	1.2
Other races.....	4	1	3	—	—	100	25.0	75.0	—	—
Wisconsin.....	53,543	25,435	27,591	350	167	100	47.5	51.5	.7	.3
White.....	53,007	25,063	27,422	342	150	100	47.3	51.7	.6	.3
Negro.....	159	107	62	—	—	100	67.3	32.7	—	—
Other races.....	377	235	117	8	17	100	62.3	31.0	2.1	4.5
Wyoming.....	4,530	460	4,037	10	23	100	10.2	89.1	.2	.5
White.....	4,416	444	3,947	9	16	100	10.1	89.4	.2	.4
Negro.....	9	—	9	—	—	100	—	100.0	—	—
Other races.....	105	16	81	1	7	100	15.2	77.1	1.0	6.7

¹ Less than one-tenth of 1 percent.

These tables show that in 1937 there were nearly one-quarter of a million live births in which there was no physician in attendance at the birth. (See chart 11, Counties With 25 Percent or More Births Not Attended by Physicians, 1937.) In a majority of these cases

CHART 11

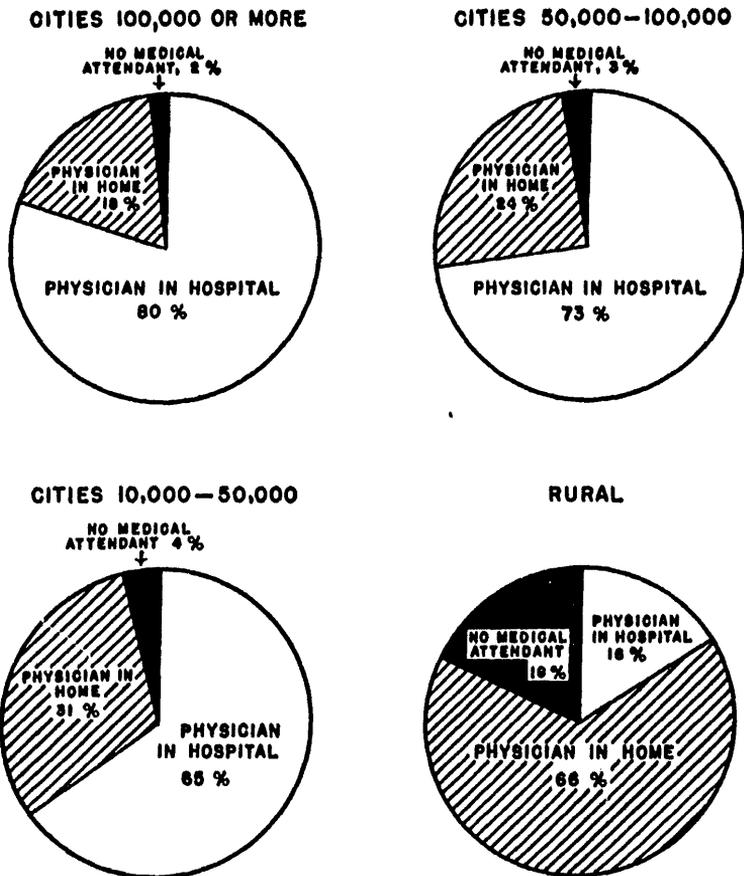


midwives, known to be ignorant and untrained, were in attendance. Nearly 90 percent of the midwife deliveries were in rural cases; 65 percent were among Negro women; 35 percent among white women. More than half of all Negro women were delivered by midwives and only 4 percent of white women.

In rural areas only 16 percent of the live births were in hospitals, whereas in cities of 10,000 population or over, 75 percent were in hospitals. (See chart 12, Attendant at Birth by Size of Place.)

CHART 12

ATTENDANT AT BIRTH BY SIZE OF PLACE OF BIRTH, 1937



CHILDREN'S BUREAU
U. S. DEPARTMENT OF LABOR

SOURCE: U. S. BUREAU OF THE CENSUS

Only 20 percent of Negro women are delivered in hospitals, whereas 48 percent of white women have this advantage. The percent of hospital births varies greatly from State to State, being highest (excluding the District of Columbia, 89 percent) in Connecticut (83 per-

cent) and New York (80 percent), and lowest in Arkansas (9 percent) and Mississippi (8 percent). In rural parts of Alabama only 2 percent of births are in hospitals; in rural parts of California 66 percent are in hospitals.

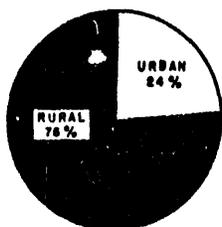
Data from the Bureau of the Census and the National Industrial Conference Board show that States with lowest income per capita have the largest proportion of births in rural areas (76 percent); they also have the largest proportion of births not attended by a physician (25 percent) and the smallest proportion of births in hospitals (20 percent). States with highest per capita incomes have the largest proportion of births in cities (70 percent), and in hospitals (65 percent). Only 2 percent of births in States with highest incomes were not attended by physicians. (See chart 13, Births in Urban and Rural Areas and Attendant at Birth by Per Capita Income of States, 1937.)

CHART 13

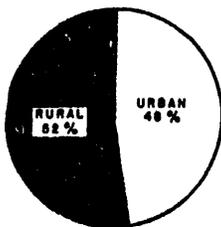
**BIRTHS IN URBAN AND RURAL AREAS AND ATTENDANT AT BIRTH
BY PER CAPITA INCOME OF STATES, 1937**

BIRTHS IN URBAN AND RURAL AREAS

**LOWEST INCOME PER CAPITA
(16 STATES)**



**MIDDLE INCOME PER CAPITA
(16 STATES)**



**HIGHEST INCOME PER CAPITA
(16 STATES AND DISTRICT OF COLUMBIA)**

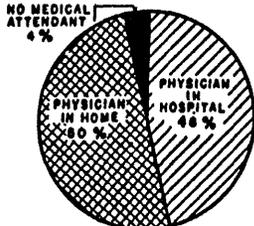


ATTENDANT AT BIRTH

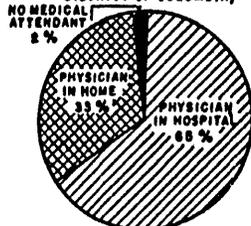
**LOWEST INCOME PER CAPITA
(16 STATES)**



**MIDDLE INCOME PER CAPITA
(16 STATES)**

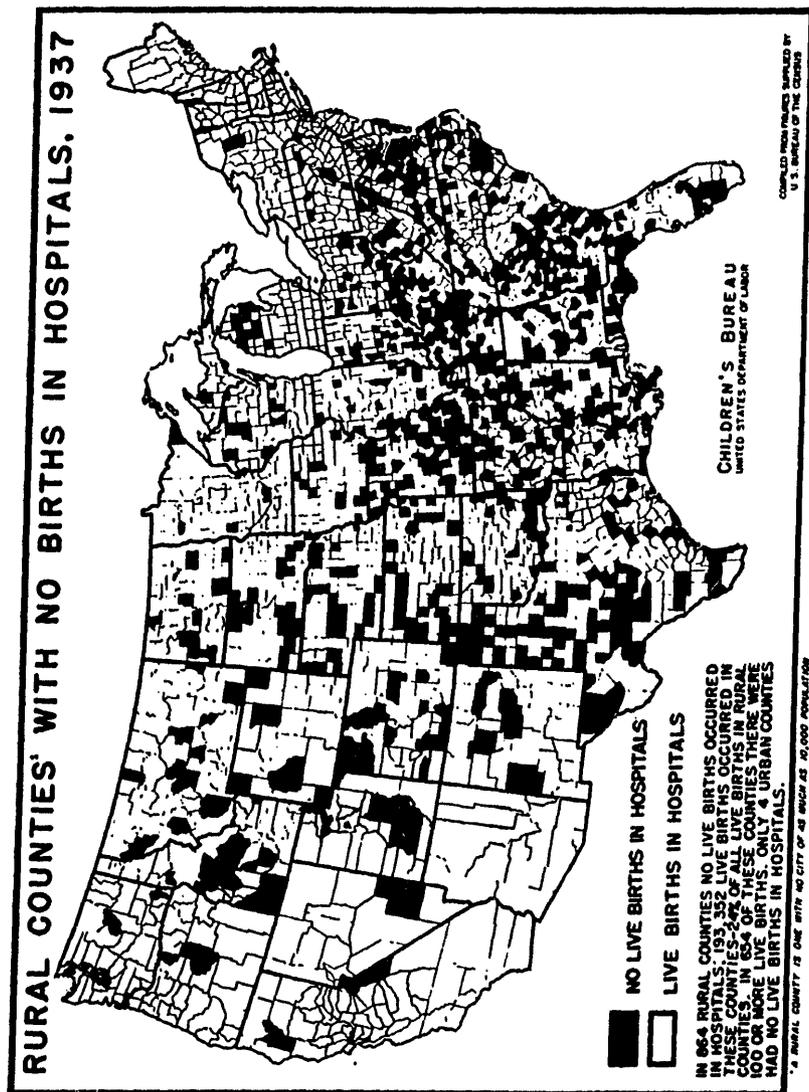


**HIGHEST INCOME PER CAPITA
(16 STATES AND DISTRICT OF COLUMBIA)**



There are 864 rural counties in the United States in which in 1937 no live births occurred in hospitals (see chart 14, Rural Counties With No Births in Hospitals, 1937), and yet nearly 200,000 live births took

CHART 14



place in these counties according to data supplied by the Bureau of the Census. In 654 of these counties there were 100 or more births in 1937; in 397 more than 200. (Only 4 urban counties reported no live births in hospitals.) It would seem to be obvious that the needs of maternity patients in many of these areas must require planning for hospitalization, either by providing resources to pay for care in existing qualified hospitals or to construct and maintain public maternity hospitals or wings of general public hospitals where needed.

Careful planning to make use of existing facilities should, of course, precede construction.

FINDINGS OF NATIONAL CONFERENCE ON BETTER CARE FOR MOTHERS AND BABIES

I would like to submit for the record (exhibit E) a statement of findings by a committee of the National Conference on Better Care for Mothers and Babies since they have a close bearing on the subject of the proposed amendments to title V, part 1, of the Social Security Act.

EXHIBIT E.—FINDINGS OF NATIONAL CONFERENCE ON BETTER CARE FOR MOTHERS AND BABIES

At a national conference on Better Care for Mothers and Babies held in Washington in January 1938,¹ the facts with regard to what constitutes good maternity care and care of newborn infants and how communities should be organized to provide it were clearly set forth. There was no disagreement with the fact that the way to save the lives of mothers and babies is known, but the resources to provide the facilities and services are not available.

To bring about this saving of lives for mothers and infants and to improve maternity care for all women not able to provide from their own resources, the committee on findings of the conference made the following statement of measures to be undertaken:

"The committee finds that preserving the lives and health of mothers and babies is of such importance to all the people that it warrants immediate and concerted national consideration and national action.

"The principal objectives to be sought are the following:

"Full opportunity for practical instruction in obstetrics and the care of newborn infant—

"For undergraduate students in medical schools, for physicians resident in hospitals, and periodically for practicing physicians in post-graduate courses.

"For student nurse and at recurrent intervals for the graduate nurse or the public-health nurse whose work includes maternity nursing in private practice or in public-health service.

"Supervision of the mother throughout pregnancy by a qualified local physician, aided by a public-health nurse, preferably one with recent training in obstetrics and care of newborn infants.

"Care at delivery by the same qualified local physician, aided by a nurse trained and experienced in delivery nursing care, such care to be given in the home or in an approved hospital provided with adequate obstetric and pediatric services and facilities for caring for emergency or complicated cases.

"Postpartum and postnatal medical and nursing supervision in the hospital and the home.

"Consultation service by obstetricians and pediatricians to aid general practitioners in their care of mothers and infants.

"Community provision for care by a qualified physician and nurse, for consultation service, and for hospital care when indicated, including transportation to the hospital, for the mother or baby to whom such care is otherwise inaccessible or who cannot obtain care unaided.

¹ See Proceedings of National Conference on Better Care for Mothers and Babies, Publication No. 246, U. S. Department of Labor, Children's Bureau.

² As a result of the interest aroused by this conference and at the request of the Annual Conference of the State and Provincial Health Authorities, a bill, S. 3914, was introduced in April 1938 in the Senate by Senator Barkley, and simultaneously H. R. 10241 in the House by Congressman Doughton, with the purpose of amending title V, pt. 1, of the Social Security Act to increase the authorization for appropriation of funds for Maternal and Child Health. The purpose of the bill was given consideration and approved by 18 national organizations concerned with problems of maternal and child health and welfare: American Association of University Women, American Farm Bureau Federation, American Home Economics Association, American Legion, American Nurses' Association, American Pediatric Society, American Public Health Association, American Social Hygiene Association, Committee for Industrial Organization, Conference of State and Provincial Health Authorities, Maternity Center Association, National Consumers' League, National Council of Jewish Women, National Grange, National Public Health Council, National Women's Christian Temperance Union, National Women's Trade Union League, Service Star Legion.

"Further progress toward these objectives can be made through concerted effort of all concerned with maternal and infant care as follows:

"By increasing professional resources through—

"Better undergraduate education and training for nurses and practitioners of medicine.

"Better graduate educational facilities for nurses and physicians.

"Adequate provision for training of nurses and physicians for special obstetric and pediatric service.

"Better distribution of competent physicians.

"More specially trained graduate public-health nurses.

"Greater facilities for education of physicians and nurses to be made available by hospitals caring for maternal cases.

"By developing in both cities and rural areas complete service for mothers and newborn infants, through the utilization of available competent service under both public and private auspices, and extension and improvement of public services not adequate to meet the need—

"The local community to provide maternal and infant care as needed, as part of its public-health responsibility.

"The State to give leadership, financial assistance, specialized service, and supervision in the development of local services.

"The Federal Government to assist the State through financial support, research, and consultant service."

The members of the conference discussed the availability of community resources to provide this medical, nursing, and hospital care, and reported that many communities and many States are unable to provide the necessary care without assistance from the Federal Government. The committee on findings proposed a plan of action along the lines of the objectives outlined and pointed out "that if this plan of action is to be carried out, Federal participation would be necessary, as follows:

"Amendment to title V, section 502, of the Social Security Act to authorize a larger sum to be appropriated annually to the States for maternal and child-health services with provision that the increased payments to the States should be used for the improvement of maternal care and care of newborn infants."

MEDICAL CARE FOR CHILDREN

Need for increased resources.—The need to provide more adequate facilities and services for medical care and health supervision of children has long been recognized by public-health workers whose function it was to develop infant- and child-health conferences or provide supervision of the health of school children. Resources are frequently inadequate or lacking for the correction of physical defects which if left uncorrected often lead to later disability, for the protection of children against diphtheria, smallpox, or other communicable diseases, for the diagnosis and treatment of sick or physically handicapped children in the home or in clinics, hospitals, or convalescent homes. The program of services for crippled children has done much to take care of children with orthopedic crippling conditions and certain conditions needing plastic surgery, such as harelip and cleft palate and contractions following burns, but the funds available have not been sufficient to provide care for the large number of children crippled with heart disease or for the children needing care because of defects of vision or hearing. The national health survey in 83 cities showed that of all the children under 15 years of age having illnesses which disabled them for 7 or more days, 28 percent had neither a physician's care nor hospital care.

Facilities for health supervision and medical care.—Though most large cities have facilities for health supervision of children in child-health centers in only about one-third of the counties were there such centers at the beginning of this fiscal year to which mothers may take their young children for supervision of health.

There are still 780 counties in which there is not a single public-health nurse serving rural areas to advise the mothers about the care of themselves or their children.

Facilities for diagnosis and treatment in an out-patient clinic connected with a general hospital are found in only 2 percent of cities with population under 10,000 persons, whereas all cities with population over 250,000 have one or more such out-patient diagnostic and treatment clinics. And yet about 50 percent of families with incomes under \$800 a year live in these cities of less than 10,000 population.

According to a survey made in 1936 by the American Medical Association⁷ there were 241 counties in the United States with more than 2,000 population per physician, and 19 of which had no physician. The report of the survey points out that—

the sections in which the supply of physicians, in relation to population, is exceptionally low fall into distinct classes. One class of counties is on the margin of settlement, in mountainous, arid, national forest or grazing sections, in which the population is sparse. The other class of counties is located principally in the Appalachian-Ozarks, cotton, and some sea-coast regions.

These areas have at least the average density of population of rural areas, but backward economic and social organization, a high percentage of illiteracy and extreme poverty.

Of physicians specializing in children's diseases only 2.7 percent practice in communities of less than 10,000 population; of those specializing in maternity care less than 1 percent practice in these small communities. Hospitals having special accommodations and staff for the care of children, whether as separate institutions or as part of a general hospital, are concentrated in the centers of population.

Medical care of children with eye defects.—It is estimated that approximately 10,000,000 school children have defective vision requiring correction with glasses. It is conservatively estimated that 1 percent of children of preschool and school age have strabismus (squint). To successfully treat strabismus a combination of muscular training and operative procedure may be necessary. Treatment must be continued over a long period to be effective.

The cost involved in correcting visual defect or treatment of strabismus is often more than a family can pay. Public authorities frequently are not able to provide the resources to pay for the necessary glasses or medical services. Over one-third of the blind lost their sight in childhood or youth.

It is estimated that at least one-sixth of all blindness in children is preventable.

Prevention of impairment of hearing and deafness among children.—The American Society for the Hard of Hearing estimates on the basis of surveys that 6 percent of school children have impaired hearing—or approximately 1,680,000 in the United States. Other studies have shown that a higher percent of rural children (14 percent) than of urban children (6 percent) have impaired hearing. Where poor hygienic conditions exist, the proportion of children with impaired hearing may be as high as 25 percent (in a Rochester (N. Y.) school) or 33 percent (in a Chelsea (Mass.) school), while under ideal conditions surrounding some private-school children the incidence of impairment was between 1 and 2 percent. In one study

⁷From Rural Medical Service. Bureau of Medical Economics, American Medical Association, Chicago. 1937. Pp. 60, 63.

in Rochester, N. Y., it was found that three times as many children had to repeat their grades in school because of deafness as from any other cause.

Impairment of hearing is nearly always associated with a history of past ear trouble and very frequently with nose and throat trouble. In one study nose and throat defects accompanied hearing loss in from 40 to 60 percent of children in different schools. It is stated in other reports that 80 percent or more of the cases of deafness in adults can be prevented or arrested if the underlying conditions are diagnosed and treated early.

Tuberculosis (as diagnosed by the tuberculin test) among young children (under 4 years) who have been directly exposed to persons with active disease is twice as frequent as among those who have not been so exposed. Special clinics for the supervision of all children so exposed and of preschool children with positive tuberculin tests are greatly needed. Facilities for care of children with active tuberculosis are inadequate in many areas, whether care is given in the home or in sanatoria. Public-health nursing supervision and care is of great importance when treatment is given in the home. At present the number of public-health nurses is not sufficient in many communities to provide needed care. Sanatorium care for suitable cases is not adequate in many States and local communities.

Mental hygiene.—Facilities for treatment of behavior problems among children are grossly inadequate. In 1936 there were reported to be approximately 500 mental hygiene clinics serving children established in cities of 10,000 or more population. In towns and rural areas regular clinics were held in only 18 places in 5 States, although traveling clinics reached some of these rural areas in 3 States. Funds are needed to develop further clinics in connection with hospitals, child-health centers, or diagnostic centers in areas where hospital clinics do not exist.

Mortality rates among children under 15 from certain important causes vary in different sections of the United States. In the country as a whole approximately 70,000 children under 15 years of age died in 1936 from respiratory diseases (including tuberculosis), diarrhea and enteritis, communicable diseases, and heart disease. Table No. 8, which follows, shows the rates for these selected causes by sections of the country.

TABLE No. 8.—Mortality rates for children under 15 years, from specified causes, by geographic regions, 1936

(Children's Bureau, U. S. Department of Labor)

Geographic region	Deaths per 100,000 children under 15 years of age					
	All causes	Respiratory diseases including tuberculosis	Diarrhea and enteritis	Other communicable diseases	Diseases of the heart	All other causes
United States.....	538	114	48	23	9	344
Southeast.....	658	139	71	26	7	415
Southwest.....	709	150	99	33	8	410
Northwest.....	620	100	40	25	10	336
Middle States.....	466	92	36	21	9	308
Northeast.....	456	98	29	17	12	300
Far West.....	556	119	39	30	8	340

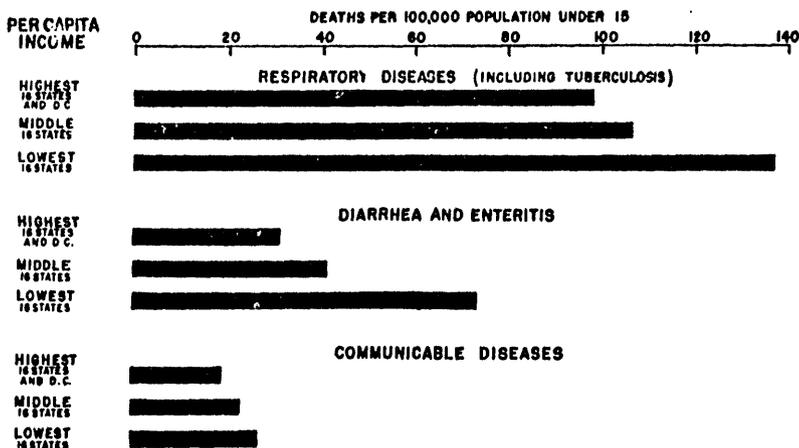
Source: Deaths, 1936, and Children, 1930; U. S. Bureau of the Census.

The death rate for respiratory diseases in the southwest section was 72 percent higher than the rate for the Middle States; that for diarrhea in the Southwest was 241 percent higher than that in the northeastern section; that for other communicable disease in the Southwest was 94 percent higher than that in the Northeast. The death rate for heart disease among children, however, was highest in the Northeast and the Northwest, lowest in the Southeast, Southwest, and Far West.

Furthermore, data from the census and from the National Industrial Conference Board show that the mortality rates among children under 15 for respiratory diseases, for diarrhea, and for communicable diseases are lowest in the States with high incomes and highest in the States with lowest incomes. (See chart 15, Mortality from Specified Causes Among Children Under 15 by Per Capita Incomes of States.)

CHART 15

MORTALITY FROM SPECIFIED CAUSES AMONG CHILDREN UNDER 15 BY PER CAPITA INCOME OF STATES



CHILDREN'S BUREAU
UNITED STATES DEPARTMENT OF LABOR

SOURCES: UNITED STATES BUREAU OF THE CENSUS (1928)
NATIONAL INDUSTRIAL CONFERENCE BOARD INCOME DATA (1937)

With more adequate provision for medical and nursing services and for consultation services, many of these children's lives could be saved.

ECONOMIC STATUS.—ITS RELATION TO MATERNITY CARE AND MEDICAL CARE OF CHILDREN

It is estimated that of the 2,000,000 births each year, 1,100,000 occur in families who have incomes of less than \$1,000 or are on relief; approximately 900,000 are in families with incomes of less than \$800 or are on relief. For families with incomes of this level the cost of maternity care must be rated in the category of major medical expenditures. To the Nation the outcome of the 2,000,000 births in terms of the survival and health of the mother and child is of suffi-

cient significance to warrant the provision by Government of facilities to insure the best possible care for all who are unable to provide it from their own resources.

Data have been cited to show inadequacy of facilities in rural areas and to show that among women who die, prenatal care is most inadequately received. A recent study of maternal care made by the Children's Bureau in a New England city has shown that the best type of prenatal care was received by 73 percent of the women who were private patients but by only 15 percent of the women who received free care. Prenatal care was given early in pregnancy to 84 percent of the private patients, but to only 35 percent of the free patients. That the adequacy of prenatal care received is related not only to the income of the family and to the size of place in which they live has been recently reported by the United States Public Health Service from a study of maternal care in which it cooperated with the Michigan State Medical Society. Prenatal care was received by all but 8 percent of women in so-called comfortable circumstances, that is incomes of about \$2,000 or more, whereas 43 percent of women on relief received no prenatal care. Women living in rural areas, especially those women who were classified as poor (incomes less than \$1,000 a year) or on relief, had much less prenatal care than women living in large cities. Women living in rural areas were twice as likely to get hospital care at delivery when they were in comfortable circumstances as when they were poor or on relief.

Women in large cities got hospital care three times as often as poor rural women. The same was true for care following delivery; more than twice as large a proportion of the women who were poor received no follow-up examination than of women who were in comfortable circumstances; more than twice as large a proportion of rural women who were poor received no such examination than of city women. The data reported corroborates facts that have been commonly believed for many years.

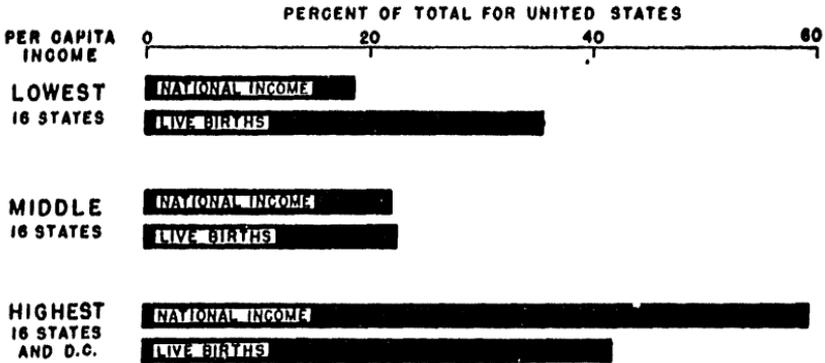
Women with low incomes cannot obtain adequate maternity care unaided.

Medical care of children as related to economic status.—Of the 43,000,000 children under 18 years of age in the United States approximately 16,000,000 are in families with incomes of less than \$800 a year or on relief. Some 700,000 dependent children are now receiving aid under title IV of the Social Security Act and it is estimated by the Social Security Board that there are probably twice as many additional children who should be getting similar aid. There is no adequate provision for medical care for this group of children, though in one way or another some care is provided in many areas, especially where clinics exist. Some better provision should be made.

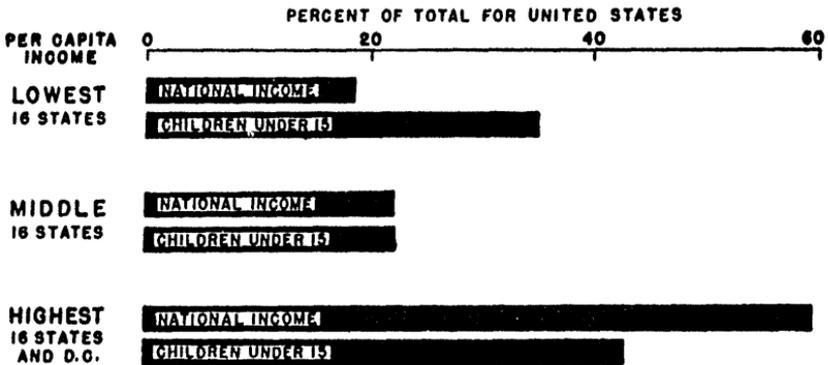
That there are great variations in the financial resources of the different States to meet the costs of health services and medical care is well known. The marked discrepancy between the proportion of national income received by the inhabitants of the States grouped by income per capita and the proportion of births or of children under 15 years of age is shown in chart 16. A picture of similar dis-

CHART 10

NATIONAL INCOME AND BIRTHS BY PER CAPITA INCOME OF STATES, 1937



NATIONAL INCOME AND CHILDREN UNDER 15 BY PER CAPITA INCOME OF STATES, 1937



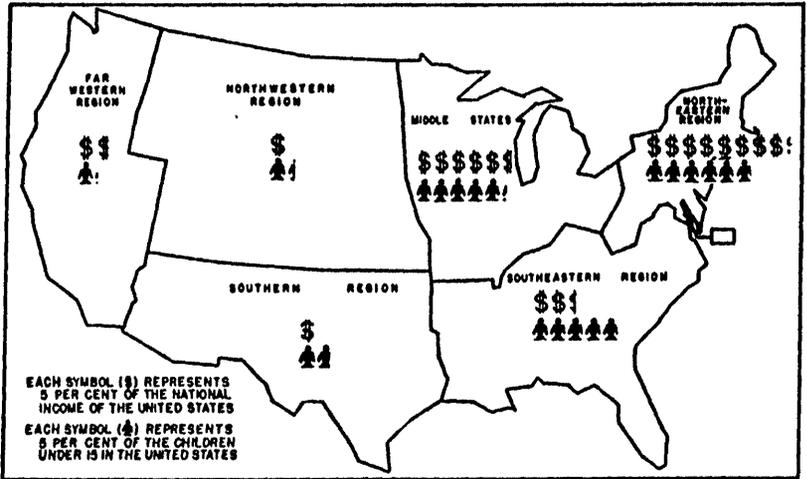
CHILDREN'S BUREAU
UNITED STATES DEPARTMENT OF LABOR

SOURCES: UNITED STATES BUREAU OF THE CENSUS
NATIONAL INDUSTRIAL CONFERENCE BOARD INCOME DATA

crepancy grouping the States on a regional basis is seen in chart 17. The discrepancies in type of professional care of women at delivery and in the incidence of respiratory, diarrhea, and communicable diseases among children found when States are grouped according to their financial resources has been pointed out.

CHART 17

NATIONAL INCOME AND CHILDREN UNDER 15 YEARS OF AGE; UNITED STATES



CHILDREN'S BUREAU
UNITED STATES DEPARTMENT OF LABOR

SOURCES: NATIONAL INDUSTRIAL CONFERENCE BOARD INCOME DATA
UNITED STATES BUREAU OF THE CENSUS

The grants-in-aid to States on the variable matching basis would go a long way to eliminate the discrepancies with respect to health supervision and medical care for mothers and children.

That the program should develop not too fast is sound from an administrative point of view and if standards are to be established to insure good quality of care. It should move fast enough to meet the needs of those who cannot provide for themselves adequately without too great delay.

Actually experience under the present provisions of the Social Security Act would make it possible to provide increased maternity care and develop a plan of medical care for children without too great difficulty or delay should funds be made available.

PROGRESS IN CRIPPLED CHILDREN'S PROGRAM UNDER SOCIAL SECURITY ACT

When Social Security funds became available for grants for medical and hospital care for crippled children, 35 States had enabling acts making some phases of the program possible, but only 12 States had acts permitting programs as broad in scope as that outlined in the Social Security Act and appropriations substantial enough to carry out a broad program (Florida, Kentucky, Michigan, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Vermont, West Virginia, and Wisconsin).

By the end of the fiscal year 1938 every State except Louisiana had submitted and had approved a State plan for these medical and hospital and after-care services for crippled children. For legal and financial reasons the program was delayed but in March 1939, the local difficulties being overcome, a plan was approved for Louisiana. All the 51 States and Territories now have active services including loca-

tion of crippled children; diagnostic clinics; provision for hospital care in public and, except for three States, in voluntary hospitals; medical and surgical care and after care, including in varying amount, convalescent-home or foster-home care, follow-up care in the child's own home by nurses or social workers.

STATE ADMINISTRATION

Administrative agency.—Under the Social Security Act the program must be administered by a State agency. The agencies at present are as follows:

State health agency.....	25
State welfare agency.....	15
Crippled children's commission.....	5
Department of education.....	4
State university hospital.....	1
Interdepartmental committee.....	1

During the past 3½ years the State health agency has been designated as the official agency in 10 States, and 6 other States have transferred their programs to the State health agency. During the same period the State welfare department has been designated as the official agency in 5 States and in 2 others programs have been transferred to welfare or social security agencies.

Medical direction.—Medical direction is given to the program in 32 States by a physician in charge; in 3 an appointment of a physician is pending; in 16 the appointment of an advisory committee of orthopedic surgeons and other physicians serves to give medical advice and assistance to the directors who are not physicians. The medical directors have usually been selected because of experience in pediatrics on public-health administration. In a few cases an orthopedic surgeon is in charge.

Other medical and allied professional personnel employed for the fiscal year 1938 by the States were as follows:

Physicians:	
Orthopedic surgeons.....	410
General surgeons.....	208
Plastic surgeons.....	82
Pediatricians and other consultants.....	655
Public-health nurses (or special orthopedic nurses).....	410
Physical therapists.....	82
Medical social workers.....	44

MEDICAL AND SURGICAL SERVICES

Payment of physicians and surgeons.—Of 846 surgeons employed by 40 States, 177 are paid on a fee-schedule basis for operations performed or consultant service given, 169 are paid part-time salaries. The fee schedule basis is used by 19 States, the part-time salary basis by 26 States; 2 States pay neither fees nor salaries, and 4 States pay fees for diagnostic clinics only. The tendency appears to be for States to adopt the method of paying part-time salaries as being more easily adjustable to a plan of care that must extend throughout the year and be flexible with respect to the load of cases which is often unpredictable due to epidemics or other factors. Consultants are usually paid on a fee schedule basis.

Qualifications of surgeons and physicians.—Fourteen States require certifications by the American Board of Orthopedic Surgery (organized by associations of specialists in cooperation with the American Medical Association), or eligibility by training and experience for such certification, as the basis for acceptance of the surgeons who are to render care. Of the 487 orthopedic surgeons participating in the program in 49 States during the fiscal year 1938, 291 (60 percent) were certified by the American Board of Orthopedic Surgery; in 18 States only orthopedic surgeons so certified actually rendered care.

The Children's Bureau Advisory Committee on Crippled Children's Services on which there are 15 physicians (including orthopedic surgeons, pediatricians, a neurologist, and cardiologist specializing in work with children) recommended in December 1935, before the funds were available, that State agencies should select orthopedic surgeons, pediatricians, and other specialists from the list of those certified by the respective boards of these specialties.

Cooperation with medical profession.—The appointment by 34 State agencies of technical committees of medical experts to advise in the selection of surgeons and physicians has done much to raise the standard of surgical and medical care and to develop interest and cooperation; in all of the remaining States except two, physicians serve on a general advisory committee. There has been active cooperation between the medical profession, especially the orthopedic surgeons and pediatricians, and the State agencies.

ALLIED SERVICES (PHYSICAL THERAPISTS, NURSES, MEDICAL SOCIAL WORKERS)

Payment.—The services of public-health nurses, or medical social workers, are usually on a salary basis. Occasionally in some States and more commonly in others the salary of a worker is shared with some other State or local official agency so as not to duplicate the individuals rendering the same type of care in any one community.

Qualifications of personnel.—The national organizations concerned with physical therapy, public-health nursing, and medical social work have each established standards for workers considered qualified to serve in various capacities, i. e., staff, supervisory or administrative positions, and have submitted these to the Children's Bureau Advisory Committee for consideration. The Children's Bureau Advisory Committee has recommended that State agencies adopt the standards so set forth in selecting personnel for State or local service.

I should like to insert here for the record exhibit F, giving the recommendations made by the Children's Bureau Advisory Committee on Services for Crippled Children related to qualifications of personnel.

EXHIBIT F.—RECOMMENDATIONS OF CHILDREN'S BUREAU ADVISORY COMMITTEE ON SERVICES FOR CRIPPLED CHILDREN AND STATE AND TERRITORIAL HEALTH OFFICERS

QUALIFICATIONS OF DIRECTORS OF CRIPPLED CHILDREN'S SERVICES

The State and Territorial health officers have made the following recommendations to the Children's Bureau with regard to the direction of the crippled children's services:

April 16, 1936.—As the program for crippled children involves diagnostic clinics and hospital care it should be directed by a physician, preferably one experienced in the care of crippled children.

QUALIFICATIONS OF SURGEONS

The advisory committee on services for crippled children has made the following recommendations to the Children's Bureau with regard to qualifications of surgeons employed in the crippled children's program:

December 17, 1935.—It was the sense of the committee that it would be desirable for the American boards of certification to make available to the States suggestions as to qualifications for physicians and surgeons to serve in the various States in connection with services for crippled children under the Social Security Act and also to give advisory service to the States as requested.

October 10, 1936.—Only surgeons who are certified by the American Board of Orthopaedic Surgery, or are eligible for such certification, should be approved by a State agency for surgical services for children suffering from orthopedic conditions.

An applicant for certification must have the following qualifications:

(a) He must be a graduate of a medical school approved by the council on medical education and hospitals of the American Medical Association.

(b) He must be of high ethical and professional standing.

(c) He must be a citizen of the United States or Canada.

(d) He must be duly authorized to practice medicine in the State or Province of his residence.

(e) He must be a member of the American Medical Association or another society approved by the council on medical education and hospitals of the American Medical Association.

(f) He must have had 1 year of internship in a general hospital acceptable to the board.

(g) After January 1, 1940, he must have had 3 years of concentrated instruction in orthopedic surgery approved by and acceptable to the board. (A residency of at least 2 years on an orthopedic service of a hospital recognized by the council of the American Medical Association is desirable.)

(h) He must have knowledge of the basic medical sciences related to orthopedic surgery.

(i) He must have had at least 2 years further experience in the actual practice of orthopedic surgery. Continuation of training (g) beyond the 3 years required will not be considered as actual practice unless the position of the candidate is considered permanent or his responsibilities equivalent to those encountered in private practice. This means that interns, residents, fellows, graduate students, and assistants will not be credited with additional periods of training unless they are permanent members of the organizations with which they are associated.

(j) He must have limited his work to the field of orthopedic surgery for at least 2 years prior to the submission of his application for examination.

(k) In the case of an applicant whose training has been received outside of the United States and Canada, his credentials must be satisfactory to the council on medical education and hospitals of the American Medical Association and to the National Board of Medical Examiners. In addition, he must have been engaged in the practice of orthopedic surgery in the United States (or Canada) for at least 3 years prior to the submission of his application.

April 7 and 8, 1937.—The advisory committee on services for crippled children reaffirmed and amplified its previous recommendations concerning the qualifications of surgeons and other trained personnel, recognizing at the same time the difficulties which confront State agencies in obtaining competent persons for sparsely settled areas.

The State and Territorial health officers have made the following recommendations with regard to qualifications of surgeons employed in the crippled children's program:

April 16, 1936.—The establishment of standards for the qualifications of surgeons, nurses, physiotherapists, and medical social workers based on the requirements of national recognized organizations in their respective fields after consultation with the technical advisory committee.

QUALIFICATIONS OF PHYSICIANS

The Advisory Committee on Services for Crippled Children has made the following recommendations to the Children's Bureau with regard to qualifications of physicians to be employed in the crippled children's program:

December 17, 1935.—It was the sense of the committee that it would be desirable for the American boards of certification to make available to the States suggestions as to qualifications for physicians and surgeons to serve in the various States in connection with services for crippled children under the Social Security Act and also to give advisory service to the States as requested.

October 10, 1936.—For consultation service, in addition to that provided by orthopedic surgeons, a physician who is certified by the national board in his specialty, or is eligible for such certification, should be engaged.

April 7 and 8, 1937.—The Advisory Committee on Services for Crippled Children reaffirmed and amplified its previous recommendations concerning the qualifications of surgeons and other trained personnel, recognizing at the same time the difficulties which confront official State agencies in obtaining competent persons for sparsely settled areas.

QUALIFICATIONS OF PUBLIC HEALTH NURSES

The Advisory Committee on Services for Crippled Children has made the following recommendations to the Children's Bureau with regard to qualifications of public-health nurses to be employed in the Crippled Children's program:

December 17, 1935.—The committee indicated that it would be desirable to have a subcommittee appointed to study and report on the question of training of personnel other than the physicians and surgeons who would be fitted to carry out the provisions of the Social Security Act with respect to the services for crippled children.

October 10, 1936.—The education committee of the National Organization for Public Health Nursing should be asked to submit recommendations concerning the qualifications for nurses in the field program.

April 7 and 8, 1937.—The Advisory Committee on Services for Crippled Children reaffirmed and amplified its previous recommendations concerning the qualifications of surgeons and other trained personnel, recognizing at the same time the difficulties which confront official State agencies in obtaining competent persons for sparsely settled areas.

December 2, 1938.—The following qualifications, based on recommendations submitted by the National Organization for Public Health Nursing, were approved by the committee:

1. Every public-health nurse engaged in the Crippled Children's program should: (a) Have the minimum basic preparation in orthopedic nursing set forth in the new curriculum guide for schools of nursing; (b) be a well-qualified public-health nurse, meeting the minimum requirements of the National Organization for Public Health Nursing.

2. Public-health nurses engaged in supervisory or consultant capacity should have advanced preparation in orthopedic nursing. These consultants or supervisors should not function as physical therapy technicians unless they have completed an approved course.

3. The approved public-health nursing courses should put more emphasis on orthopedic service in their general programs and encourage, in centers where there are adequate facilities in the university and community agencies, the development of opportunities for basic preparation.

The State and Territorial health officers have made the following recommendations to the Children's Bureau with regard to qualifications of public-health nurses employed in the Crippled Children's program:

April 16, 1936.—The establishment of standards for the qualifications of surgeons, nurses, physiotherapists, and medical social workers based on the requirements of nationally recognized organizations in their respective fields after consultation with the technical advisory subcommittee.

QUALIFICATIONS OF MEDICAL SOCIAL WORKERS

The Advisory Committee on Services for Crippled Children has made the following recommendations to the Children's Bureau with regard to qualifications of medical-social workers employed in the Crippled Children's program:

December 17, 1935.—The committee indicated that it would be desirable to have a subcommittee appointed to study and report on the question of training of personnel other than the physicians and surgeons who would be fitted to carry out the provisions of the Social Security Act with respect to the services for crippled children.

October 10, 1936.—The recommendations concerning the qualifications of medical social workers engaged in programs for the care of crippled children, as formulated by the education committee of the American Association of Medical Social Workers, should be accepted as the basis for employment of medical social workers under the act.

These qualifications are as follows:

A. Qualifications for medical social administrator, supervisor, or consultant: Applicants for executive and supervisory positions must meet the professional qualifications stated below in I or II. If it is impossible to secure personnel meeting these requirements, only those who qualify under section B may be employed, and such persons should, as rapidly as the educational policy of the program will permit, complete the following requirements under section A:

I. (a) Two years of professional education in a school of social work which is a member of the American Association of Schools of Social Work, at least 1 year of which must be on a graduate basis. This preparation must include courses and field work in medical social case work; **(b)** in addition, 3 years' experience in the practice of medical social work in a recognized⁴ social-service department in a hospital or clinic, including some experience in supervision.

II. Six years of experience in medical social work, during which the applicant has demonstrated the ability to perform acceptably. This experience must include 4 years of supervised medical social case work in a recognized⁴ department of medical-social work in a hospital or clinic and 2 years of supervisory responsibility in such a department.

B. Qualifications for medical social field workers: Applicants for staff positions must meet the professional qualifications stated below in I or II. Whenever possible they should meet the higher requirements under section A.

I. Two years of professional education in a school of social work which is a member of the American Association of Schools of Social Work, 1 year of which must be on a graduate basis and must include courses and field work in medical social case work.

II. (a) One year of professional education in a school of social work which is a member of the American Association of Schools of Social Work; **(b)** plus 2 years of experience in the practice of medical social case work in a recognized⁴ department of social work in a hospital or clinic.

April 7 and 8, 1937.—The Advisory Committee on Services for Crippled Children reaffirmed and amplified its previous recommendations concerning the qualifications of surgeons and other trained personnel, recognizing at the same time the difficulties which confront official State agencies in obtaining competent persons for sparsely settled areas.

The State and Territorial health officers have made the following recommendations to the Children's Bureau with regard to qualifications of medical social workers employed in the Crippled Children's program:

April 16, 1936.—The establishment of standards for the qualifications of surgeons, nurses, physiotherapists, and medical social workers based on the requirements of nationally recognized organizations in their respective fields after consultation with the technical advisory subcommittee.

⁴ This means meeting the requirements given in "A Statement of Standards to Be Met by Medical Social Service Departments in Hospitals and Clinics," adopted May 1936.

QUALIFICATIONS OF PHYSICAL-THERAPY TECHNICIANS

The Advisory Committee on Services for Crippled Children has made the following recommendations to the Children's Bureau with regard to qualifications of physical-therapy technicians to be employed in the Crippled Children's program:

December 17, 1935.—The committee indicated that it would be desirable to have a subcommittee appointed to study and report on the question of training of personnel other than the physicians and surgeons who would be fitted to carry out the provisions of the Social Security Act with respect to the services for crippled children.

October 10, 1936.—Only trained physical therapists, registered by the American Registry of Physical Therapy Technicians or eligible for such registration, should be employed in any program of services for crippled children under the act. Physical therapy should be given to crippled children only under supervision of a qualified physician.

April 7 and 8, 1937.—The committee accepted as adequate the statement of qualifications and functions of physical-therapy technicians as submitted by the council on medical education and hospitals of the American Medical Association and the American Physiotherapy Association.

These qualifications are as follows:

I. QUALIFICATIONS

A. Physical therapists should be eligible for membership in:

1. The American Physiotherapy Association or
2. The American Registry of Physical-Therapy Technicians.

B. Education:

1. Prerequisite—candidates for admission to courses and schools in physical therapy should be able to satisfy one of the following requirements: (a) Graduation from an accredited school of nursing; (b) graduation from an accredited school of physical education; (c) 2 years or 60 college-semester hours, 26 of which shall include physics, chemistry, and biological sciences.

2. Professional: Graduation from a course or school in physical therapy acceptable to the American Medical Association, by which is meant a course in physical therapy of not less than 9 months.* (If anything could be gained by offering training to nurses already employed, in portions less than the 9 months consecutively, in those schools already approved, the council would show no objection to their splitting it, provided they register for the entire course and no less than 2 years intervene for the entire course. These special courses should be taken in two periods of 4½ months each or one 6-month period and one 3-month period. The latter combination would probably be most advantageous. Not more than 2 years should elapse between the beginning of the first and the end of the second period.)

C. Experience of physical therapists employed:

1. Hospital: (a) Supervisor—(1) Meet requirements of section I, A and B; (2) not less than 3 years' experience in physical therapy for crippled children; (b) assistant—(1) Meet requirements of section I, A and B.

2. Field service: (a) Supervisor—(1) Meet requirements of section I, A and B; (2) not less than 3 years' experience in physical therapy for crippled children, including field and administrative work.

(b) Assistant—(1) meet requirements of section I, A and B; (2) not less than 2 years' experience in physical therapy for crippled children.

3. Orthopedic school: (a) Supervisor—(1) meet requirements of section I, A and B; (2) not less than 3 years' experience in physical therapy for crippled children; (b) assistant—(1) meet requirements of section I, A and B.

The State and Territorial health officers have made the following recommendations to the Children's Bureau with regard to qualifications of physical therapy technicians employed in the crippled children's program:

April 16, 1936.—The establishment of standards for the qualifications of surgeons, nurses, physiotherapists, and medical social workers based on the requirements of nationally recognized organizations in their respective fields after consultation with the technical advisory subcommittee.

* See Survey of Schools for Physical Therapy Technicians, Reprint from Journal of the American Medical Association, vol. 107, No. 9 (August 20, 1936), pp. 676-679.

STANDARDS FOR HOSPITAL CARE

The Advisory Committee on Services for Crippled Children has made the following recommendations to the Children's Bureau with regard to hospital care under the crippled children's program:

October 10, 1936.—The following should be considered minimum standards for hospital care of crippled children under the Social Security Act: (a) A hospital used for services for children suffering from orthopedic conditions should have on its staff a physician who is certified by the American Board of Orthopaedic Surgery or is eligible for such certification; (b) such a hospital should have on the staff of its in-patient department at least one physical therapist. All physical therapists employed should be registered by the American Registry of Physical Therapy Technicians or eligible for such registration. The physical therapists should be responsible to the surgeon in charge; (c) such a hospital should have on its staff at least one qualified nurse with experience in pediatric and orthopedic nursing; (d) a hospital used for services for crippled children should conform at least with the minimum standards established by the American College of Surgeons; (e) such a hospital should employ on its staff at least one qualified medical social worker; (f) physical-therapy equipment should include a room equipped with at least an exercise table and some form of radiant heat.

April 7 and 8, 1937.—Registration of hospitals by the American Medical Association was recommended as an additional safeguard to the desirable standards formerly suggested by this committee.

The committee suggested that the Children's Bureau should assist State agencies in reviewing the type of care given to individual children in hospitals.

The committee recommended that State agencies be urged to extend convalescent facilities and aftercare services in reducing the duration of hospital care.

December 2, 1938.—That any hospital used by State agencies should provide adequate facilities for the detection and isolation of children suffering from communicable diseases and those contracting such diseases during the period of hospitalization.

That hospitals and convalescent institutions used by State agencies in caring for crippled children should be regularly inspected for fire hazards and should comply with the minimum requirements of the State law with respect to adequate fire protection.

That State agencies should provide a means of reviewing regularly through qualified technical consultants the quality of care being given to children.

The State and Territorial health officers have made the following recommendations to the Children's Bureau with regard to the standards for hospital care under the crippled children's program:

April 16, 1936.—The establishment of standards of hospital care for crippled children based on the requirements of the American College of Surgeons, the council on hospitals of the American Medical Association as shown by information to be obtained from these organizations.

DIAGNOSTIC CLINICS

Two types of diagnostic clinics have been developed, permanent clinics in connection with large hospitals usually in large cities, and, itinerant clinics held at strategic points throughout a State at intervals of from 1 to 6 months to serve the smaller cities and rural areas.

During the fiscal year 1938, 296 permanent diagnostic centers were in use by the official State agencies in 35 States and 572 itinerant clinics were held in 38 States. In 15 States, only the itinerant type of diagnostic clinic was held. The large number of itinerant clinics made it possible for children in many rural areas to have this service.

The clinics are staffed in all cases by orthopedic surgeons who are assisted by different types of workers in different States, such as public health or orthopedic nurses, physical therapists, social workers, brace makers, and representatives of vocational rehabilitation agencies. A few States arrange for a pediatrician to see children at these

diagnostic clinics so that general medical advice may be given to crippled children who do not require hospital care or to those who do not have a crippling condition, but nevertheless are in need of some sort of medical care. Many States report that parents bring children to these itinerant diagnostic clinics to obtain advice about a variety of conditions.

Acceptance of a child for care.—As a rule acceptance for hospital care is authorized by a State agency, or its duly authorized local agent, only after examination by an orthopedic surgeon or by a plastic surgeon if the case falls in that group. A child may be accepted for the State register on the report of a general practitioner.

Eligibility for care is determined on policies laid down by each State. In general the policies have been broad. As a rule, acceptance of children for whom care is sought has been limited only by the State definition of type of case to be accepted and by the medical need of the child. Because of the prolonged care necessary for this type of case, the costs are such that but relatively few families can bear them from current income. In many areas the only facilities for expert diagnosis are those provided at the itinerant diagnostic clinics, and frequently local practitioners refer their patients to the clinics or accompany them to seek the assistance of the orthopedic surgeon at the clinic. Medical social workers assist in diagnostic clinics and give consultation advice to local workers with respect to social problems and assist in determining eligibility for care after the medical need has been determined.

HOSPITAL CARE

Types of hospitals used.—The number and types of hospitals now being used is shown in table 9, which follows, for all States and for each State separately.

TABLE NO. 9.—*Types of hospitals in use under Crippled Children's program*¹

[U. S. Department of Labor, Children's Bureau]

State	Total	Government		Non-profit, voluntary	Proprietary
		State	Local		
United States.....	601	27	62	469	35
Alabama.....	8	0	1	6	1
Alaska.....	1	0	0	1	0
Arizona.....	5	0	3	1	1
Arkansas.....	6	0	1	5	0
California.....	23	1	8	10	1
Colorado.....	6	0	0	6	0
Connecticut.....	9	0	0	9	0
Delaware.....					
District of Columbia.....	5	0	2	3	0
Florida.....	6	0	4	2	0
Georgia.....	12	0	3	6	3
Hawaii.....	7	0	2	4	1
Idaho.....	2	0	0	2	0
Illinois.....	21	1	1	19	0
Indiana.....	4	1	0	2	0
Iowa.....	1	1	0	0	0
Kansas.....	19	1	2	16	0
Kentucky.....	8	0	0	8	0

¹ Classification according to ownership or control as reported in Journal, American Medical Association, March 1938.

² 3 hospitals not listed in Journal, American Medical Association, March 1938.

³ 1 hospital not listed in Journal, American Medical Association, March 1938.

TABLE NO. 9—Types of hospitals in use under Crippled Children's program—Con.

State	Total	Government		Non-profit, voluntary	Proprietary
		State	Local		
Louisiana.....	12	2	0	7	3
Maine.....	4	0	0	4	0
Maryland.....	18	1	1	15	1
Massachusetts.....	15	2	1	12	0
Michigan.....	25	2	3	19	0
Minnesota.....	23	2	0	19	2
Mississippi.....	2	0	0	2	0
Missouri.....	5	1	0	4	0
Montana.....	6	0	0	4	1
Nebraska.....	8	1	1	6	0
Nevada.....	4	0	2	2	0
New Hampshire.....	8	0	0	6	2
New Jersey.....	49	0	3	46	0
New Mexico.....	2	1	0	0	0
New York.....	48	1	5	41	1
North Carolina.....	21	0	1	20	0
North Dakota.....	8	0	0	8	0
Ohio.....	38	1	5	31	0
Oklahoma.....	10	1	0	4	5
Oregon.....	5	1	0	4	0
Pennsylvania.....	46	3	1	42	1
Rhode Island.....	5	0	3	4	0
South Carolina.....	6	0	0	3	2
South Dakota.....	2	0	0	2	0
Tennessee.....	17	0	4	13	0
Texas.....	34	0	3	23	8
Utah.....	5	0	1	4	0
Vermont.....	10	0	0	8	2
Virginia.....	4	1	0	3	0
Washington.....	4	0	0	4	0
West Virginia.....	11	0	1	8	2
Wisconsin.....	2	2	0	0	0
Wyoming.....	1	0	0	1	0

* 1 hospital not listed in Journal, American Medical Association, March 1938.

Of the 601 hospitals approved for use under the various State programs for crippled children 15 percent are governmental, 79 percent are voluntary, nonprofit, 6 percent are proprietary (privately owned).

Method of payment for care in hospitals.—In all cases official State agencies purchase care for crippled children on a per diem rate basis, frequently under a contract or agreement with each individual hospital, whether governmental or voluntary. The contract or agreement indicates the rate of pay and other conditions of acceptance and discharge.

Authorization for care is given by the State agency or a duly authorized local agent on an individual case basis on forms filed with the State agencies.

Notice of discharge is given to State agencies by hospital authorities prior to discharge so that proper arrangements may be made for follow-up care.

Per diem rates of pay are based upon estimates of cost of board, and included are such extras as laboratory service, X-ray and operating-room costs, and cost of plastic casts applied in the hospital. Surgeons' and physicians' fees or salaries, and the more permanent types of appliances are not included, except in the case of certain governmental or university hospitals where full-time surgeons or physicians render the medical services. Systems of hospital cost accounting, such as that suggested by the American Hospital Associa-

tion, which will be uniform throughout a State are being gradually developed and are necessary to determine whether the lower than average rates being paid in some hospitals are sufficient to insure an adequate quality of care and whether the higher than average rates paid in other hospitals are warranted on the basis of care. In some cases insistence by the State agency on certain basic equipment and staff and willingness to pay a per diem rate that would make it possible for the hospital to meet the minimum standards, has improved the quality of care given to all crippled children in such hospitals, not only those paid for from public funds.

Standards of care in hospitals.—Standards of care for crippled children in hospitals depend on equipment, staff, and routine and special services provided. Of the 601 hospitals approved for use, 529, or 88 percent, have been approved by the American College of Surgeons. In 32 States all hospitals either must be approved by the American College of Surgeons, or meet the requirements of the American College of Surgeons. This insures basic standards of general care, such as record keeping, laboratory service, and staff organization.

In 1936 the Children's Bureau Advisory Committee recommended that the minimum standards for a hospital in which an official State agency should place a crippled child for care should be as follows: (a) A hospital used for services for children suffering from orthopedic conditions should have on its staff a physician who is certified by the American Board of Orthopaedic Surgery or is eligible for such certification; (b) such a hospital should have on the staff of its in-patient or out-patient department at least one physical therapist. All physical therapists employed should be registered by the American Registry of Physical Therapy Technicians or eligible for such registration. The physical therapists should be responsible to the surgeon in charge; (c) such a hospital should have on its staff at least one qualified nurse with experience in pediatric and orthopedic nursing; (d) a hospital used for services for crippled children should conform at least with the minimum standards established by the American College of Surgeons; (e) such a hospital should employ on its staff at least one qualified medical social worker; (f) physical-therapy equipment should include a room equipped with at least an exercise table and some form of radiant heat.

The standards of service in many hospitals used by State agencies far exceed these minimum standards. In a considerable number of cases hospitals have raised their standards to meet the minimum in order to be eligible to receive children under the State program, and in some cases hospitals have been rejected by State agencies until they are prepared to meet these minimum standards.

CONVALESCENT CARE AND AFTER CARE

Convalescent care is given in convalescent homes in 82 States, in hospitals in 21 States, in foster homes in 30 States. Other after-care services are provided at treatment and follow-up clinics by orthopedic surgeons, physical therapists, and also in the child's home by physical therapists, public-health nurses, and social workers.

REPORTS OF SERVICES RENDERED

The following table (No. 10) gives the number of children reported as on State registers of crippled children and the services rendered under the State programs for the calendar years 1937 and 1938. It shows the percent of increase in services rendered where record has been kept through both years.

TABLE No. 10.—Crippled children on State registers and services for crippled children—Reported by official State agencies administering State plans under the Social Security Act, title V, pt. 2—Calendar years 1937 and 1938

[U. S. Department of Labor, Children's Bureau, Division of Statistical Research, Washington]

Item	Number reported		Percent change from 1937 to 1938
	1938	1937	
Crippled children on State registers at end of year ¹	184,798	182,826	+24
Services for crippled children:			
Clinic service (diagnostic or treatment):			
Admissions.....	98,777	76,811	+29
Visits.....	200,780	193,404	+39
Hospital care:			
Children under care during year ²	49,308	42,346	+16
Children under care at end of year.....	4,017	3,899	+3
Days' care provided during year.....	1,631,866	1,323,441	+23
Convalescent-home care:			
Children under care during year ²	6,761	5,358	+26
Children under care at end of year.....	1,630	1,054	+45
Days' care provided during year.....	500,841	380,405	+32
Foster-home care:			
Children under care during year ²	2,067	1,141	+81
Children under care at end of year.....	378	18	+100
Days' care provided during year.....	114,240	87,763	+98
Public-health nursing service:			
Admissions.....	64,201	125,531	-----
Field and office visits.....	243,463	202,351	+20
Physical-therapy service:			
Admissions.....	20,288	9,020	-----
Field and office visits.....	249,122	189,147	+81
Social service:			
Admissions to case-work service by—			
Medical social workers.....	18,294	4,773	-----
Other social workers.....	10,412	4,688	-----
Vocational rehabilitation: Children referred for vocational services.....	4,920	3,684	+35

¹ Reports for 1937 were received from 42 States, Alaska, and Hawaii. Connecticut, the District of Columbia, and Texas, although participating, had no registers; Georgia, Louisiana, and Oregon were not participating; and Delaware did not report. For 1938, reports were received from 47 States, Alaska, Hawaii, and the District of Columbia. Louisiana was not participating.

² Reports for 1937 were received from 46 States, Alaska, Hawaii, and the District of Columbia; Louisiana and Oregon were not participating. For 1938, reports were received from 47 States, Alaska, Hawaii, and the District of Columbia; Louisiana was not participating.

³ Total of children under care at beginning of year and those admitted or readmitted to care during year.

⁴ This increase is due partly to the fact that 8 more States reported this service in 1938 than in 1937. However, an increase occurred in more than 75 percent of the States that reported this service for both years.

⁵ Includes only admissions during latter half of 1937. Before that time separate reports on admissions to this type of service were not requested.

NOTE.—These figures are preliminary and incomplete; they include all corrections received through Mar. 31, 1939. Apparent increases from 1937 to 1938 may be due to an increase in the number of States reporting, to a real increase in the amount of service provided, to a difference in the number of agencies and institutions included in the reports, to a difference in the accuracy or completeness of reporting, to statistical errors due to variations in interpretation of terms, or to other factors. The figures on admissions and visits are fairly dependable as an indication of the amount of service provided, but, on account of inconsistencies in the methods used by the States in reporting, these figures should not be used for computing average visits per admission. The figures on services represent primarily those provided by the official State crippled children's agencies but include some services provided by other public and by private agencies.

EVIDENCE OF NEED OF EXPANSION OF CRIPPLED CHILDREN'S PROGRAM

The sum appropriated each year for grants to States for services for crippled children, \$2,850,000, is not sufficient to take care of the

number of children known to be in need because of orthopedic conditions and does not provide for the children crippled from other conditions such as heart disease, defects of vision or hearing, or injuries at birth.

On May 15, 1939, there were 14,573 children on the lists of the official State agencies awaiting hospital care. Of these 12,918 were awaiting care because of lack of funds; 1,253 because of lack of hospital beds; 402 for other reasons. To care for the children awaiting hospitalization at the present time because of lack of funds or lack of beds would cost at least \$3,000,000. The following table (No. 11) shows the distribution by States. It should be noted that there are 230 on the waiting list in New Mexico because of lack of beds.

TABLE No. 11.—Number of crippled children on waiting lists of State agencies as of May 15, 1939

[U. S. Department of Labor, Children's Bureau]

State	Due to lack of funds	Due to lack of beds	Due to other reasons	Total
United States.....	12,911	1,253	402	14,573
Alabama.....	3,189			3,189
Alaska.....	55			55
Arizona.....	79			79
Arkansas.....	255			255
California.....	199			199
Colorado.....	60			60
Connecticut.....			80	80
Delaware.....		2		2
District of Columbia.....		17		17
Florida.....	315			315
Georgia.....	625	75		700
Hawaii.....			18	18
Idaho.....	91			91
Illinois.....	300			300
Indiana.....		206		206
Iowa.....	1,200			1,200
Kansas.....			100	100
Kentucky.....	2,000			2,000
Louisiana.....		200		200
Maine.....		2		2
Maryland.....		29		29
Massachusetts.....		8		8
Michigan.....	0			0
Minnesota.....	23	49		72
Mississippi.....	339			339
Missouri.....	200			200
Montana.....			64	64
Nebraska.....	25	35		60
Nevada.....	24			24
New Hampshire.....	20			20
New Jersey.....	0			0
New Mexico.....		230		230
New York.....	2			2
North Carolina.....	397			397
North Dakota.....	0			0
Ohio.....	750			750
Oklahoma.....		200		200
Oregon.....			65	65
Pennsylvania.....	300	100		400
Rhode Island.....	14			14
South Carolina.....	239			239
South Dakota.....	160			160
Tennessee.....	201	24		225
Texas.....	522			522
Utah.....	325			325
Vermont.....		76		76
Virginia.....	130			130
Washington.....	65			65
West Virginia.....			25	25
Wisconsin.....	494			494
Wyoming.....			50	50

These figures represent only the children awaiting admissions to hospitals on a single day, not the total number in need of care. The State agencies estimated when submitting plans for the current fiscal year that there were approximately 160,000 in need of care for which funds were not available. Many States have not yet developed satisfactory methods of locating crippled children. The number of crippled children reported on the registers of the different States varies from 8.8 per 1,000 population under 21 years of age in North Carolina and 7.5 in Michigan to 0.6 in Georgia and 0.5 in Connecticut. These differences are due more to inadequacy of facilities for registering all crippled children than to lack of crippling conditions in the States with low rates. On the basis of the average rates where location of children is best carried out, it is estimated that there are approximately 365,000 crippled children in this country, all of whom should be on State registers. Table 10 shows that less than half are registered.

NEED FOR CARE OF SPASTIC PARALYTICS

Included in the estimate of the number of crippled children are approximately 36,000 children crippled by injury at birth or from congenital malformation of the brain or other conditions resulting in so-called "spastic paralysis." Care for this group of children is long and costly. It is estimated, however, that with proper care 10 percent may become self-supporting and 22 percent partially self-supporting. These are children who are in special need of care because today there are very few institutions where the proper treatment can whose mentality is not impaired results are sufficiently satisfactory to be given. Where prolonged care has been provided for children whose mentality is not impaired results are sufficiently satisfactory to warrant an extension of the program. At the present time, moreover, there are almost no facilities for the care of the more hopeless cases that must be given custodial care.

CARE OF CHILDREN WITH RHEUMATIC HEART DISEASE

There is no provision today by State agencies administering the program of care for crippled children to provide needed care for children with rheumatic heart disease.

In 1936, 3,333 children under 15 years of age died from heart disease, very largely from rheumatic heart disease.

It is estimated conservatively that there are more than 200,000 children 5 to 15 years of age in the United States who have rheumatic heart disease. Rheumatic heart disease in adults consists in very large part of the damage arising out of disease in childhood. It is estimated that there are 840,000 cases (including children) in the United States, and 40,000 deaths annually from this cause.

Rheumatic heart disease in children requires prolonged care in hospital or convalescent homes, as well as long periods of care in the home. With early and adequate care, however, it has been shown that 60 percent will recover and have no limitation of activity, while another 14 percent survive but have moderate or marked limitation of activity. Facilities for care of these children in northern States are

inadequate, and public resources to pay for care are often lacking. An expansion of the Crippled Children's program to include this type of crippling condition is urgently needed. In his testimony on May 12, Dr. C. G. Grulee, executive secretary of the American Academy of Pediatrics, spoke of this need.

From data in the reports of the Committee on the Costs of Medical Care, it is estimated that the bill each year for the care of individuals with rheumatic heart disease is approximately \$60,000,000. It is further estimated that the loss in wages caused by unemployment due to rheumatic heart disease is \$250,000,000. Much of this loss could be avoided if proper care were given to children in the early stages of the disease.

I am also submitting a statement (exhibit G, which follows), on need for the development of postgraduate centers for the training of physicians, nurses, and medical social workers in the field of obstetrics and pediatrics, and a statement (Exhibit H, which follows exhibit G), of needs for studies, investigations, and demonstrations in the fields of maternal and child health and crippled children.

The basis of all progress in this whole field of health and medical care is the fundamental knowledge we have of causes and methods of prevention and cure. Without research to find the causes and demonstrations to prove the cures and how best treatment may be applied, progress will not be made.

EXHIBIT G.—NEED FOR INCREASED FACILITIES FOR POSTGRADUATE PROFESSIONAL EDUCATION

PHYSICIANS

If high quality of medical services are to be maintained in a community, the physicians must be not only well trained in their undergraduate years, but they must continue to keep abreast of the advances which are continuously taking place in all branches of medicine.

Undergraduate teaching of obstetrics in medical schools in the United States is not satisfactory, according to a statement of the council of medical education and hospitals of the American Medical Association. "The teaching of obstetrics is at a lower level than that of the other major clinical departments. Comparatively few schools offer to their students an adequate practical experience under competent supervision." Approximately 5,000 students are graduated from our medical schools each year, and only 287 positions were listed in the Journal of the American Medical Association, March 1937, which offered a minimum of 1 year's postgraduate experience in obstetrics in approved hospitals, yet over 70 percent of those graduates will include obstetrics in their practices. The opportunities for physicians already in practice to obtain postgraduate training in obstetrics are limited indeed.

Undergraduate teaching of pediatrics and of child-health protection in medical schools is also inadequate. In pediatrics, as in other branches of medicine, the emphasis in teaching and in practice has been on the curative phases with far too little attention paid to preventive aspects. Pediatrics and obstetrics both offer as their greatest contributions the prevention of sickness and of premature death.

Inaccessibility of educational facilities, the cost, reluctance to leave practice long enough to take a postgraduate course and indifference have been reasons given for the failure of most of the physicians who have failed to engage in postgraduate study. In an effort to overcome these difficulties, State medical societies, medical schools, and State departments of health have studied the matter and have cooperated in developing various types of courses designed to stimulate postgraduate study and to bring facilities to the physicians particularly in the rural areas. During fiscal year 1938, over 10,000 physicians attended postgraduate lectures in obstetrics and pediatrics which were held in over 300 communities in 38 States as a part of activities in maternal and

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child health in State health departments with the cooperation of State medical societies and medical schools. There is a general feeling, however, that the lectures to be effective must be combined with clinical observation and actual experience.

There is great need for the establishment of medical centers where the practicing physicians of the area could receive clinical training in modern obstetric and pediatric procedures. Such teaching centers should be equipped and staffed to provide clinical obstetric experience in clinic, hospital, and in home-delivery services; experience in the care of newborn infants; experience in medical care of children, both in-patient and out-patient service, and in the preventive services customarily rendered in a child-health conference. At such centers not only could physicians be given clinical postgraduate training in obstetrics and pediatrics, but nurses, including public-health nurses, could be trained in maternity nursing procedures and care of newborn infants, and medical social workers could be given experience and training in this special field.

PUBLIC-HEALTH NURSES

It was recognized at the outset of the Maternal and Child Health program under the Social Security Act that there was a great shortage of qualified public-health nurses, especially those having special preparation for maternity care. To meet this need in part, the States have granted 844 training stipends for the training of public-health nurses, from funds made available to them from titles V and VI of the Social Security Act.

In addition to the need for training nurses for general staff duty, there has been great need for providing specialized training in obstetrical and pediatric nursing for those nurses who will have charge of home-delivery nursing services and for those who will have advisory and supervisory positions on the State and local staffs.

There is need for more centers where public-health nurses can obtain special experience in maternity nursing including home-delivery nursing experience. There is also need for more opportunities for the study of pediatric nursing including experience with the well child, nursery school, and child-guidance activities, the modern school-health program, and the care of premature infants.

In recent years the academic and professional preparation of public-health nurses in official agencies has been steadily advancing and an increasing number are meeting the requirements of the National Organization for Public Health Nursing. If the results of the program are to be effective, an increasing number of stipends for educational leave particularly in the field of maternity and in the care of infants and children need to be provided as well as well-planned programs of in-service training.

MEDICAL SOCIAL WORKERS

The medical social worker has a great responsibility in connection with the problems confronting medicine today. If she is to meet this responsibility effectively, a sound educational preparation is essential and expansion of present facilities for training is necessary. Stipends for educational leave need to be provided to permit an adequate number of social workers to be given training in the special field of medical social work, and for the purposes of the Maternal and Child Health program special experience in maternity and children's teaching clinics and centers.

There are 11 schools of social work with approved training courses for medical social workers. They are well scattered geographically from Washington to San Francisco and from Minneapolis to New Orleans. Because of expanding medical programs requiring medical social workers, 12 additional schools of social work are planning to offer a curriculum in the special field of medical social work.

Medical social preparation is part of a 2-year graduate professional course leading to a master's degree. This course consists of theoretical instruction and supervised field work. The subject matter includes medical information, community organization for health needs, the social and emotional components in illness, and the nature and methods of medical social case work. For field work students are assigned to a family agency or a child-welfare agency and then to the social-service department of a hospital. In order to qualify for a degree each student must complete a research project.

MIDWIVES

According to the progress reports submitted by the States for the fiscal year 1938, there were 35,274 midwives known to be practicing in various parts of the country. Most of them are ignorant, superstitious grannies, without any training whatever. The State health departments of most of the States having large numbers of midwives are trying to exercise some supervision over their work, but the size of their staffs is insufficient to make it possible to adequately handle this enormous problem. Some of the States are beginning to employ trained nurse-midwives for this purpose, but the supply of these well-trained persons is very small, as there is only one school in the country which trains them, the Lobenstein Clinic in New York City.

There is need for the establishment and maintenance of schools of midwifery, especially for Negro midwives in the South. The graduates of such schools are needed not only to render direct midwife service under medical supervision in areas where there are too few physicians but to serve as supervisors of the work of the untrained midwives who today are delivering nearly one-quarter of a million women each year. When funds are available to pay physicians for obstetric service the number of midwife deliveries will decrease, without doubt, but in certain rural areas trained midwives working under the supervision of physicians will be needed to provide adequate maternity care.

NUTRITIONISTS

Proper nutrition is now recognized as one of the basic health needs of growing children and of pregnant and nursing women. Education of the people in the principles of good nutrition of children and education of all health workers in the techniques and procedures necessary to effectively teach parents what good nutrition means are now recognized parts of any Maternal and Child Health program. To serve State or local health departments most effectively a nutritionist needs not only her basic training, but she must have training and experience in community health work, and an understanding of education, welfare, and other public programs involving service to mothers and children. Special courses of training for public-health nutritionists are being developed. Stipends for the training of these workers are needed.

EXHIBIT H.—NEED FOR STUDIES, INVESTIGATIONS, AND DEMONSTRATIONS

MATERNAL AND CHILD HEALTH, CRIPPLED CHILDREN, AND MEDICAL CARE FOR CHILDREN

Section 541 (b) of the Social Security Act provides that "the Children's Bureau shall make such studies and investigations as will permit the efficient administration of this title, except section 531." During the past 3 years, with the funds available, the Children's Bureau has been able to make only limited studies of procedures and programs undertaken by the States in connection with the Maternal and Child Health services and services for crippled children.

Under the national health bill provision is made in section 541 (a) for "making such studies, investigations, and demonstrations * * * as will improve the quality of the services and promote the efficient administration of this title, except section 531."

In order to be able to assist the States with technical advice related to (1) administration of the program, (2) establishment of standards that will insure high quality of service and care, (3) establishment of methods to assure economy of service not inconsistent with quality of care, (4) the development and standardization of new methods and procedures designed to improve administration or quality of service, the type of work that should be undertaken by the Children's Bureau would fall under the general headings of (1) studies or investigations; (2) demonstrations of procedures and care, to be carried out under longer periods of time in cooperation with the State or local agencies concerned.

Some of the studies, investigations, and long-time demonstrations in the field of maternal and child health and medical care of children that are greatly needed are as follows:

I. MATERNITY CARE

Administrative studies.—A. Studies of the availability of adequate maternity care in small cities and rural communities to determine availability of hos-

pital care, medical service, nursing service; quality of medical, nursing, and hospital service available; need for consultation service of specialists in obstetrics and pediatrics; cost of care; economic needs of families. Such studies should be made in representative areas throughout the United States, to determine the needs of different types of communities and to provide data on the basis of which more adequate programs of care can be developed in such communities.

B. Studies of hospital facilities in cities of all sizes, including quality of care, accounting procedures, duration of stay in hospital, cost of care.

C. Methods of establishing and maintaining standards of care in a complete maternity-care program, to include: (1) Review and evaluation of care now being rendered; (2) methods of establishing and maintaining standards of care in home or hospital; (3) use of standing committees of experts to evaluate care currently.

Clinical investigations.—A. Investigations into the etiology of toxemias of pregnancy, the cause of 25 percent of all maternal deaths in 1937, and the most important cause of death in several States. Such studies should include relation of nutrition to occurrence of the severer and the milder forms of the disease, as well as other biochemical problems. Such an investigation should be made in connection with a demonstration over a period of years of methods of control of toxemia through dietary procedures and the provision of adequate medical care during the prenatal period.

B. Investigations of the prevention and treatment of puerperal infection through chemotherapy. Infections caused 35 percent of all maternal deaths in 1937. Recent use of sulfanilimide and other chemical preparations in recent years has been sufficiently indicative of good results in the reduction of puerperal infection to warrant carefully controlled studies in the use of these drugs on a large scale.

Cooperation with hospitals and investigators in this field in various medical centers would be necessary to carry out such a program of investigation.

C. Investigations of methods of making blood transfusions more readily available in small hospitals and in homes. Hemorrhage causes 12 percent of maternal deaths each year.

Investigations of this sort would involve the development of: (1) Laboratory facilities and procedures; (2) methods of procuring, testing, and making available donors; (3) methods of providing the financial resources necessary to pay for medical and nursing services.

D. Investigation of effect of anesthetics and analgesics on the newborn infant. Such a study should be carried out for a sufficient period of time to compare the effect of different drugs on large groups of infants. Such studies should be made in more than one medical center.

E. Investigation of the value of oxalic acid in the lowering of blood loss at time of delivery.

II. CARE OF NEWBORN INFANTS, ESPECIALLY PREMATURELY BORN INFANTS

A. Clinical investigations of care of prematurely born infants over a period of years, including study of methods of ascertaining and control of environmental conditions.

B. A demonstration of home care in urban communities and in rural areas, including type of medical and nursing service and care needed, methods of providing care, and costs.

C. Investigation of causes of neonatal mortality and morbidity, in relation to maternal care, economic and social conditions. Two years.

III. CARE OF OLDER CHILDREN

Administrative studies.—A. Study of the methods of organization and supervision of child-health conferences and of methods of establishing and maintaining high quality of medical and nursing service rendered.

B. Study of methods of providing for adequate medical services, hospital care, and other facilities for the care of children in smaller cities and rural areas, including so-called well children with physical defects in need of correction, and sick children in need of short-time or long-time medical care; methods of evaluating the need for diagnostic centers, consultation services, and hospital facilities for children in areas not now provided.

C. Investigation of the effectiveness of present methods of treatment of children crippled from birth injuries, children crippled from heart disease; studies and demonstrations of methods for the prevention of deafness among children; studies of methods of locating deaf children or children with defects of vision.

Experience under the Crippled Children's program has indicated that further administrative studies in this field should be made to include studies of intake and discharge from hospitals, studies of hospital sojourn, of after-care procedures, of types of appliances used, of the quality of care being rendered.

The exact duration of many of the suggested conferences and demonstrations cannot be defined at the present time. Many of them should be continued for from 2 to 5 years if results are to be obtained which will influence the procedures now in use or to be developed in the provision of maternity care, and health supervision and medical care of children. It has been estimated that an expenditure of \$500,000 a year over a period of several years would provide for such studies and demonstrations.

Senator MURRAY. That will conclude the hearing today unless there is some other witness present who would like to present a short statement.

Mr. ZIMMER. The Secretary of Labor asked me to come over and make a statement in regard to the bill.

Senator MURRAY. Very well; give your name and representation for the record.

STATEMENT OF VERNE A. ZIMMER, REPRESENTING THE UNITED STATES DEPARTMENT OF LABOR

Mr. ZIMMER. My name is Verne A. Zimmer, Director of the Division of Labor Standards of the United States Department of Labor.

Despite the fact that this statement won't take very long, the Secretary and the Department feel that it is very important. It refers particularly to that part of the bill which relates to allotments for industrial hygiene activities.

The objection is specifically against the provision which gives to State health agencies complete control or supervision over a State labor department in respect of plans and policies for industrial hygiene activities carried on with aid of Federal funds—section 603, subdivision 3, page 19.

The United States Department of Labor believes that industrial hygiene activities, at least in their practical application, are a function properly belonging to the State agency charged with the responsibility for regulating conditions of employment in industry.

By common consent among the several States the duty and responsibility of enforcing rules, laws, and regulations dealing with health and safety of workers is vested in the State labor departments.

I shall leave with your secretary a copy of a digest of the acts of the different States in which that is shown. This shows that with two or three exceptions in which there is joint control by the State labor departments and the health departments, all of the States have placed this function in labor departments, industrial commissions, or similar agencies. While in some State acts the State health departments are given authority to determine effects of employments upon the public health, the health agencies do not and have never been recognized as responsible for inspecting and regulating health exposures due to industrial processes.

PHOTOGRAPH

The Department points out in justification of its position that prior to 1935, when funds were first made available to the State health departments through the Surgeon General, the only existing industrial hygiene activities in the States were carried on wholly by the labor departments, with the single exception of Connecticut—i. e., New York, Pennsylvania, Illinois, and Massachusetts. Only because of the ruling that the Social Security Act of 1935 did not permit allocation of funds to labor departments, both Pennsylvania and Illinois transferred these activities to the State health departments. Subsequently the United States Public Health Service allocated funds to a number of States for the purpose of setting up industrial hygiene bureaus or divisions in health departments.

At one of the previous hearings I heard the representative from the New York State Hygiene Bureau, Dr. Greenburg, make the statement before your committee that his State was unable to get funds for the operation of the bureau in the labor department. The question was asked of the Surgeon General as to whether that was so, and I believe the answer was that there was no application for funds.

Senator ELLENDER. He further stated that under the present bill as drafted any funds allocated for that purpose would have to be under the control of the department established to carry on the work.

Mr. ZIMMER. I will come to that later, Senator. I do know personally, because of my contact with these State labor departments, that had this money been available to labor departments under the social-security grant of 1935 a great number of the States that now have these agencies in the health departments would have had them in the labor department, because it ties in definitely with the apparent will of their legislatures in setting up these rules and regulations and placing in the labor departments. I do happen to know, too, that both Massachusetts and New York, and, indeed, California, attempted to get some money for the labor departments and were not successful.

One of the best proofs, as we in the department see it, that an industrial hygiene bureau can effectively operate in a labor department is the statement submitted by Dr. Greenburg before your committee, perhaps a little bit too modest because he was at the head of it. The fact of the matter is that it is the oldest and the best-equipped industrial hygiene unit in the United States, and it has always been in the department of labor, I think it is significant that the New York State Health Commission in 1932, When Dr. Parran was secretary, in reporting to the then Governor Roosevelt on this subject, not only commended the industrial hygiene activities in the labor department, but recommended that the legislature give its labor department more money to function even more broadly and more effectively.

The United States Department of Labor recommends amendments to this act which will permit allotments for industrial hygiene activities direct to the labor departments, with no control or supervision by public-health agencies, whenever the State in its discretion desires the work carried on in the labor department.

Senator ELLENDER. The State could, under this act and in its plan, provide for that, could it not?

Mr. ZIMMER. Yes; I would like to point out to you there, Senator, though, that although this bill says that funds may be allocated to any agency within the State, there is a qualification.

Senator ELLENDER. You would not want to force the Government to do that, would you?

Mr. ZIMMER. To do what?

Senator ELLENDER. I mean to say, that it has to be done this way or that way. We are trying to keep away from permitting the Federal Government to dictate.

Mr. ZIMMER. Indeed, no; I say to leave that entirely to the discretion of the State.

Senator ELLENDER. The bill so provides, does it not?

Mr. ZIMMER. I am afraid not.

Senator MURRAY. Where is that in the bill?

Mr. ZIMMER. Page 19, subdivision 603 (3). That provides for the administration of the plan by the State health agency or for provision by the State health agency that any part of the plan administered by another State agency—I don't know what you get out of that meaning. As I understand it, in the State of New York, for instance, the industrial commissioner who today operates an industrial hygiene bureau costing in the neighborhood of \$140,000 a year, would necessarily submit to the State health officer of that State the complete detailed plan of just how this money was to be used, and usually the man who controls the purse controls how it shall be used. I do not think much of that particular system. I think in that particular case, and perhaps I am a little bit prejudiced because I was 22 years in that department, I think they are perfectly competent to run that industrial hygiene unit with no control from any other State agency. I feel this very strongly, and I am sure that the Secretary feels the same way because we have discussed it, that very likely a continuous conflict will develop when you take away from the agency enforcing safety and health regulations in the State and vest some of the supervisory authority in another agency.

Senator ELLENDER. Look at page 17, under title VI, beginning at line 2 or 3. The act designates the purposes for which the money is to be allocated to the State agency and among the departments is for industrial hygiene activities. Certainly if the industrial hygiene activities are carried on by the State of New York in a special department, any money allocated for that department would necessarily have to be under the control and supervision of that particular department. The same way in Illinois and two or three other States, wherein those activities are carried on by a specially designated State agency.

Mr. ZIMMER. Yes; but, Senator, I think that is qualified by the section, subdivision 3, on page 19.

Senator ELLENDER. The purpose of that subdivision 3 is that the State is to deal only with one agency; it must not go, for instance, for tuberculosis to an agency established for that, or for malaria to go to another agency. The idea, as I conceive it, is that they will all work through the health department. Each of these departments in a State, if they are to be separate departments for each of these facilities, will make their recommendations and get whatever

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money is appropriated or allocated to those States, and it will necessarily have to be administered by the agency established for that purpose. I do not think there is any doubt about it.

Mr. ZIMMER. Then would you say in the State of New York it would have to be administered by the State health department?

Senator ELLENDER. No; not necessarily.

Mr. ZIMMER. Does not this make it necessary for the State health service there to supervise it? It says so. That any plan that is presented for the industrial hygiene activities among other things must be supervised—either administered or supervised. That is what it says.

Senator ELLENDER. Who supervises it now in the State of New York?

Mr. ZIMMER. The commissioner of labor.

Senator ELLENDER. The health department has nothing to do with it?

Mr. ZIMMER. Absolutely not, has nothing to do with it and never did have in 25 years, and, as I just read to you, so far as 4 or 5 years ago was concerned, the health department did not recognize that it needed to do any such thing as that. I am glad you brought up one point, Senator. If I may divert just a minute—

Senator ELLENDER (interposing). Just before you go into that. What objection would there be then to have the bill provide that the allocation of the funds may be done through the department of health, let us say, but its spending shall be under such a department as has been established by the State for the purpose, because the thing is, I believe, that this bill ought to be so drafted that the Federal Government is going to deal with as few agencies as possible throughout these various States of the Union. We are trying to limit it to one rather than to have the Federal Government have to go to maybe four or five different departments in a State.

Mr. ZIMMER. Well, I think at least from our own reasoning, Senator, the thing is simplified. We think that the industrial hygiene is a segment of the State agency having to do with the control of the health of workers in industry.

Senator ELLENDER. And you would want that agency to deal with Washington direct?

Mr. ZIMMER. I think so.

Senator ELLENDER. And then if there is another one that deals with tuberculosis in the same State you would want that agency to deal with Washington direct; and malaria—

Mr. ZIMMER (interposing). I am not speaking for those.

Senator ELLENDER. I know, but the others are just as much entitled to that as you are.

Mr. ZIMMER. I suppose so.

Senator ELLENDER. So that you can readily see where that would lead us to.

Mr. ZIMMER. There is a difference in policy, Senator, as between the health department and the labor department, in a number of States that has come to our attention, and which I think is most disturbing. Let us take the case of Connecticut, for instance, where, before the Social Security Act of 1935 their industrial hygiene unit was in the health department, but under what conditions? Here is

what they provided in that State by statute, that no information gleaned by the industrial hygiene bureau, paid for by the State, could be used in connection with a workman's compensation claim, also a function of the State. This means that one particular hand of the State government can not come to the aid of the other one. I think that important because in my own experience in administering a workmen's compensation act, there were very few cases in which we did not have occasion to call upon the staff of the industrial hygiene unit to determine whether a worker sustained his disability, and the only way to determine that in most cases is to send a staff member with the right to enter that plant and determine precisely what the exposure was when that man was working. Unless they have that, your worker is absolutely helpless if the case is contested.

Senator LA FOLLETTE. But from an administrative standpoint, don't you think there would be more confusion and overlapping and conflict unless the various programs that are contemplated in this legislation would have to come up to some single agency in the State in order to be coordinated and integrated before submission to the various departments or agencies of the Government that are to allocate these funds?

Mr. ZIMMER. Yes, Senator; I do, and I think the labor department is in the best possible position to appraise what those standards of attainment should be in connection with industrial hygiene. I do not agree with a great deal of the testimony that I have heard presented to this committee that this is essentially a medical question. Industrial hygiene in its practical aspects is essentially an engineering proposition. A number of occupational diseases in your own State, for instance, have been pretty well controlled, including silicosis. How? Not by the use of the industrial hygiene bureau or medical staff, but by engineering application. The same thing applies in a State in its everyday operation. An industrial hygiene bureau can be of most use to its State by being integrated with the inspection authority; in fact, that is the origin of the industrial hygiene bureau in New York. They were once medical factory inspectors and later took on the dignity of a separate unit, and gradually emphasized the educational function. I do not want to disparage the educational work. It is important. But in my opinion it is not so important as the every-day job of inspection, or regulation, and of enforcement. That is one point that we want to present here.

Senator ELLENDER. Why would it not be better, as far as the administration in Washington is concerned, to let the States iron out their differences before they come up to Washington for an allocation?

Mr. ZIMMER. I think that is right, Senator.

Senator ELLENDER. Not if we follow your suggestion, because the public-health department could make a request for a certain thing, and the hygiene department may make another, and the malaria, the pneumonia, the cancer, and the mental health departments still others, and we would probably have quite a lot of confusion.

Mr. ZIMMER. I can answer that very well by just reciting what we think a competent industrial hygiene bureau must be equipped to do,

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and if they do not do it, I do not think that they should be given any funds.

Senator ELLENDER. You want to take them out of the bill?

Mr. ZIMMER. If they do not come up to a certain standard and if they do not function in the direction that the department thinks is proper for an industrial hygiene bureau.

Senator ELLENDER. Why would it not be satisfactory simply to state that any funds that are allocated, let us say, for hygiene activities or for mental health shall be under the direction and shall be spent by such an agency as is created in the State for that purpose? Would that not satisfy your views?

Mr. ZIMMER. In principle, provided that in its spelling out, that there was not what I would call a sleeper such as is contained in this one, which I think is very bad.

It would take me only a minute to tell you how an industrial hygiene unit should function, and it is my opinion that they should not get any money unless they function 100 percent.

(a) First, it must study and determine what health hazards exist in places of employment and determine the most effective methods of eliminating or reducing hazardous exposure. The carrying on of such studies only by invitation of management will not serve the purpose effectively. It must be integrated with and work in close cooperation with the regular inspection agency which has the legal right of entry.

(b) The industrial hygiene unit must be equipped with technicians who can give regular factory inspectors assistance in appraising the extent of hazards due to atmospheric contaminants, testing the effects of solvents, and poison substances, and generally appraise hazards which may exist unknown to the lay inspector.

(c) The industrial hygiene unit must be available to the State agency charged with the duty of adjudicating workmen's compensation claims. In this field, it must be ready to go into plants or places of employment to determine precisely the nature and degree of the hazard allegedly causing disability in a claimant for workmen's compensation benefits.

(d) The foregoing duties must not be subordinated to exploratory research or survey work, but the hygiene unit must function primarily as an adjunct or aid to the agencies enforcing labor and workmen's compensation laws.

(e) The industrial hygiene staff members and experts must be available as witnesses when needed in the prosecution of violations of existing regulations and as witnesses in workmen's compensation claims.

(f) The industrial hygiene staff should be able to assist in the formulation of industrial codes and regulations or labor laws needed for protection against hazardous exposures. For this further reason, also, there must be close integration with the labor departments.

(g) The industrial hygiene unit should carry on a continuous educational program, issuing pamphlets on industrial-health hazards and methods of prevention, consulting with and advising management, giving information to labor on hazards encountered in employ-

ment, and on part to be played by workers in prevention of occupational diseases.

Senator MURRAY. Management has generally been very much opposed to a lot of the activities of an industrial hygiene department in many instances, has it not?

Mr. ZIMMER. I should say so, Senator. In the years that I was in that work I never had a plant management meet me with open arms when I went in to pass out some orders or regulations. However, in many instances industrial outfits or organizations do welcome advice and counsel in the manner in which they can prevent these health exposures.

Senator MURRAY. But they go to the State legislatures and vigorously oppose appropriations for the prevention of silicosis, and so forth, and claim there is none existent, and that they will take care of it themselves.

Mr. ZIMMER. You must remember that regulation means expense. One organization in Senator La Follette's State spent \$170,000 to prevent silicosis in that plant.

I think that unless these hygiene units set up in the States by the aid of Federal money can meet those specifications that I have outlined that they should not get any money.

Senator ELLENDER. Are there any States that have laws measuring up to the specifications that you have just mentioned?

Mr. ZIMMER. Yes. Those functions that I have just outlined are performed by Dr. Greenberg's unit day after day in New York State. That is because the unit is in the labor department, and all the commissioner of labor has to do if there is any hesitancy about it is to say, "You go down and assist the workmen's compensation," or "You go out and assist the factory inspector," or "You assist the code committee on these rules." Actually it has been done so long it is not necessary to insist upon it, but it is part of the routine work.

Senator ELLENDER. Is New York the only State that you know of that has that?

Mr. ZIMMER. That performs all of these functions?

Senator ELLENDER. Yes.

Mr. ZIMMER. Well, I think it is when you come to include the workmen's compensation administration; yes.

Senator ELLENDER. According to you, then, all the other States should not be given any money for that purpose except New York; is that right?

Mr. ZIMMER. They can easily come within that, Senator.

Senator ELLENDER. You mean by passing a law?

Mr. ZIMMER. No; they do not have to pass a law. They can just take it over as their duty. You do not need to pass a law in order to require industrial hygiene staff members to come in and assist on a compensation case.

Senator ELLENDER. In order to go into a man's factory for certain things you would not have to have a law for that purpose?

Mr. ZIMMER. No; because all but one or two of the labor departments in this country have that police power. They have it in your State.

Senator ELLENDER. But they have a law to that effect.

Mr. ZIMMER. The fundamental law setting up a labor department usually includes the right of entry, and, incidentally, that is what the industrial hygiene units have not got, in many instances, in the health departments.

I want to call your attention before I step out of this picture to a resolution introduced and passed last November at the fifth annual-conference on labor legislation here in Washington. This is it:

Resolved, That in furtherance of centralized administration of laws for the protection of workers this conference recommend that industrial hygiene activities be centered in the agency of the State which administers labor laws, and that any funds appropriated by the Federal Government for assistance in this field be made available to the State labor departments meeting suitable standards as to organization, effectiveness, and program.

We think that the Department of Labor is in a position to evaluate whether or not they meet those standards. I should like to leave that digest with you.

Senator MURRAY. Does the Department of Labor intend to present any other statement or any other witness here in connection with the bill?

Mr. ZIMMER. I think not, Senator.

Senator MURRAY. Have you any amendments to propose?

Mr. ZIMMER. We have thought about some.

Senator MURRAY. I would suggest that you formulate and present what you think would be proper to make the bill provide and meet those problems the way you think it should.

Mr. ZIMMER. I would be glad to do that, Senator. Shall we give it to you?

Senator MURRAY. Yes; for the consideration of the committee, of course.

We will adjourn now subject to the call of the Chair.

(Whereupon, at 3:45 p. m., subcommittee adjourned subject to call of the Chair.)

TO ESTABLISH A NATIONAL HEALTH PROGRAM

THURSDAY, JUNE 29, 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 Allen J. Ellender presiding.
Present: Senator Ellender (presiding).

Senator ELLENDER. The first witness this morning is Dr. Kingsley Roberts.

Dr. Roberts, will you give us such descriptive matter about yourself as you desire for the record?

STATEMENT OF DR. KINGSLEY ROBERTS, NEW YORK CITY, DIRECTOR OF THE BUREAU OF COOPERATIVE MEDICINE

Dr. ROBERTS. My name is Kingsley Roberts, my address is 5 East Fifty-seventh Street, New York City. I am at present Director of the Bureau of Cooperative Medicine at the same address, and I am appearing in response to a telegram from Senator Murray. I practiced as a practicing surgeon in New York for 15 years. I am a graduate of Jefferson Medical College, Yale Sheffield Scientific School, and have been studying the question of medical economics intensively and exclusively for the past 4 years.

It gives me great pleasure to appear before this committee in response to the telegraphed request by Senator Murray on June 22, 1939. I feel that my experience of 15 years in the practice of surgery in New York, as well as my studies in methods of extension of medical services to those in the middle-income groups as well as to the needy and the medically needy render me qualified to speak on this subject.

It is of vital importance that the dollar raised by taxation which is designated for expenditure in the future for the health of the people should purchase as much medical care as is possible. After a study of the Wagner Act it strikes me that there are certain very definite features of the bill which do not incline toward a favorable solution of this original problem.

First. The administration of the act should, in my mind, be vested in one authority rather than the three now specified. This authority should be, or should closely resemble, a secretariat of health as a cabinet officer.

Second. It has been found that where funds are allocated to the study or cure of specific disease the results have not been as good medical care, or as efficient health service, as when funds are allocated for general care of people. In other words, funds set aside should be set aside for the broadening of general medical facilities rather than

for the alleviation of specific conditions such as cancer, tuberculosis, etc., as specified in the act. Maternal welfare and child welfare is only a part of general medical care and I can see no reason why they should be selected as a specific topic.

Third. Medical care can be most effectively and efficiently administered to large groups of the population when health conservation is the primary motive of the system employed. Money spent in the prevention of disease is money which is saved in the cure of disease. Health education of the public is of vital importance to the effectiveness of any broad public-health policy and there is no provision for this in the act.

Fourth. In my experience, the distribution of public funds to the medical profession, as it is now generally so loosely organized, is not the most effective manner in which to purchase medical care. Therefore, I believe that the act should lay more emphasis upon the development of health centers which will be established around correlated, coordinated groups of physicians under competent, professional administration. This method, known as group medical practice, has proven a very efficient means for distributing medical care.

Senator ELLENDER. What would be the function of these medical centers that you speak of?

Dr. ROBERTS. The distribution of general medical care. Instead of just being individual physicians as they are now working in their own offices, each with his own equipment, each with his own problems, you put the doctors into groups just as you put lawyers into groups in law firms in partnerships.

Senator ELLENDER. Would you have them work from a hospital?

Dr. ROBERTS. Let us call it a medical center. A hospital, after all, is only a part of a medical center. You would have to have a diagnostic clinic, a place for outpatient care, a place for education and study, and organized as medical centers rather than just hospitals. A hospital is a place to go to when you are ill. I am looking at these places as places from which health will be distributed.

Senator ELLENDER. You mean preventive medicine?

Dr. ROBERTS. Both preventive and curative.

Senator ELLENDER. To what extent would you have hospital facilities at these centers?

Dr. ROBERTS. As much as needed. Plenty of beds and operating rooms and laboratories and all that sort of thing, but they would be places from which health is distributed rather than places for people to go to when they are sick. Perhaps I do not put the accent correctly.

Senator ELLENDER. How would you take care of the needy in sparsely settled communities scattered throughout the Nation, if your method of centers as you indicate would be followed?

Dr. ROBERTS. The distribution of medical centers and the placement of medical centers, must of course be a matter of careful study. We are improving roads and our transportation facilities are getting better, and areas in the country which are really isolated from medical facilities are growing less and less, and I would rather see an extensive system of ambulances used to bring patients to the medical centers rather than to build a lot of medical centers.

Senator ELLENDER. How would those medical centers be maintained? By funds from the Federal Government supplemented with those furnished by the States?

Dr. ROBERTS. Yes; they also could be maintained partially by a subject that I would like to bring up next, which is the question of having the Government help voluntary health organizations who themselves are in a position to immediately set up such centers.

Senator ELLENDER. What do you mean by that?

Dr. ROBERTS. May I go on?

Senator ELLENDER. Just one more question. How would the medical fees be paid for? Out of this fund at regular prices, or would there have to be some understanding between the local communities and the physicians?

Dr. ROBERTS. Of course, I believe that the most efficient method of paying for a physician is to pay him on full time rather than the fee for service basis. My idea would be the fees of hospitals or medical centers would be—they would be staffed by physicians who were on full time. Certain physicians who would be paid by funds as the bill suggests, and made up to a certain extent by the Federal Government funds and the others by State funds.

Senator ELLENDER. What class of people would you take care of in the hospitals?

Dr. ROBERTS. In some cases, you would have to take care of all of the people because they would be the only sources of medical service for the community, but the answer to your question is really for the medically needy and the needy. But in some instances, these health centers would undoubtedly be so placed that they would be the only hospitals in the community; therefore you would have to be able to take care of all of the community in them, not necessarily without charge. Those who could afford to pay would pay.

Senator ELLENDER. You would charge according to the ability to pay?

Dr. ROBERTS. Yes. To continue:

Fifth: Nowhere in the records of this country nor any country abroad are there any data which will enable us to accurately estimate the cost of the administration of a broad community health project, and such figures are of great importance.

I would like to emphasize that, that nothing that I have to say is predicated on any foreign experience and my belief is that we in America now have got to go ahead and make our own mistakes. We have to lay out our own pattern. I don't care what has happened in England or Russia or any place else, as I believe that is really of no great importance except to show us what not to do.

It is my belief that provision should be made in the act for the encouragement of voluntary health protective mechanisms now in existence and later to be formed, and that funds should be allocated to these institutions for the purpose of expanding their activities in return for having their experiences made available to the administrators of the act.

In other words, at present you have a means whereby you can encourage voluntary action which will establish costs, and when it comes right down to it, that is what we actually have got to find out—how much does it cost to take care of the medically needy and the needy? We don't know; you don't know and I don't know. The only way we can find out is by taking care of large numbers of people, and until such mechanisms are established under legislation you have the possibility of encouraging their establishment on a voluntary basis.

These voluntary health agencies at present operate only in the middle classes, who can afford them, and it is a matter of great importance that they should be made more effective and economical in order that they may be enjoyed by those in the lower income brackets.

It is very probable that a most effective method for the distribution of medical care to the needy and the medically needy might be the subsidy of these voluntary organizations for the care of those who cannot afford to pay the dues.

In other words, as I hinted a moment ago, if you have a voluntary health organization set up in a community—let us think of the country now and not necessarily in the cities all the time—then the most effective way to take care of the medically needy for that location is not to set up a tax-maintained medical mechanism, but to subsidize the existing voluntary mechanism to take care of the needy.

Senator ELLENDER. How would those voluntary organizations be created? Who would promote them?

Dr. ROBERTS. Around existing social forces such as unions, fraternal organizations, groups of employees of a common employer, and so forth.

Senator ELLENDER. Private hospitals?

Dr. ROBERTS. Private hospitals. Private doctor groups. There are many nuclei from which they can come, but the most logical one, I believe, is labor. Take the word "organized" out of that. The workingman, the man who is dependent upon his ability to earn his living by being in good health.

Senator ELLENDER. How do you think the doctors of the community would look upon such a plan?

Dr. ROBERTS. Perhaps I can speak with as much authority on that as anybody. In the first place, the members of organized medicine, the presidents of the county societies, and representatives of the American Medical Association, and so forth, such people as you have had here, some of them, before this committee, look upon it in horror. But there are a great many physicians who would look upon it with a much more calm and sensible attitude, and would probably help.

Senator ELLENDER. If the plan that you have indicated just prior to this—that is, voluntary organization—were in effect, and you would supplement it with these voluntary organizations, what group of people would there be left for the remaining physicians in a community to treat?

Dr. ROBERTS. About 10 percent of the population, and that is about all that can afford to pay their medical bills the way they are rendered now.

Senator ELLENDER. In other words, let us say in a community like mine in south Louisiana, where we have a parish, or a county as you would call it, with a population of 35,000 people in round figures, and I think in the neighborhood of 12 physicians.

Dr. ROBERTS. How many are there in the parish? I did not get that.

Senator ELLENDER. Thirty-five thousand.

Dr. ROBERTS. Thirty-five thousand, with 12 physicians?

Senator ELLENDER. Eleven or twelve physicians. If such a plan as you have just indicated—the organization of a medical center—supplemented by these voluntary organizations were effected, I am just wondering how the majority of those physicians could live from

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the fees of about 3,500 people? Have you had much experience along that line, or have you any data?

Dr. ROBERTS. Of course, 11 physicians for 3,500 people is too many physicians anyhow, taking it by and large.

Senator ELLENDER. About 35,000.

Dr. ROBERTS. I thought you said 3,500.

Senator ELLENDER. Thirty-five thousand in all.

Dr. ROBERTS. With thirty-five thousand people, 11 physicians are too few physicians.

Senator ELLENDER. Just a minute. I am a little in error there. I forgot several others. There are about 18 or 20, as I now recall.

Dr. ROBERTS. Studies all over the country go to show that there is about 1 physician for every 850 people, approximately. One thousand would be the maximum. About 35,000 people that you are talking about, if they follow the usual economic distribution—of course in some particular parish the conditions might be very different—at least 50 percent of them are not able to pay medical bills at all under any circumstances. Probably 30 or 40 percent of them belong to what we call the middle-income group or the great American middle classes, and, if given a chance to spread their medical costs, would be medically self-supporting. Then there are probably 10 percent, the upper crust, who are able to pay their medical bills at the present time. That is about the distribution of the economic groups as we find it all over the country, the idea being if you had a central health center established, it would be subsidized by tax-maintained funds to take care of this 50 percent who are truly medically needy. This voluntary type of organization, which those who could afford to could join, and would thereby become medically self-supporting and not dependent upon tax-maintained medical facilities, and it would offer its facilities to the upper 10 percent if they choose to have it.

In other communities where you have more people, and in each one of these economic groupings, there is a greater population, and it might be advisable to set up separate institutions for the care of each particular class, but I am thinking of it in just the terms of the people, the terms of the nonurban community, or rather the rural type.

Senator ELLENDER. Have you made a study indicative of what number of people in this country are really in need of medical care?

Dr. ROBERTS. Not in a formal way; no. I am rather willing to accept the figures of the Inderdepartmental Committee of Miss Roche.

Senator ELLENDER. About 40 million, I think it was?

Dr. ROBERTS. Yes.

Senator ELLENDER. You do not mind being interrupted?

Dr. ROBERTS. No; I am perfectly glad to answer questions.

As I have said, it is very probable that a most effective method for the distribution of medical care to the needy and the medically needy might be the subsidy of these voluntary organizations for the care of those who cannot afford to pay the dues. As suggested in my report of the selected areas of the Southern Appalachian coal fields submitted in the spring of this year, I believe that certain steps should be taken in coordination with existing social forces for the rapid establishment of voluntary health protective mechanisms which can be set on almost as broad an actuarial base as that made possible by compulsory health insurance.

You see, the trouble with most voluntary health activities is that they have difficulty in getting on a broad actuarial basis. After all, it is the application of the insurance principle on a broad actuarial basis which is necessary, but in this particular instance through the efforts of organized labor, you have a chance to step into a particular position and set-up, which could be a very interesting thing.

In regard to the compulsory health insurance, I quite agree with the sponsors of the bill in the fact that there is nothing in it which makes State action in this matter obligatory. Compulsory health insurance and the provisions of medical care to the needy are two entirely separate projects. I think that it is very foolish to confuse the two systems.

I am inclined to agree with those critics of the bill who feel that it has not specifically provided for the utilization of existing hospital facilities, but I wish to add that such utilization of existing hospital facilities should only be under conditions and at prices which are justified by careful local studying. Once more I refer to the fact that there is no data available on local medical care and hospitalization costs that is not subject to considerable question. I repeat that in the matter of hospitalization, as the in matter of general professional care, experimentation by encouraged voluntary organizations is strongly indicated.

Insofar as the Wagner bill, S. 1620, follows the general suggestions made by the interdepartmental committee at the National Health Conference last July, I feel it is laudable. But a national health program that is going to be effective and efficient will contain many features not considered in the act. I think that the bill is particularly weak in its provision and recommendation of the training of personnel and the support of medical education.

It is my feeling that the attitude of the American Medical Association in opposing this bill is injudicious because it is not accompanied by any constructive suggestions.

I feel that the attitude that the Committee of Physicians for the Improvement of Medical Care, Inc., is taking as shown in their publication of May 5, 1939, deserves most careful consideration.

Because we are in a new and uncharted region, we will undoubtedly make mistakes—the sooner they are made the sooner corrected.

Senator ELLENDER. Thank you very much.

The next witness is Miss Florence Greenberg, Miss Greenberg, will you give your full name and such descriptive matter as you wish for the record?

STATEMENT OF FLORENCE GREENBERG, REPRESENTING CITIZENS COMMITTEE FOR ADEQUATE MEDICAL CARE

Miss GREENBERG. My name is Florence Greenberg of the Citizens Committee for Adequate Medical Care. I wonder if I could not be permitted to complete my statement?

Senator ELLENDER. Certainly.

Miss GREENBERG. It is just a year ago that I came before the National Health Conference to represent the Councils of Auxiliaries of the Steel Workers Union of the Chicago district. At this time, I speak not only for them but for the vast movement for health which has developed out of the needs of the people.

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I am here to speak for those in Chicago, and Illinois, who have in the past year voiced their endorsement of a National Health Program. Among the organizations who have done so is the Citizens Committee for Adequate Medical Care, of which I am vice chairman, which was formed by those who firmly believe that a government is responsible for the health of its citizens. This committee held a conference in Chicago on the problem of sickness at which over 700,000 people were represented. I am also speaking for the workers in our labor unions who have come to believe that national legislation for the betterment of health is a thing of most vital importance to working people and to their families. The 20,000 members of the Packinghouse Workers Union have asked me to represent them here, as have the 30,000 members of the Farm Equipment Workers, the 5,000 members of the International Ladies' Garment Workers Union, and the hundreds of thousands members of the Steel Workers Organizing Committee, the Carpenters and Joiners Union, and others.

I am also making known here the deep convictions for the Wagner national health bill of the Chicago Association of Medical Students, the Consumers' Clubs, the National Negro Congress with its 20,000 members, the 18,000 members of the International Workers Order, the National Lawyers' Guild, various social work organizations, settlement houses, the Industrial Clubs of the Y. W. C. A., and many others.

I take the time to speak of these organizations of people because I want to make it clear that the question of adequate medical care is rapidly becoming an issue of major importance in Chicago, in Cook County, and Illinois.

That during the recent April elections in Chicago there was hardly an aldermanic candidate who stated that he stood for the betterment of the lives of the people who did not have a health plank in his program. This has never before happened in any Chicago election. That "A Better Chicago League" conference representing hundreds of thousands of people unanimously endorsed the Wagner national health bill. That the recently held Illinois conference for social legislation at which Mayor Kelly of Chicago and the Lieutenant Governor of Illinois spoke and at which delegates representing over 400,000 people from all parts of the State participated added its unanimous endorsement.

I have with me statements of endorsement, or their names as sponsors, of the Wagner national health bill which I shall leave for the record by civic, political, and labor leaders of Chicago, such as Mr. W. F. Levander, president, Amalgamated Association of Street & Electric Railway Employees of America; Mr. Albert Matha, president, Elevator Operators & Starters Union; Mr. Ishmael P. Florey, secretary, Joint Council, Dining Car Employees Union; Mr. Gunnar Hallstrom, president, Patternmakers Association; Mr. Harry Deck, executive director, Chicago Labor's Non-Partisan League; Miss Grace Stafford, metropolitan health secretary, Y. W. C. A.; Mr. H. R. Crawford, health director, Wabash Avenue Y. M. C. A.; Alderman Paul Douglas, Alderman Earl Dickerson, and Alderman Oliver Grant, as well as Miss Charlotte Carr of Hull House, Dr. Philip Seman of the Jewish Peoples' Institute, Dr. Charles Bacon, Dr. Rachel Yarros, Dr. Margaret Kunde, and many others.

Chicago and Illinois are indeed fertile ground for widespread sentiment for the Wagner national health bill, despite the fact that the American Medical Association has its national offices in Chicago, and despite the fact that those who support the bill have no source of incomes like that of those who oppose the bill apparently have found in the Gannett Committee.

The movement for health in Chicago and Illinois has been completely supported by those groups who are supporting other measures, and they have been able to give it very little money, otherwise I am sure that I would be able to bring to you the support of many other organizations.

It has been said that large metropolitan areas are better provided with free health facilities than small towns. This may be true but then the small communities must indeed be in very bad shape. The city of Chicago, which is one of the largest industrial centers of the world fits very well into the health picture that has been painted by the Government technical committee. With a population of well over 4,000,000 people there is not a single city or county public general clinic for the ambulatory sick. The private free clinics which take care of the poor people who are sick depend almost entirely upon an unpaid medical staff who must spare hours from their private practices when they can. These clinics are very overcrowded especially for the past 10 years when the number of free visits have increased by 300 percent and hardly any additional facilities have been provided. X-ray, laboratory, and other departments are booked as far as 6 months ahead. Sick women, children, and old men travel 27 miles or more to these overcrowded private clinics, since most of the clinics are located within 4 miles from the Loop and are thus great distances from outlying areas, and wait hours, often standing up, before they are seen. Then many of them may be told that the clinic is so busy that it accepts emergencies only. Of course, if they become sick enough, maybe they are taken to Cook County Hospital in a police patrol wagon.

And what about hospital care? Some people have been on waiting lists for free hospital beds for a year or more. Yet there are plenty of hospital beds in Chicago—but not enough free ones. When in Chicago over 1,137,000 people are in families that are estimated to be on relief or to earn under \$1,000 a year, surely one public general hospital for the entire county and not one single city hospital is not enough. And about ambulance service: There are two free ambulances, operated by a private ambulance board. If you are sick and poor in Chicago, the city provides for a police patrol wagon to transport you to a hospital, unless you are fortunate enough to have a contagious disease or a premature birth.

Of course, this sometimes results in almost humorously tragic situations like this picture from the Chicago Times [indicating]. This occurred during the elections. This man died because it was 35 minutes before the accident squads could reach him, and the chief reason for the delay was that the accident squads were detailed to election duty on this day.

Let us look at Chicago's facilities for tuberculosis, and this is an extremely important disease in Chicago because of her industries, both the steel mills and the stockyards, and we find that despite the high death rate due to this disease, especially among its Negro population, and that according to accepted standards, there should be over

4,000 free beds, yet there are only a little over 2,000 beds. Especially is the care of the Negro tuberculosis patient sadly neglected. While one-third of the deaths in 1937 in Chicago were among the colored people, there is only one-eighth of one bed per tuberculosis death among them whereas standards call for at least two beds per death. It is important to note, however, that Illinois is among the 12 States that has no State tuberculosis sanatorium despite its relatively high tuberculosis death rate. And speaking about Illinois, for those who say that the Social Security Act does little, let me point out that as Dr. Richardson pointed out, that the Illinois conference for legislation showed that 80 percent of the counties in Illinois had no public-health unit. These are preventive units. And that 20 units which do exist are existing because of the Wagner Social Security Act.

As for Chicago again, another important fact is, there is only 1 public nurse per 10,000 population, although according to a reasonable standard there should be 1 nurse for at least 3,000 population. As for district health centers, preventive health centers, as yet they are castles in the air for Chicagoians; there is not a single one in Chicago.

Dental care is indeed pretty tragic. One of the teachers said to me that if the children in his school did not get dental care soon, the majority of them would be needing plates by the time they finished the eighth grade. As for the adults, as one man said, they won't fill them—meaning the teeth—they pull them when they hurt them, and they cannot get new ones. Imagine if you will a young adult man or woman, let alone an older adult, looking for a job with most of their front missing, let alone all of their teeth. They are practically unemployable as far as most jobs are concerned, and yet I do not believe there is a single agency in Chicago that has had any such work done—perhaps some for relief patients and then not very much is done.

If these facts are examined, you will see why, when I came back from the National Health Conference, where I had presented from my own experiences, as a member of the organized womenfolk of steel workers, stories of the desperate need of medical care, stories of destitution caused by sickness—where in the name of the people who live in slums and hunger, in the name of those people who work in industries where life is often cheaper than low wages or healthful working conditions—in the name of those people who are sick because they are unemployed and because the unemployed are not expected to need good food or enough food—yes, in the name of those Americans who are being denied the right to life and to health because they are poor, I, among others, urged that something be done by the Federal Government when I came back. My voice was joined by thousands of others in asking for the human right to all that science can offer in the way of adequate medical care.

I think we are beginning to do away with the idea that only the doctors are concerned with health, and to realize that it is highly possible that the people who know they cannot afford medical care when they are sick are also concerned about it, and perhaps even more so than the doctors.

This is my message to you. The people of Chicago and Illinois need and want the added medical care that the Wagner National Health Bill can bring them.

Before I left my organization, I talked over whether or not we should present or discuss any possible changes in the Wagner health bill, and we decided that what we wanted to do most was to leave a message here that there is support for the Wagner health bill. Certainly if the bill as a whole is good, amendments and changes can be relatively easily worked out. I thank you.

Senator ELLENDER. You have made an astonishing statement about your city, Miss Greenberg.

Miss GREENBERG. Yes.

Senator ELLENDER. How many people do you represent today, who are members of your own organization and those whom you are representing? Just in round figures, have you any idea?

Miss GREENBERG. Well, this is what we do represent. We represent the people who are directly affiliated with the citizens' committee for adequate medical care, and we also represent organizations who are taking up the close affiliation in the meantime that endorse the Wagner health bill. And the organizations I have mentioned have given me permission to speak for them.

Senator ELLENDER. I mean the number of people involved? That is what I have in mind.

Miss GREENBERG. I would have to add them all up.

Senator ELLENDER. They go up into the hundreds of thousands?

Miss GREENBERG. Yes; who have endorsed the Wagner health bill at our request.

Senator ELLENDER. Did I understand you correctly when you said that neither the city of Chicago nor Cook County had general hospitals that were maintained by the State or the county?

Miss GREENBERG. No. What I said was this, that this is a city of 4,000,000 people, with a great many of them with incomes under \$1,000, and we have only one general public health hospital for the county and none for the city.

Senator ELLENDER. How many beds are there in that general hospital?

Miss GREENBERG. I have forgotten, but I think it is around between three and four thousand beds.

Senator ELLENDER. Is that entirely maintained by the county?

Miss GREENBERG. That is entirely maintained by the county.

Senator ELLENDER. You spoke of clinics that are maintained by the physicians.

Miss GREENBERG. By private agencies. That means the private clinics in the private hospitals.

Senator ELLENDER. Private agencies?

Miss GREENBERG. Yes, sir.

Senator ELLENDER. Is that by way of insurance collections?

Miss GREENBERG. No. A private hospital such as, let us say, the Michael Reed Hospital will get a certain amount of voluntary contributions to set-up a free clinic, and they will have most of the services in the clinic given by physicians voluntarily, I mean out of their private practice. They may have a staff physician or so, but they won't pay any physicians.

Senator ELLENDER. And the money for maintenance for necessary equipment and things of that kind is furnished from these voluntary contributions?

Miss GREENBERG. Yes.

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Senator ELLENDER. Who usually donates? Businesses or any particular individuals?

Miss GREENBERG. I think it differs in different hospitals. Sometimes they have a general drive and they get a number of people to donate. Since the depression they have been getting less donations.

Senator ELLENDER. Do you have a public hospital wherein tubercular patients are taken care of?

Miss GREENBERG. We do, but we have no State hospital.

Senator ELLENDER. That is what I am talking about.

Miss GREENBERG. We have one that is in part maintained—it is under a separate supervision. It is under in part the supervision of the State, and the money comes in part through the county, and there is an investigation of that sanitarium right now by the State authorities. It has been said that Negro people can barely get into it. There is a long, long waiting list for people to get into it.

Senator ELLENDER. How many people does that take care of normally?

Miss GREENBERG. I have the figures that I can leave here. I will have to look that up, but I don't know offhand just how many.

Senator ELLENDER. Is that hospital entirely maintained by the State or county?

Miss GREENBERG. Yes. As to a small part of the money, it is given by the city.

Senator ELLENDER. Are patients admitted beyond Cook County in the State?

Miss GREENBERG. In this hospital? No; I don't think so. I am not exactly sure whether or not some of the counties—I know there is no State tuberculosis sanitarium. I don't know whether some of the counties have set up small sanitariums of their own, but this investigation has, of course, disclosed the fact that the facilities are very very inadequate for the State as a whole.

Senator ELLENDER. Has any drive been made by your association and others interested to have the legislature of the State finance other hospitals?

Miss GREENBERG. Yes. One of the major purposes, of course, of our committee is not only to have the Federal Government participate, but to start the State and the county on the road to helping.

Senator ELLENDER. The reason I asked you the question is that I am wondering what difficulty you would encounter in attempting to obtain from the State, the county, or the municipality involved, a sufficient sum to match the Government funds?

Miss GREENBERG. Well, I think we can compare this to unemployment compensation. I think Illinois was one of the last States to contribute her part of the Illinois unemployment compensation.

Senator ELLENDER. It is rather hard to extract it from big business, is it not?

Miss GREENBERG. I think this is it—I think that when there is a Federal grant of money set up and the State has to match it, it is a great stimulation to the State to provide the money, but right now it is just like pulling teeth, although the State public-health officials we have spoken with feel that the State can provide some of the money if there is some Federal stimulation to do that.

Senator ELLENDER. Thank you very much. The next witness is Mr. Polakov. Mr. Polakov, will you give your name and representa-

tion and such other descriptive matter as you desire to appear in the record with regard to your appearance here?

STATEMENT OF WALTER N. POLAKOV, REPRESENTING UNITED MINE WORKERS OF AMERICA

Mr. POLAKOV. My name is Walter N. Polakov. I am an engineer by profession. I have been about 35 years the head of my own consulting engineering firm, and now I am directing engineering activities and investigations for the United Mine Workers of America in the capacity of director.

Senator ELLENDER. Have you a prepared statement?

Mr. POLAKOV. I have a prepared statement which I would like to elaborate, if you care to ask me any questions.

Senator ELLENDER. All right, sir.

Mr. POLAKOV. I am here by the invitation of Senator Murray.

Senator ELLENDER. You may proceed, sir.

Mr. POLAKOV. The United Mine Workers of America wish to go on record as supporting the national health bill known as S. 1620. This group of organized labor for some 50 years of its activities has undoubtedly had more experience in the field of public health and group medicine than any other body of men of similar size. The miners of this country spend annually not less than \$25,000,000 for medical service, the quality of which leaves much to be desired. From our point of view, therefore, \$90,000,000 for the first year of a national health program and two hundred-odd million dollars in future years represent a very modest investment in national defense against disease and premature death.

For the sake of comparison, consider the fact that 2,500,000 miners and their families pay about \$7 per capita per year for health, whereas the health bill will render within its scope services at less than 70 cents per capita.

The subject of national health has for many years been vital among industrial workers in general, and among miners particularly. A bill of this nature is not legislation imposed by well-wishers from above, but a modest and inadequate answer to the long-felt need and definitely expressed wish of the masses of the population.

At the National Health Conference in Washington on July 18 to 20, 1933, I made a presentation of the specific needs of coal-mine workers of this country in the field of health. In my address, published on pages 68 to 70 of the proceedings, I stated that—

The mortality rate among miners is * * * appalling, about 1,300 per 100,000 in comparison with only 900 per 100,000 for all gainfully occupied. Now these statistics are compiled in a comparison of miners with other gainfully employed people, not with the population as a whole, including groups that are economically capable of taking care of themselves.

Within the last decade or more, since the advent of the power age and the death of the machine age, the mechanization of mines has been going on at a fast rate, and it claims an increasing toll of dead, maimed, and sick. From 1906 to date those killed by electrical machinery in the mines increased over 25 percent. This mechanization and rationalization of mining nearly doubled the productivity per man per day. In 1900, miners produced per day 2.9 tons; last year they produced about 6.7 tons. In some mines the work is so intense that a single miner loads from 30 to 40 tons in 7 hours. Such enormous intensification naturally increases the strain not only on the physique of a man but also on his nervous and mental capacity. Indeed, the state of mental hygiene among the miners may be

best illustrated by the fact that the rate of suicide among miners is about 53 per 100,000 while among other gainfully employed workers it is only 35.

Among the prevalent diseases which are bred under these circumstances among miners, we find that tuberculosis ranks first. It claims 120 per 100,000 as against 87 for all workers. Nephritis and cerebral hemorrhage are close seconds, the former claiming 71 per 100,000 among miners and 57 among all workers and the latter, 46 and 41, respectively.

The information I presented at this conference moved the directors of the Good Will Fund and of the Twentieth Century Fund to assist financially in a study of the health situation among miners. Such a study, started in the latter part of 1938 and concluded early in 1939, was conducted by the Bureau of Cooperative Medicine which was recommended by Dr. Michael Davis of the Rockefeller Medical Research and conducted by the doctor who testified here this morning.

The findings of this health survey were submitted to me on March 1, and while covering only a middle section where the northern, western, and southern Appalachian coal fields join, the picture presented by these doctors has been so shocking and appalling that it commanded the sympathetic attention even of the most conservative press. While several weak objections have been made by interested individuals whose pride was pricked by the truth, I still commend this report to the attention of this committee, knowing full well, from over 2 years of personal investigation, that the findings as reported are an understatement rather than the complete story.

I should like to introduce at this point some quotations from the report of the recent investigation by Dr. H. U. Stephenson, Medical Examiner of the State of Virginia. This report was apparently to be a sedative for the shock created by the report of the Bureau of Cooperative Medicine, and indeed while it starts with the statement, "I found the medical set-up for the care of the injured miners to be good in all of the mines," in the rest of the report a number of instances are recited, as follows:

I visited the case, talked with the injured man who had had an accident three months ago, breaking his thigh. This happened some distance in the mine. He was approximately an hour getting out of the mine and nearly another hour before a doctor saw him. The injured stated that he was handled roughly by one of his coworkers and due to the low pitch of the mine, had considerable difficulty getting out of the mine. After a delay of approximately 2 hours the doctor arrived and the injured man was taken to a private hospital about 5 miles from the mine and there remained for several weeks during which time infection set up on the broken leg and he had quite a stormy time.

The procedure of getting medical care to an injured miner is likewise illuminating, as stated in this State of Virginia report:

A few minutes following the accident the mine doctor was notified by telephone, the message being sent from within the mine, notifying the doctor of the accident, and telling him to be at the opening of the mine to meet the injured. The doctor was at the time attending a miner's wife in confinement, this woman was having a stormy time and nearing the point of delivery. Not being able to leave under such circumstances, he called another doctor. He, too, was on a case of confinement and could not go. Finally they got a doctor to see the injured.

Later in the same report of the Virginia medical examiner there is another interesting remark:

Sometimes they would take a patient to the hospital and they (the hospital) would not be able to take him on account of being crowded. I asked him if that happened when an injured employee went to the hospital. He said, "No; that was a member of a miner's family."

A still more indicative case was reported in the examiner's report concerning crowded conditions in the hospitals:

I told the surgeon in charge about the complaint. He stated that sometimes the hospital was crowded but that never had an injured miner come to the hospital that he wasn't admitted at once. He stated that when a miner is injured in the mines, the mine doctor telephones the hospital he is bringing over this injured man. The hospital at once prepares for the injured man * * * they prepare the operating room for an operation and if the hospital is at that time crowded, they prepare a place by discharging a patient * * *.

This official confirmation of the report submitted to me by the Bureau of Cooperative Medicine is as gratifying, because of the verification of the truth, as it is mortifying that such gross neglect of health is so prevalent, especially in view of the fact that the miners pay regularly and liberally by means of check-off for such deplorably negligent service.

I may note here that this type of service is further limited by exclusion of maternity cases, of pediatric cases, of communicable or infectious diseases, of mental disease cases, and of all patients with any form of venereal infection.

As a result of these disclosures and verification of facts, the United Mine Workers of America at the Joint Appalachian Conference with the operators presented among other demands the following:

8. Medical care and hospitalization in mining communities: Tragic inequality, inefficiency and dishonest practices in the rendition of medical care and hospitalization in mining communities require the consideration of the Appalachian Joint Conference. Abuses must be corrected and skillful and adequate medical services must be accorded.

Equal participation with the coal companies in the selection of physicians shall be accorded. Mine workers shall participate in the supervision of hospital, medical, surgical and nursing facilities, in all cases where they are financed through the medium of deductions from mine workers' pay.

Yet, the operators summarily refused the miners the right to spend their earnings for competent medical care of their own choosing.

Since then, it has been my sad duty to register other gross abuses of neglect of national health. In the common demand for ordinary decency and honesty, I must record instances where even after collecting hospital dues from miners, the operators fail to turn this money over to the hospitals so that the hospitals refused to accept patients. I shall submit to you copies of letters describing such instances.

One is addressed to E. D. Hodson, representative of the United Mine Workers of America at Beckley, W. Va., dated July 9, 1939:

DEAR SIR: No doubt you know the method used in paying in to the hospital. The Lecony Smokeless Coal Co. collects \$1.25 off of each employee for the hospital, but still we have our members refused admittance to the hospital because the coal company fails to turn the money over to the hospital.

We will appreciate it very much if you will do something to see that this money is turned over for the purpose it was collected for. Dr. McCulough told us that Claude Jarrett owed them around \$3,000 for hospital fees collected from his employees.

Fraternally yours,
[LOCAL SEAL]

WILLIS TRENT,
Secretary, United Mine Workers of America,
Local No. 6147, Besoco, W. Va.

Senator ELLENDER. How are those funds collected? Is that in the contract between the United Mine Workers and the employers?

Mr. POLAKOV. It is not in the general Appalachian contract, but each individual miner signs to the company and really he has no choice but to sign with the company, the right to subtract from the wages

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before he receives the wages a certain amount of money for hospital and a certain amount of money for other things.

SENATOR ELLENDER. Are these hospitals privately owned or are they operated by the company?

MR. POLAKOV. A majority of them are privately owned and contracted by the company. Very few of them are owned by the company and still a lesser number owned by the coal miners.

A similar letter from Amigo, W. Va., dated March 20, 1939, addressed to the same Mr. Hodson, district representative of the United Mine Workers of America of Beckley, W. Va.:

DEAR SIR AND BROTHER: I am writing you relative to the hospital situation here at Wacomah. As you know our hospital dues are checked off our wages by the Wacomah Coal Co. for the Beckley Hospital, but recently we were advised by the hospital that no more of the employes of this company would be admitted to the hospital due to the fact that the company had failed to turn over to them the money that had been checked off of us to take care of our hospitalization.

We would appreciate it very much if you would take this matter up and force the coal company to turn this money over to the hospital so that we will have some protection, as it may be necessary at any time for some member of our local union or their family to have hospital services.

Thanking you for your past services and with best wishes, I remain.

Fraternally yours,

ROBERT GRAHAM,
Recording Secretary.

SENATOR ELLENDER. Recording secretary of what?

MR. POLAKOV. Of the local union at Amigo, W. Va.

SENATOR ELLENDER. Have they ever attempted to force these companies who take this money to furnish medical care?

MR. POLAKOV. The district president of the particular region invariably takes the matter up with either the superintendent or the manager or the president of the company and tries to settle the matter in a friendly way, but usually he is told sad stories that the company is short of money, and if they would turn the money over to the hospital, they probably would default in the payment of the wages, and in some instances—I don't know about these two—but in previous instances, it was necessary to go to the court and prefer the charges of misappropriation of funds, and in two or three cases known to me the company promptly settled the case by arrangement of some sort that was negotiated with the hospitals or the hospital advised us that they would take care of the injured or sick people.

SENATOR ELLENDER. Would you be able to tell me the average yearly income of these miners, let us say, in that particular locality?

MR. POLAKOV. In that particular locality it is in the neighborhood of \$800. That, of course, is the gross receipt out of which the company subtracts for the cost of illuminating the mine, the cost of exploding the coal, the cost of sharpening the tools in the tool room, certain check-offs for school, a certain amount for the church, a certain amount for the privilege of getting water for washing hands after work, and things like that, which generally amount to about 22 percent of the gross, so it is \$800 or whatever the figure is for that district less about 20 or 22 percent for the deductions for occupational expenses.

SENATOR ELLENDER. What minimum salary should a miner receive so as to afford him sufficient revenue to pay his food, clothing, and ordinary doctor bills?

Mr. POLAKOV. Last March the United Mine Workers of America made an offer to discuss with the operators a minimum of 200 working days a year guaranteed, which would amount on the average wage to \$1,200 annual income. That was considered the rock-bottom minimum on which a man could afford a decent existence in that neighborhood.

Senator ELLENDER. And that \$1,200 would be, in your mind, sufficient to take care of the ordinary medical care?

Mr. POLAKOV. Miners now are paying by means of check-off approximately \$36 per year.

Senator ELLENDER. I understand, but the point that I had in mind was, what class of employees or persons should be admitted to these hospitals and to be entitled to free medical care? You see, we are going to have to establish a limit. This bill is supposed to take care of the indigent.

Mr. POLAKOV. But the indigent, of course, will not be able to pay, but those who are earning \$800 or more, these by all means contribute a certain amount.

Senator ELLENDER. So you would say that about \$800 would be the minimum?

Mr. POLAKOV. Well, I would say that from actual experience. It may not be desirable, but it has been going on for a great many years.

I have dealt at length with our experience in the field of national health. While it concerns only a small corner of the country and only one industry, it is undoubtedly indicative of the general situation in other parts of this country and in other industries, and among those who were squeezed out of industry by economic contraction.

Now, referring to the bill as presented to the Seventy-sixth Congress, while it has our whole-hearted approval as far as it goes, we must of necessity view it merely as a first easy step for little feet, for it does not go so far as conditions warrant. I should commend to the attention of this committee the necessity of incorporating in this bill more adequate provisions concerning the study of industrial hygiene. In mining, especially where air is sometimes to be paid for, where dust frequently causes silicosis, where men work without the invigorating effect of sun-rays and daylight, and frequently wet from dripping water and standing in puddles, where as a rule there aren't even facilities to change from wet, dirty clothes to dry ones before going home—sometimes a considerable distance over the hills—where there are not the advantages of having a hot meal during the rest period, no industrial hygiene study has ever been undertaken, to our knowledge, and the records of sickness, its duration and extent are nowhere reliably recorded.

Furthermore, I should like to call to your attention the astonishing fact that, although the act establishing and describing the functions of the Bureau of Mines, Department of the Interior, as amended in 1913, provides—

that the Director of said Bureau shall prepare and publish * * * reports of inquiries and investigations with appropriate recommendations * * * with special reference to health, safety, and prevention of waste in mining—

yet in the Bureau of Mines no studies of industrial hygiene or preservation of health are conducted. While it is true that under the Director of Safety, there is one first-aid physician located in the Pittsburgh

laboratory, as well as five chemists, the provisions of the act, both in spirit and to the letter, are not carried out. It is a sad commentary that, while recently some investigation of the tunnel work under the East River, N. Y., has been carried on by the Bureau of Mines with Public Health acting as adviser, yet such studies are not carried on in connection with the tunnelling of thousands of miles in coal mines.

Senator ELLENDER. What suggestion would you make as to industrial hygiene? As I understand it, the bill specifically provides for money to be used for that purpose.

Mr. POLAKOV. By the Bureau of Mines.

Senator ELLENDER. Of course, under the bill, as you may know, the plans must be submitted by the States asking for it, and necessarily if the States have established a particular department under which industrial hygiene is to be carried on, those States would be entitled to money for that purpose.

Mr. POLAKOV. These are Federal moneys.

Senator ELLENDER. I understand.

Mr. POLAKOV. These are moneys appropriated to the Department of the Interior and allocated to the Bureau of Mines, but they have been used for other purposes, and this particular phase has not been attended to, and the last physician that has been with them a great many years ago now is with the Public Health, and so on.

Senator ELLENDER. What I have reference to is the bill before us.

Mr. POLAKOV. I am not a lawyer, Senator—you understand that—but as a layman, it seems to me that one of the two courses is possible and desirable. Either that the authority which will be created by this act will have authority to supervise and enforce the health provisions, not only in the State but also in the Federal bureaus or else—

Senator ELLENDER (interposing). That is what we are trying to get away from. One of the objections against the bill is the fear that if this bill is enacted as written, it may be that sooner or later the Federal Government would go down in the States and grab hold of the health departments and control them, and the first thing you know everything would be dictated from Washington. What we are trying to do is to have the Federal Government subscribe a certain sum under certain conditions, but always with the understanding that the money is to be spent under the direct supervision of the State authorities, with this limitation only, that the Federal Government would have the right to see to it that the plans as submitted are carried out and no further. If we were to give supervision as you have just indicated, I doubt if you would get this bill out of committee.

Mr. POLAKOV. As I said, I am not a lawyer and I am not familiar with the technique of legislation, but something has got to be done, and I deal with just that point now, and that is, I feel that the bill should be strengthened, that is, by providing an explicit section describing the scope and authority of Federal supervision of national health activities. By that I mean the enforcement not merely by means of withholding Federal participation in inadequately conducted State programs, as W. P. A. has been doing, but a definitely conferred authority to visit and inspect State health work and an unchallenged authority in cases of inefficiency or infractions, so that the Federal authorities must have the right to take over and administer the affairs

that have been neglected, which apparently, from your point of view, is inadmissible.

Senator ELLENDER. It is not exactly inadmissible, but you know that legislation results from give and take—sometimes you give more than you take—but one of the things that we have to meet is this centralized government argument, that is, the fear that if we keep on permitting the Government to get into the States little by little for schools, for health, for this, that, and the other, that sooner or later there won't be any more State lines, and it would be rather difficult, I am sure, to put through the Congress any bill that would give to the Federal Government any such right to go down there and take charge of the situation. The plan as we propose to work it out is simply that the Government is to furnish money under certain conditions, and if those conditions are met, the States are to share in the funds.

Mr. POLAKOV. We thought that probably a little further than that would be desirable, but it is for the legislators to consider the matter.

Senator ELLENDER. I fear that such a proposal would fall on deaf ears.

Mr. POLAKOV. The last suggestion is that such a provision should apply not only to the programs conducted by the States, but likewise and perhaps in even greater measure to all other programs of health, sanitation, and preventive medicine carried on by private organizations, especially when the people in whose behalf the alleged work is being done are contributing to it financially.

What I mean by that is, the abuses of industrial check-off and no service. At the present time, there is no recourse except going to court and spending considerable time and money and litigation, and really it is ridiculous that one has to resort to such means.

Senator ELLENDER. I do not see why it would not be possible to tie that in with your contract when you bargain collectively under the Wagner Act.

Mr. POLAKOV. The last time we did not succeed in doing it.

Senator ELLENDER. It strikes me that is a good way to do it. I do not see why an organization engaged in mining should collect from its employees and then not pay the money out when the time comes. That is nothing short of larceny.

Mr. POLAKOV. It is.

Senator ELLENDER. Absolutely. To let people suffer that way after collecting their money, and then not using it for the purpose for which it was obtained, is collecting money under false pretense.

Mr. POLAKOV. Thank you very much.

Senator ELLENDER. The next witness is Mr. John B. Andrews.

Mr. Andrews, will you give such descriptive matter about yourself as you desire to have appear in the record?

STATEMENT OF JOHN B. ANDREWS, SECRETARY, AMERICAN ASSOCIATION FOR LABOR LEGISLATION, NEW YORK CITY

Mr. ANDREWS. My name is John B. Andrews; I am secretary of the American Association for Labor Legislation of New York City.

The American Association for Labor Legislation is in favor of this legislation as a forward step in a national general health program. It is especially interested in those incidental features which offer

very modest encouragement to the States which may set up systems of sickness disability compensation. It urges that these provisions, which have had relatively little attention, be not subordinated, and it urges that favorable action on the bill be expedited.

Thank you.

Senator ELLENDER. Mr. Richard Mackenzie.

Mr. Mackenzie, will you state whom you represent and such other descriptive matter as you desire to appear in the record?

STATEMENT OF RICHARD MACKENZIE

Mr. MACKENZIE. I am not representing any group. Recently I was consultant for the Bureau of the Budget on the operation of Federal hospitals.

I can best explain the matter which I wish to bring to your attention by reading briefly from the report of the technical committee:

Bed accommodations also vary with the States from 1.26 to 5.5 per thousand population, with a figure of 3.1 representing the median State. To bring all State averages up to 4.5 will require the addition of 180,000 beds. Some of those beds would be added to existing hospitals, but most of them would call for new units to be located in the areas now without hospitals or having hospitals whose physical or financial deficiencies preclude their becoming true community institutions.

It seems proper to question the adoption of a standard for the number of beds per thousand that should be required. The technical committee has set 4.6 beds per thousand. There are many factors which determine the number of beds necessary. For certain types of cases, hospitals are the admission of failure of other health measures. In a community where there is adequate sanitation and adequate appropriation and expenditure, intelligently, for public health education, where there are sufficient facilities for ambulatory patients, such as in the out-patient department of hospitals so that patients may be treated in the early stages of the illness, where there are periodic physical examinations, where there is proper housing, and where the income of the people is sufficient to purchase proper food, clothing, and shelter, it is apparent, I believe, that fewer hospital beds would be necessary in that community than in the community where these things are lacking. I believe it is fallacious to adopt a standard except that of supply and demand.

The technical committee report of the percentage of occupancy of the hospital beds of the country, I believe, should be questioned for the reason that the figures used are those of the American Medical Association, which are based on the number of beds set up and not the rated capacity which is the number of beds that can be properly set up in the present buildings.

To give you a clear example of what I mean, I will take the District of Columbia as an example. In the municipal hospital of the District, Gallinger, there was overcrowding. The overcrowding was mostly in the colored wards. There were, however, 66 additional beds that could be set up in Freedman's Hospital for colored people, but were not set up because of the lack of funds.

In a survey made recently by the Public Health Service of hospitals and Health Service in the District, they reported that there were 276 beds that could be set up but were not set up. In figuring their percentage of occupancy of beds of the District, they used the number

of beds set up and not the number of beds which could be set up in the present hospital buildings. The same method has been used in computing the percentage of occupancy of the hospitals of the country, so that we may have, if the percentage applies in the country as a whole as it does in the District, a difference of about 8 percent, which is an appreciable amount.

In conclusion, I believe that if greater emphasis is to be put on preventive medicine, the chance of needing the number of beds which is computed as being necessary is very much reduced. I believe that education should be the prime objective—education of the health officers of the States and the localities, and education of the hospital administrators, such as is being carried on now by the institutes for hospital administration by the College of Hospital Administrators, and the American College of Surgeons. They are holding these institutes of about 10 days in different sections of the country.

I also think that the laws of health should be preached and taught to the general public much more intensively than they have been in the past. The Gallup poll recently reported on the knowledge of the general population regarding causes and cure of tuberculosis, and it showed that the campaign on education in tuberculosis has been reasonably successful. Let me repeat: For many types of patients, hospitals are the admission of failure of other health measures.

Senator ELLENDER. Let me ask you this: I am very much interested in preventive medicine; I feel as you do that if we could educate our people more along that line, that it would mean fewer sick people and probably the same thing would result with reference to dental care. If we could educate the young people while at school, they would have less trouble in the future. If you had a limited amount of money appropriated by the Congress to carry on this program, and not sufficient to take care of hospitalization as we intend to, would it not be better in the long run to spend what we do appropriate for preventive medicine rather than make a start now on a lot of these various plans that are described in the bill? What is your view on that?

Mr. MACKENZIE. I agree with you absolutely. I believe that, as I pointed out, the necessity for brick and mortar can be prevented to a very great extent by a much increased campaign of preventive medicine. I believe that the public health nurse is one of the greatest factors in preventive medicine. I say that from experience in both the city and in the rural communities. I believe that the extension of our out-patient services of hospitals should be carried on promptly. Here in the District there is an example of the inadequacy of our attitude, if I may express it that way, regarding our out-patient services. The District government pays only 15 cents per visit to the voluntary hospital for the indigent sick who come to the dispensary. That does not pay for that service.

Senator ELLENDER. Of course, in the statement that I have just made, what I had particular reference to was the fund that was provided for the establishment of hospitals. It may be that a fund could be provided to purchase space, let us say, in the already established hospitals and the rest of the money could be spent toward educating our people to take care of their health.

Mr. MACKENZIE. Quite right.

Senator ELLENDER. Thank you very much, sir.

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The next witness is Mr. John P. Davis.

Mr. Davis, will you come forward and give such descriptive matter as you desire concerning your representation, and so forth, as you desire to appear in the record?

**STATEMENT OF JOHN P. DAVIS, NATIONAL SECRETARY OF THE
NATIONAL NEGRO CONGRESS**

Mr. DAVIS. My name is John P. Davis, and I am national secretary of the National Negro Congress, which has 70 local organizations in 70 urban communities in the country.

Senator ELLENDER. How many States?

Mr. DAVIS. Twenty States. Because of the limited time allotted, I would like permission to simply discuss generally the provisions of the legislation being considered and to submit a report which has been prepared by our technical committee concerning the bill.

Senator ELLENDER. What do you mean by the limitation of the time allotted?

Mr. DAVIS. I mean the 15 minutes.

Senator ELLENDER. That is all right; if you want more time, I will be glad to hear you.

Mr. DAVIS. The point is, if it is permissible, since I am not a technical authority on the question of health, I would like to present, supplementing my statement, a report prepared by a technical committee of Negro physicians, showing the impact, the possible impact, of this bill upon the Negro communities throughout the country.

First, I would like to say that as a result of careful consideration of the proposed National Health Act, our organization wishes to give its endorsement to the bill in principle, to the principles established in the bill as a minimum that is necessary in order to provide a better national health for the American people.

There can be little question that such legislation is especially necessary after a period of 10 crisis years, during which poverty, the disintegration of the housing and sanitation and other community facilities throughout the country, have created a problem among the working people, among the poorer people of America, which is certainly intolerable.

The health of the Negro people, because of their poverty, because of their lack of facilities for housing, for recreation, for sanitation, as well as the lack of adequate educational facilities for them, has been notoriously bad for a great many decades.

Just a few simple facts about Negro health. Greater detail will be given in the brief that I have referred to.

For 1930 the death rate per 1,000 persons, for white persons in America was 9.9 as contrasted with that of Negroes of 18 for each 1,000 persons.

Senator ELLENDER. Have you the figures to show where the death rate is the greatest, in various sections?

Mr. DAVIS. By States?

Senator ELLENDER. By States or by sections.

Mr. DAVIS. Yes. I don't have the figures here, but we can certainly give you that. That will certainly be included in the information which we shall submit.

Senator ELLENDER. Will you send that to me?

Mr. DAVIS. Yes. I can say generally now that for the South, of course, the death rates are considerably higher than for northern and western centers; that for rural areas where there has been a lack of hospital facilities, a greater lack of hospital facilities, that the death rate is higher than for urban areas, and that this is the general situation with regard to it.

The specific data, in terms of actual percentage figures, will be submitted in this brief.

At every age period from infancy to old age, the Negro death rate exceeds that of the whites. Some typical figures that would serve to indicate this point can be taken from the infant mortality rates, that is, the deaths of children under 1 year of age per 1,000 live births.

For Pennsylvania, a typical Eastern State, the average rate is 67 per 1,000 live births; for Negroes it is 115 per 1,000, and for whites, only 64.

For Missouri, a typical Midwestern State, the average is 63; for Negroes it is 108; for whites it is 60.

For Georgia, a Southern State, the average is 68; the Negro figure is 86; and the white figure is 57.

If we take the District of Columbia as just one city where we can get a typical picture which is parallel to the picture in most of the other cities where there is a large Negro population, we find that tuberculosis kills six times as many Negroes as whites, pneumonia kills twice as many Negroes as whites, childbirth kills twice as many Negro women as white.

For the age period between 10 and 14, tuberculosis kills 10 times as many Negro children as white children; and for heart disease, 6 times as many Negro women die as do white women, and more than twice as many Negro babies die as do white babies.

The life expectancy of Negro people in the District of Columbia is about 10 years shorter than that for the average white person.

Of course, the underlying causes for the type of situation in the District of Columbia, which as I have indicated is simply typical in more or less degree for the country at large, are the unemployment of Negro people in the District of Columbia, the intolerable slum conditions, the general situation of overcrowding with regard to housing, poverty, the lack of funds with which to secure paid medical care, and the woeful lack of facilities for treatment.

This picture is, of course, to be duplicated throughout the country. We have an estimate by the Interdepartmental Committee, that the number of doctors per 100,000 population is 128; for the country at large, the number of Negro doctors per 100,000 population is only 32; and if we take the State of Alabama, the number of Negro doctors per 100,000 is 12; and if we go into Mississippi we find that the number of Negro physicians per 100,000 in that State is only 6.

Such a situation would certainly indicate the necessity for the inclusion in this bill of a training program which would provide the possibility for Negro physicians to secure, or for Negro men and women to secure training as physicians.

In Alabama, for example, the lack of funds has made necessary recently the disbanding of a training school for nurses at Tuskegee Institute, a private institution. This training school for nurses was one of the few which existed in the South, and of course the same figures that I have given for doctors have their parallel when we look

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at the figures with regard to dentists, nurses, and other persons engaged in caring for the Negro sick throughout the country.

The lack of hospitals, the lack of hospital beds, for Negro—

Senator ELLENDER (interposing). Just before you get to that, what have you in mind that should be put in the bill? After all, what you are interested in is having a little more adequate care given to the people of your race?

Mr. DAVIS. That is correct.

Senator ELLENDER. Now would you want the Government to establish facilities to educate physicians?

Mr. DAVIS. As a matter of fact I think the National Youth Administration has met the problem of supplementing the inadequate educational facilities, both in terms of scholarships and in giving direct aid to institutions.

Senator ELLENDER. That is their elementary purpose, but when you come to talk about getting funds to educate physicians, that is a horse of a different color.

Mr. DAVIS. I think it is perhaps a horse of the same color as that proposed by the President, and agreed to by Congress, for the training of air pilots. For example, the Civil Aeronautics Authority, and the National Youth Administration, has been provided with funds for the training of 20,000 young people when the optimum of the program is reached, to be mechanics and air pilots in the interest of national defense, which I think is a very commendable and necessary thing. Certainly the picture with regard to health of the people of America is another item in our national defense, and certainly the records of the draft, the medical records during the last draft, with regard to the persons conscripted, would indicate that if we were to become engaged in another conflict we would find a large percentage of the able-bodied men of the country, and an unusually large percentage of the Negro men of the country, completely physically unfit to take part in any program of national defense. And I think it is a serious enough problem to justify exactly what I propose, namely, the training of physicians; the providing of the types of scholarship aid; the type of aid to institutions; to create, if necessary, medical schools.

We have only two Negro medical schools in the country which can train not more than 100 to 110 Negro physicians in any one year, and yet in contrast with the need, it is quite clear that we are just about 25 percent as well off as the white population, on the basis of the figures for doctors that I have given you, and if you take Mississippi or some of the other States in the South, of course the comparison becomes even more acute.

Senator ELLENDER. Well, I think if Congress can begin a program to take care of the health of the people, I would be more interested in that than to provide medical schools. I think we have quite a sufficiency of those in the country now. We may help out in a measure by scholarships and things like that, but to spend any mone to establish medical schools and things of that kind, especially built for the training of the Negroes and the training of the whites, I believe that is expecting too much.

Mr. DAVIS. Perhaps not, Senator, but the establishment of scholarships would certainly be a step in the right direction, and certainly would seem to be indicated on the basis of the woeful under representation of Negro physicians in the whole occupational picture.

We turn to the question of hospitals, and we find a situation equally bad, so far as the Negro communities in America are concerned.

I would like to, at this point, give an instance which, though not statistical, is certainly impressive, and indicative of what is necessary, and of why we are in full accord with the provisions in this bill which provide further for the erection of hospitals, for additions to hospitals, for the building of medical centers, and the like.

I once taught at a Negro school in the South, and during that time a group of the young men from that school was en route to a football game in lower Alabama. The car turned over and one of the young men broke his back. I came along a little later and reached the scene of the accident, and we spent at least 8 hours going from small town to small town without being able to find a single hospital which would admit this young man. There wasn't a hospital within 90 miles of the place where we were where a Negro could be admitted. In addition to that we couldn't even rent an ambulance and had finally to take the young man to Chattanooga, Tenn., in a hearse, and he died on the way.

I have seen with my own eyes, in New Orleans, a few years ago, in a privately owned Catholic hospital, Negro patients sleeping, Negro sick people sleeping three in a bed because that was the best facilities that could be afforded, and there were many hundreds of others that couldn't even get one-third of a bed to sleep in.

Senator ELLENDER. How long ago has that been?

Mr. DAVIS. That was before the erection of the present Flint-Goodrich Hospital.

Senator ELLENDER. What year was that, do you know?

Mr. DAVIS. It must have been about 1935.

I would like to point out in that connection that the Flint-Goodrich Hospital, which is a model institution, erected by private funds, during the first 3 or 4 months that it operated, its facilities had already become overcrowded, and that already we have a situation in New Orleans—and I don't want to imply that New Orleans is any worse than other centers, it is not—

Senator ELLENDER (interposing). I think it is better—I know it is.

Mr. DAVIS. I would be inclined to agree with you.

Senator ELLENDER. I happen to have been a member of the legislature of my State for 12 years before coming to the Senate, and I know that since 1928 we have provided in our State for about 4,500 hospital beds. I can produce data for the record that shows that although in the city of New Orleans the population of the Negro is about 28 percent of the entire population, yet the number of Negroes taken care of at the Charity Hospital greatly outnumbers the whites in comparison to the percentage of whites and Negroes in the city.

Now we have recently completed a new Charity Hospital, but prior to this I myself have seen some of the conditions that you have just described, three in a bed. And not only in the Negro section, but in the white section also has that been true. We have been trying to correct that condition right along, and I am certain that if you were to go back now, or within the next 2 or 3 months, you would find an appreciable difference. Today Louisiana is one of the States of the Union that is forging ahead in that endeavor.

Mr. DAVIS. I am sure that that is correct, and I am sure that Louisiana is certainly no worse, and perhaps in many instances I know of much better, than many other States.

I use this small specific instance simply to indicate what I know to be a typical condition in most of the Southern communities, so far as Negro hospital facilities are concerned. Certainly in many of the smaller communities there are no hospital facilities of any character for Negro patients.

Senator ELLENDER. Well, you mean of a private character?

Mr. DAVIS. Or a public.

Senator ELLENDER. Well, we do have in the State——

Mr. DAVIS (interposing). I am not talking about the State, I said many other smaller Southern communities, I didn't mean the State of Louisiana. I am thinking, for example, of Montgomery, Ala., where there is no hospital of any character, private or public, for Negro patients, where the Negro ward that they did have in a general hospital, maintained in part by the city, was closed for lack of funds and has never been reopened.

These are some of the conditions, and of course we don't need to stay in the South. Evidence has already been presented of what the situation is in Washington, what it is in Chicago, and similar figures could be given for New York, for Boston, and for other sections of the country, where there simply do not exist anything like adequate facilities for Negroes; where, although the situation with regard to the poor white families is almost indescribably bad, the situation with regard to Negroes is even worse.

Senator ELLENDER. Well, when you consider the percentage of population, generally speaking, as between whites and colored, in the North and in the West, you will find that if you use that as a yardstick, that the poor Negro people are taken care of about to the same extent as are the white people.

Now I grant you that there may be some exceptions in some of the real poor States of the South, such as Mississippi and Alabama, and maybe two or three others, but generally speaking, you will find that in proportion to population, and I speak now of personal knowledge in Louisiana, I know that that condition does exist in Louisiana. As a matter of fact, I pointed out to you a while ago, and I exhibited in this record actual figures, that show a greater percentage in proportion to population of Negroes are taken care of than are poor whites.

Mr. DAVIS. Well, as I indicated before, I am not here attempting to give the statistical data which our committee will present to you, which will give the facts, and I am not prepared to controvert the statement that you have made. I have every reason to believe that you have spoken correctly.

However, certainly we must agree that the situation with regard to the health of the Negro and with regard to the facilities for improving that health, is sufficiently grave to justify the need for a bill such as this.

We have spoken, for example, to take one other example, of medical centers.

We have in the District of Columbia one venereal disease clinic. The venereal-disease rate for Negroes is far in excess of that for whites. The actual number of cases needing treatment is disproportionately higher for Negroes than for whites, and there exists only one clinic where Negro patients may be treated 2 days a week. It is in the 500 block of K Street. On Negro days you can go there any day and see

as many as 150 people in line, and I am informed by the Health Department that the average amount of treatment, the average time for the treatment of each patient, is about 50 seconds, which indicates, of course, very definitely that this is a rather primitive form of giving medical care in so serious a disease as venereal diseases to patients.

Certainly here is the type of thing which would support the position taken by Senator Wagner in introducing this bill.

I want to deal a moment or two with the question of the need for supporting the health-insurance features of this proposed legislation.

Let's take a few simple examples of the Negro occupations and of Negro pay to indicate the general conclusion that the Negro worker throughout America, if employed at all, is underpaid, is in the lowest economic bracket in our community, and in our country as a whole.

Two out of every three Negro women who work are domestic workers. They receive no protection from legislation of the Social Security Act, unemployment compensation, old-age insurance. They receive no protection from Workmen's Compensation Acts, either on a State or Federal scale. They are not protected by wages-and-hours legislation. These constitute a large body of wage earners, more than 2,000,000 of them, who earn wages as low as \$1 and \$1.50 a week for 72 and 80 hours of work, who have no way to save for their old age, no way to save for hospitalization during their periods of sickness, and no way whatsoever to be assured that they will be able to protect themselves during periods of ill health.

Certainly, such a group as this can't lay away any savings for medical care, nor can they afford to purchase adequate medical care for themselves.

This, to a large extent, accounts for the high death rate from heart disease and from other types of things, that we find among Negro women. It accounts for a higher death rate and a lower life expectancy among Negro women than among Negro males, who themselves are badly enough off.

If we go to other occupations we find the proverbial to be true, that the Negro has the least security on the job, the lowest wage, and is the most recent entrant into the industrial system of our country. A disproportionately high number of them are still engaged in agricultural pursuits which are not productive because of cotton crises and other crises of other types, and they do not have a regular income; and then in the rural areas, there is this type of situation: I have frequently been in the plantation areas of Mississippi and Alabama and in Texas, where, if a Negro sharecropper wants a physician he has to pay a dollar a mile for that physician to come from the nearest town, and frequently the nearest town is 8 or 10 or 20 miles away.

It is practically impossible for a sharecropper, whose total annual earnings probably do not amount to what the cost of one doctor's fee would be for one visit, to have anything like adequate medical care. And moreover, it is also true that we find, as a result of this inaccessibility of hospitals, of physicians, of nurses, that 54 out of every 100 Negro children are born without the services of even so much as a midwife. Certainly a larger percentage are born without the services of a physician. It is for reasons such as these that we feel that the provisions for health insurance in the bill are particularly important.

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Certainly a program of health education by itself, and we are all for health education, we feel it means something, a program of health education by itself, would not reach the hundreds of thousands of Negro people who need to be reached, and whom, if they are not reached, will create a situation among themselves which cannot help but spread to the entire community, for there is no such thing as segregating a tuberculosis germ or segregating other contagious diseases. We just haven't found that type of thing.

Finally, I would like to suggest one amendment to the bill. Certainly Federal aid is the only thing that can provide an adequate national health program. The States are already debt burdened, they are already, because of the low incomes, low tax revenues, finding it difficult to maintain even their present social services. Therefore, I think it is obvious that this bill should be passed. But I think it should be passed with safeguards written into it, to guarantee equitable apportionment of funds provided by the Federal Government, covering all phases of this bill, the guaranty of an equitable apportionment between the Negro and white people in those areas where separate institutions are provided.

I would not attempt to suggest that there should be Federal control, as contrasted with the right of State authorities to direct the expenditures. I would only suggest that one of the specifications before a State could qualify for receipt of these funds, should be the agreement of the State equitably to provide for both the minority and majority races within their boundaries.

Precedent for that has been established in Senate bill 419 on Federal education, a bill introduced by Senator Thomas, first introduced by Mr. Justice Black, and I think Senator Harrison, of Mississippi, and both of those southern Senators were in agreement that such a provision should be included in their bill, and agreed and accepted these amendments.

For example, a typical one of these amendments which might form at least a basis for devising an amendment of a similar character for the present bill S. 1620, is to be found on page 10 of S. 419, introduced in the Seventy-fifth Congress, third session, by Mr. Harrison and Mr. Thomas, in which it points out that a State plan for improving the preparation of teachers and other educational personnel must—and these are the qualifications established by the Federal Government which must be met by the States:

(c) In States where separate institutions are maintained for separate races, provide for an equitable apportionment of such funds for the benefit of the institutions maintained for separate races, without reduction of the proportion of State and local moneys expended for the preparation of teachers and other educational personnel for the schools maintained for minority races.

In other words, this provision says that when you have money given by the Federal Government you have to allocate it on the basis of the existing program of expenditures between the races, where separate institutions are maintained. I think that this does apply, of course, to the southern section of the country, where we have separate schools and other separate institutions, but I think the acceptance of such amendment would have a great deal of meaning for all of the South, for both the Negro and white people of the South, for certainly it seems true to us that there can be no improvement of the conditions.

in the southern section of our country without a very careful and conscious effort to see that that improvement is made equitably for the Negro and white populations in that area.

Thank you.

(The report prepared by a technical committee of Negro physicians and other data was filed with the committee.)

Senator ELLENDER. The committee will stand in recess, subject to the call of the Chair.

(Whereupon, at 12 o'clock noon, an adjournment was taken, subject to the call of the Chair.)

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TO ESTABLISH A NATIONAL HEALTH PROGRAM

THURSDAY JULY 13, 1939

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

The subcommittee met, pursuant to adjournment, at 10:30 o'clock a. m., in room 357, Senate Office Building, Senator James E. Murray (chairman) presiding.

Present: Senators Murray (chairman), Ellender, and Davis.

Senator ELLENDER. The committee will be in order. Dr. McCaughan?

Dr. McCaughan, will you give your name in full and such other descriptive matter as you desire to say about yourself for the Record?

STATEMENT OF DR. R. C. McCAUGHAN, EXECUTIVE SECRETARY, AMERICAN OSTEOPATHIC ASSOCIATION

Dr. McCAUGHAN. I am Dr. R. C. McCaughan, the executive secretary of the American Osteopathic Association.

I should like to state at the outset that we are appreciative of the invitation of this committee to appear at this hearing. The American Osteopathic Association is a federation of State divisional societies of osteopathic physicians and surgeons. The policies of the association are shaped and determined by a house of delegates, apportioned among the States and elected by the component State associations, which meets annually. At its recent convention, its forty-third, held at Dallas last month, this bill, S. 1620, was considered and a resolution of the house of delegates was adopted approving the objectives of the bill.

I am glad of this opportunity to discuss with this committee the need for amendment and extension of the health titles of the Social Security Act. Section 2 of Senate bill 1620 revises and extends the maternal- and child-welfare title of the act. It authorizes more money and increases the scope of medical services to be supplied. I wish to discuss the maternal- and child-welfare provisions in particular, but what I have to say will be applicable in large part to the other sections as well.

We have passed the half-way mark of the fourth year under the Social Security Act. When that act was pending before the House and Senate committees in 1935, a brief was filed on the part of the American Osteopathic Association and incorporated in the hearings. In that brief we expressed commendation for the objectives of the legislation and we stated what we took to be the intent of Congress with regard to the administration of the contemplated health programs,

that legislation of medical importance applies four-square to practitioners of the healing art without discrimination or preference as between recognized, regulated, and licensed systems of healing. Throughout the formative stages of that legislation it was pointed out again and again by the proponents of the measure that the health programs would be largely dependent upon the cooperation of the healing arts groups. That fact was so emphasized that Congress wrote into the law the requirement that no State plan for maternal and child welfare qualification under the act could be approved by the Federal administrative agency, the Chief of the Children's Bureau, unless that plan should specifically provide, (I am reading from one such provision of the law, Section 503 (a) (6)) "for cooperation with medical, nursing, and welfare groups and organizations." That provision applies to maternal and child health plans. A similar provision applies to crippled children's plans. I call your attention to the fact that these provisions calling for medical cooperation are parts of the Federal act. The States are required to provide it.

Desiring to be as helpful as possible as an organization of physicians, the American Osteopathic Association called on the officers of the State societies of osteopathic physicians to familiarize themselves with the provisions of the law and its aims and purposes, in order that they might the more effectively cooperate in the State plans in such manner and to the extent indicated by the State health agencies, which in the case of the maternal and child health plans was required in the Federal act to be the State health officer. The American Osteopathic Association offered its cooperation to the Children's Bureau and the State osteopathic societies offered their cooperation to the State health officers in effectuating the Social Security medical programs of maternal and child welfare.

We felt that in requiring the States to show medical cooperation, Congress had meant to include osteopathic cooperation within the term "medical cooperation." We expected that under that provision of the Federal law a State plan of maternal and child health or services for crippled children would be required to contain provision for osteopathic assistance and advice in the improvement and extension of the proper medical programs. With osteopathy licensed and practiced in all the States, and osteopathic physicians doing obstetrical, pediatric, and orthopedic surgical work, we had a right to assume that its cooperation and participation was included in the Federal provision.

But within a few months after the law was enacted the Children's Bureau set up a general advisory committee on maternal and child welfare with three additional subcommittees on maternal and child health, crippled children, and child welfare services, on each of which there were from 8 to 12 doctors of medicine and no osteopathic representation on any of them. The Children's Bureau urged the State agencies to set up State and local advisory committees, and following the lead of the Children's Bureau, the States did set up such committees without any consultation or representation of the osteopathic profession.

Notwithstanding the fact that the Children's Bureau's maternal and child welfare advisory committee have not at any time contained osteopathic representation, and notwithstanding the fact that none of the States included osteopathic representation on their advisory committees, the American Osteopathic Association in the late fall of

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1937 called a series of five regional conferences which were attended by the officers of the various State osteopathic societies for the purpose of receiving further instructions on the intent and meaning and operation of the medical programs of the Social Security Act. Again the State societies proffered their cooperation to the State agencies, and requested to be advised on the contents of the State plans already in operation in the States, none of which plans contained anything providing for the cooperation of the osteopathic group in any State, although the plans for all the States were being approved periodically by the Federal approving agencies and the Federal money furnished. In some instances the State plans were made available in full. In other instances they were not. Those that were made available demonstrated the extent of the Social Security programs of medical service. The annual reports of the Federal Social Security Board, which include summaries of the programs administered by the Children's Bureau, also contain information on the medical programs in the States in a general way.

The osteopathic profession is interested in the practical application of the Social Security Act. Some evidence of that practical application is contained in the State plans and in the Federal Social Security Board reports. This national health bill proposes to magnify and extend the programs already in operation. I want to call your attention very briefly and in a very limited way to the manner in which the present programs, without the extension contemplated in this bill, affect the practice and the standing of the osteopathic doctor in his own community. "The past is prologue." Those words are carved in the stone butments of the Federal Archives Building.

The Children's Bureau advisory committee on maternal and child health services met at the Children's Bureau on December 16-17, 1935. That committee consisted of a professor of biochemistry, 2 registered nurses, 1 dentist, and 8 doctors of medicine; a total of 12 members. In addition 4 members of the general advisory committee, all of whom were doctors of medicine, sat with the maternal and child health committee meeting. From the report of that meeting, I quote:

It was the opinion of the committee that as far as possible the maternal and child health work in any given area should be carried on by local qualified physicians; and where such are not available, that other arrangements be made in local maternal and child health centers. The committee also agreed that the medical men taking part in this program should be paid for their services.

The report then says, and I quote:

The development of advisory committees for the purpose of facilitating cooperation of the State health department with medical, nursing, and welfare groups and organizations was discussed. It was the sense of the committee that the purpose of this provision of the act could best be met by the formation of one or more advisory committees on which there should be representatives of medical, nursing, welfare, and other interests concerned.

I have already stated that osteopathic physicians were not then and are not now represented on the Children's Bureau advisory committees, nor the States' advisory committees, and osteopathic advice and services have not been utilized in the local maternal and child health program.

In the third annual report of the Social Security Board the Children's Bureau states:

Some indication of the extent of maternal and child health services under the State plans is shown by the following figures taken from reports of State health officers for the calendar year of 1937: Medical service at prenatal and child health conferences included 185,541 patients' visits for maternity service and 777,594 children's for child health service—more than 12,500 midwives were under instruction and nearly 10,000 midwives' classes were held.

In a few selected areas the plans provide complete medical and nursing service, for those unable to purchase such service, during the prenatal, delivery, and post-partum periods. The funds now available do not permit further extension of strictly medical services for the large number of mothers and children unable to procure such care.

Postgraduate courses of obstetrics and pediatrics arranged by the State health agencies in cooperation with State medical societies have been attended by thousands of local practicing physicians.

In the second annual report of the Social Security Board the Children's Bureau had already stated:

Most of the States have provided for staff-training programs, stipends for nurses and physicians to enable them to obtain specialized maternal and child health and public health training, and, in some States, training centers in local areas. Brief courses of lectures and demonstrations in obstetrics and pediatrics for physicians in active practice in rural areas and in the smaller cities have been arranged in cooperation with State and local medical societies.

In its 1938 Report to the Secretary of Labor, the Children's Bureau said:

Postgraduate lecture courses in obstetrics for local practicing physicians were held in 316 centers in 32 States and were attended by more than 8,000 physicians. Post-graduate lecture courses in pediatrics were attended by more than 6,000 physicians in 234 centers in 26 States. Incomplete reports from 38 States show that in the fiscal year 1938, 274 public health nurses were granted stipends for further training from Children's Bureau funds.

Although the osteopathic profession in the States is engaged in obstetrics and pediatrics, in no case has the cooperation of any State osteopathic society been sought in making any such post-graduate training available to osteopathic physicians. Now, we do not claim that either the State or the Federal Government is obligated to furnish osteopathic physicians post-graduate courses in obstetrics or pediatrics, but we do assert that if the Federal Social Security Act contemplates the improvement of professional services to mothers and children by providing for post-graduate courses to physicians doing obstetrics and pediatrics, such as is being done, it aborts the aims and purpose and dilutes the effectiveness of the act to restrict that service and instruction to doctors of medicine only, when osteopathic physicians are likewise licensed and practicing obstetrics and pediatrics in the States.

Osteopathic physicians are not even permitted to attend the refresher courses which are arranged for the doctors of medicine, excepting one or two cases. In the State of Washington the State department of health consulted the State medical association and the State medical association agreed that osteopathic physicians might sit in on the courses arranged for the doctors of medicine in that State.

The same procedure was followed in Missouri, but with different results. The State Medical Association in that State called on the

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State health officer in the name of "Aesculapius and Hippocrates" "not to look for guidance, education, help, or relief in matters pertaining to health and disease except to doctors of medicine," and requested him not to permit osteopathic participation in the maternal and child-health program. The question whether osteopathic physicians should be allowed to sit in on the refresher courses arranged for Missouri doctors of medicine was actually submitted to the State attorney general of Missouri and the final reply was made by an assistant attorney general under date of February 26, 1938, addressed to the State health officer, in which he says, in part, as follows:

On March 31, 1937, Dr. Gove, director of medical licensure department, State board of health, requested an opinion from this office as to whether or not the refresher courses should be restricted to regular practitioners of medicine.

On April 2, 1937, I replied to said letter and declined, on behalf of the Department, to give him an opinion concerning same. My reason for doing so was that I had been informed that this project, which was financed by Federal funds, had the approval of the Federal Government. Therefore, I thought it a question for the Federal Government rather than for this department.

It is that conception of the State attorney general that I wish beyond everything else to impress upon you gentlemen today. It is not enough that the Federal act does not specifically prohibit osteopathic cooperation and participation in the medical programs involved under the Social Security Act. The fact that osteopathy has not been mentioned as included in the Federal act has been sufficient to raise a doubt in the minds of the administrative officials concerned with carrying out the act, and as I have pointed out and will further show, that doubt has been resolved against permitting osteopathic cooperation and participation.

I have mentioned that there is no osteopathic representation on the Children's Bureau Advisory Committee, and that the States but followed the lead of the Children's Bureau in denying osteopathic representation on the State advisory committee. The States are not any less likely to follow the recommendations of the Federal advisory committee, sponsored as they are by the Federal administrative agency, the Children's Bureau. I call your attention to some of those recommendations.

At its meeting on December 2-4, 1938, the Children's Bureau Advisory Committee on Maternal and Child Health Services reported that:

The committee recommends that local practicing physicians paid from maternal and child-health funds for services in child-health or maternity clinics or conferences, shall be graduates of medical schools approved by the council on medical education and hospitals of the American Medical Association.

The osteopathic colleges are approved and accredited by the American Osteopathic Association, not by the American Medical Association, and that recommendation I just read if followed in the States will disqualify participation by any osteopathic physician.

Consider that recommendation in connection with recommendations made by the same committee at a meeting at the Children's Bureau on April 7 and 8, 1937. At that meeting the Federal advisory committee saw the need for a further extension of maternal and child-health services, a preview of the program contemplated under S. 1620. The committee requested the extension in two directions, first, increased and improved maternity care and care of the newborn. According to the report, the first direction would involve, I quote—

more adequate provision for (a) care in the home at delivery and during the ante-natal and postnatal periods by qualified physicians aided by a Public Health nurse trained and experienced in maternal care; (b) delivery care in approved or acceptable hospitals; (c) consultation service by obstetricians and pediatricians to aid general practitioners in their care of mothers and infants.

The report then states:

In the development of such an extended program the right of the patient to select her own physician should be preserved.

In view of the committee's recommendation that only graduates of American Medical Association approved schools should be permitted to participate, that right of choice of physician means choice among participating doctors of medicine and no others.

With regard to the second direction for extension of maternal- and child-health services—that is, a program of training in these fields for physicians and nurses—the committee stated as its opinion—

That a center or centers of postgraduate education should be established to teach urban and rural practitioners of medicine and nurses the fundamental principles of complete maternal and infant care. Having accepted the principle of providing short intramural courses in obstetrics and the care of the new-born infant for general practitioners, the committee recommends (a) that such training positions carry maintenance and necessary traveling expenses; (b) that intramural postgraduate instruction be a special assignment of members of the teaching staffs of medical schools.

The health program of the Social Security Act is a Federal program, implemented in the States under State plans which have the approval of Federal administrative authorities. But because it is a Federal program, it is natural and I have demonstrated that it is a fact, that the State authorities look to the Federal authorities for guidance. It is now proposed to magnify and extend that medical program. I have tried to point out the necessity for definite inclusion of the osteopathic profession in the Federal act in order that the difficulties already incurred in that regard may not be magnified in proportion to the extension of services authorized under the national health bill, S. 1620.

The maternal- and child-health section of the present act states its purpose to be "to extend and improve services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress." As amended by this bill the purpose of the section is amplified expressly to comprise supplies and facilities and "medical care during maternity and infancy, including medical, surgical, and other related services, and care in the home or institution, and facilities for diagnosis, hospitalization, and aftercare," and "the training of personnel," quite complete, I should say. The bill provides medical care for children during infancy under the amended section 501 and through childhood through the amended section 511. In neither section is there a requirement that the recipient shall be "needy." We ask that such a requirement be inserted in both sections and have prepared and will offer amendments to that effect.

In making allotments to the States for maternal and child-health services and for medical services for children and services for crippled and physically handicapped children, the Children's Bureau is required (on pp. 3 and 10) to take into consideration certain specified factors, which include the total number of births, the child population, the number of mothers and children in need, the financial.

resources of the State, the special problems of maternal and child health and medical care of children. It may be that the quantity and quality of medical care available is intended to be included in the factor of special problems. We think, however, that that is an item of sufficient importance to warrant its specific inclusion, thereby bringing it out in the open as a matter of concern to the Federal administrative authority, and dealing with it accordingly. We have prepared and will offer amendments to that effect, which amendments also provide, in connection with the inclusion of quality of medical care as a factor, that any rules and regulations prescribed by the Federal agency shall provide that licensed practitioners of osteopathy shall be eligible to render the medical services referred to within the scope of their practice as defined by State law.

Senator ELLENDER. Dr. McCaughan, would you have that placed in the Federal statute and make it obligatory on the States to do that?

Dr. McCaughan. That they shall make them "eligible." The next sentence explains that. There is no compulsion involved in that.

Senator ELLENDER. The thing that we have been trying to accomplish in this bill is to make it absolutely certain that the Federal Government will in no wise interfere with the States, or any subdivisions of the States, or in fact dictate to them with respect to their respective health problems.

Dr. McCaughan. If I might comment—I cover it a little later—but I should say that we have attempted to show it already, and other speakers will attempt to show, that that very intent of Congress has been aborted by the failure to include the type of amendment which we would like to submit to you.

Senator ELLENDER. Well, isn't this language broader than that in the other bill?

Dr. McCaughan. We think it is very much more definitive and very much clearer, and gives to the State the right a good deal better than it does under the present suggestion, and prevents misunderstanding and misinterpretation of the law. I think I do cover it as I carry on, and others will touch on the same thing.

Senator ELLENDER. All right, you may proceed.

Dr. McCaughan. There is no compulsion involved in that, but neither is there any further room for doubt about Federal intention and authority for osteopathic participation. That would prevent the respective Federal administrative agencies from expounding, directly or indirectly, any Federal policy, advisory or otherwise, which would interfere with participation by the osteopathic profession in the social-security medical program in the States within the scope of osteopathic practice as defined by State law.

Senator ELLENDER. What is there in the bill to prevent the State plan from incorporating your profession?

Dr. McCaughan. The bill as it is proposed now?

Senator ELLENDER. Yes.

Dr. McCaughan. We think it would perpetuate the situation from which we quoted one example in Missouri where the misinterpretation of the ideas in the—

Senator ELLENDER (interposing). I thought that the present bill made it more definite as you yourself said, and the language is broader, and certainly if a State had the authority or desired, I may say, to include osteopaths, they could do so.

Dr. McCAUGHAN. That is true if the State does not misunderstand. The attorney general in the State of Missouri misunderstood. He is one example of many.

Senator ELLENDER. That brings up this question: Is it not true that your profession, that is the members of your profession, had quite a lot of difficulty in getting recognized in many of the States?

Dr. McCAUGHAN. In days gone by, that is true; yes.

Senator ELLENDER. That is what I am talking about. It strikes me that the thing that you ought to do is to fight your battles back home and not here. I think the trouble really lies in the various States where you practice. If the State plan incorporated the use of your services, certainly the Government could not and would not object to it, and I really believe just offhand that your difficulty lies back home.

Dr. McCAUGHAN. Our intent was to provide that the bill should be unmistakable in its language that what you have just said was your intent, and future speakers will try to give you evidence that it has been misunderstood and misinterpreted.

Senator ELLENDER. If you desire that the bill define what is meant by "medical care" and who should do it—

Dr. McCAUGHAN (interposing). The bill does.

Senator ELLENDER. Beyond that, I do not know what we could do unless you would put compulsory language in the measure, that is what we are trying to avoid.

Dr. McCAUGHAN. We put it in the language of specific permission.

Senator MURRAY. Have you prepared a proposed amendment?

Dr. McCAUGHAN. We have several amendments that I expect to submit to you at the end of this presentation and after the other speakers.

I wish now to direct your attention to certain of the requirements which this bill provides must be met in the various State plans in order to obtain Federal approval and subvention. Under the maternal and child-health section on page 4 as well as others, the State plans are required to provide "methods of establishing and maintaining standards of medical and institutional care, and of remuneration for such care." In arriving at those methods the State agency is required to consult with professional advisory committees, established by the State agency. The Federal agency, however, reserves the right to decide whether the methods adopted by the State agency are sufficient for the efficient operation of the plan. We have prepared and will submit an amendment to that requirement, to the effect that State plans establishing methods for standards of medical care shall recognize and prescribe that licensed practitioners of osteopathy shall be eligible to render the medical care included in the State plan within the scope of their practice as defined by State law. Again there is no compulsion in that. Again, also, there can be no further room for doubt regarding Federal intention and authority for osteopathic participation.

The bill also requires the State plans for maternal and child health as well as those for other services, to provide for State advisory councils composed of members of the professions and agencies that furnish services under the State plans, and other persons informed on the need for provision of the services involved under the State plans.

It is important that all professions of the healing art which are legalized in a State and furnishing services under a State plan should have a place on the advisory council. If the advisory councils are to be consulted as required by this bill on questions involving standards of healing arts services and other matters involving such services, it is merely following after the democratic way to guarantee a voice to all the professions involved. We have prepared and will submit amendments to that effect.

The maternal and child-health section, as well as other sections, provide for the establishment of a Federal advisory council to be composed of the members of the professions and agencies which are concerned with the provision of the service contemplated under the respective titles. Some States license more healing arts professions than do others. There are some professions that are licensed only in a few States. We are not prepared to say whether all the healing-arts professions that may be licensed in one or a few jurisdictions have such an interest nationally or are in a position to contribute nationally, as to entitle them to representation on the Federal advisory councils. We have no hesitancy, however, in asserting that any healing-arts profession that is recognized, regulated, licensed, and practiced in each and every State of the United States, such as is the profession of osteopathy, and which is concerned with and engaged in maternal and child-health services, maternity care and care of infants, medical care for children and services for crippled and other physically handicapped children in need of such care, and public health work, and the construction and operation of hospitals and health centers, and the furnishing of medical care to those unable to provide adequate medical care, such as is the osteopathic profession, in each and every State of the United States, are entitled to assurance under the law that the Federal administrative agencies shall grant that profession representation on the respective Federal advisory councils. We have prepared and will submit an amendment to that effect.

I wish now to direct your attention to title XI of the Social Security Act, as amended by section 5, page 46 of this bill, which includes the definitions generally applicable throughout the act. We have prepared an amendment defining the term "medical services" to include the services of osteopathic practitioners within the scope of their practice as defined by State law. There is no compulsion in that. Neither is there any further room for doubt of the Federal intention and authority for osteopathic participation.

Senator ELLENDER. That is the point that I was emphasizing to you a while ago, that if you could include in your definition of "medical care" or whatever term is used, in your profession, that to my way of thinking, would not be objectionable.

Dr. McCAUGHAN. I think we offer one that is very definitely along that line to which you would not take exception from what you say.

Senator ELLENDER. Along those lines, I could not see any objection to it, provided, of course, that it would come within the scope of the State plans.

Dr. McCAUGHAN. That amendment says that.

Senator ELLENDER. And in that definition, I believe if you had it defined so as to make it specific that a State could not say that it was not intended, then I believe that you would be entirely protected.

Dr. McCaughan. I think that is true, and that is exactly what these amendments refer to.

I desire to file the amendments which I have referred to. It will be found that they are consistent with resolutions adopted by a number of the State osteopathic societies regarding this bill which were mailed directly to this committee and the author of the bill, Senator Wagner. Replying to some of the State societies, I am informed that Senator Wagner suggested that the matter of osteopathic participation and recognition under the medical programs contemplated by the bill were matters solely for determination by the States, and further observed that there is nothing in this bill which will interfere with the State practice acts. I should like to reiterate the fact that this is essentially a Federal program and the State looks to the Federal Government for guidance. The bill expressly provides guidance requirements which must be followed by the States.

In view of the fact that there is doubt among State administrators, as I have demonstrated, as to whether osteopathic cooperation and participation is contemplated and authorized under the provisions of the Federal Act regarding medical programs, we ask Congress expressly to resolve that doubt by amending the bill making it clearly evident that such cooperation and participation is considered by the Federal Government to be a necessary and integral part of the medical programs involved.

Senator Ellender. If we use such language to carry that thought out, it is bound to come within the category of compulsion, is it not?

Dr. McCaughan. You said to them that they must show cooperation with medical societies and organizations. That is already in the Social Security Act. That was ignored in the State, as we have shown. We would like to have this bill amended so that it will be understood that under "Medical organizations" as you require, the osteopathic organizations are to be considered on these advisory committees. That is evidently what you intended, but it was not so interpreted. That is what you have said and what every member that we have talked with has said.

Regarding Senator Wagner's suggestion that the bill does not interfere with State practice acts, I would say that it is small consolation to an osteopathic physician to know that while his State license remains inviolable, his practice is diverted away from him by subsidies to his competitors. If the needy or the medically indigent are to be furnished medical services under systems and devices subsidized by Federal funds and other Federal assistance, which operate under practices and policies such as I have already evidenced to you that deny the cooperation and participation of osteopathic physicians and employ only those of doctors of medicine, that is an unfair preference; yet not a violation of State practice acts. It is, however, a deprivation that is the direct result of a program sponsored by the Federal Government and partially financed by it.

We respectfully submit that the Federal Government has a responsibility on that account, which cannot be shunted to the States. A responsibility, if you please, to the osteopathic profession as citizens of the United States, to make it clear that the eligibility of osteopathic physicians to participate in all the medical programs assisted under the provisions of this act directly or indirectly must be provided and preserved. We think the people that prefer medical services by

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an osteopathic physician, if they are in need and are to be aided in procuring medical services, ought to be protected and allowed to have osteopathic care as a part of the services provided. There is a great prejudice which is attached to the fact that a Federal program, implemented by the States or not, offers assistance to procure medical services from a certain brand of physician but refuses such assistance in case the physician is osteopathic. Under State law we are licensed to practice and we have equality of opportunity in obtaining the patronage of the people. This Federal program has been used to offer inducements to the people to prefer other types of physicians and to refuse osteopathic physicians.

That is why we say it is up to the Federal Government to restore that equality of opportunity, and preserve it in all programs which are sponsored or assisted by the Federal Government. That is the object of the amendments which we suggest should be incorporated in this bill, which I submit for your consideration. That is the object of a resolution regarding this bill which was adopted by the house of delegates of the American Osteopathic Association at its forty-third annual convention held in Dallas, Tex., June 26-30, 1939, and which I should like to submit for the record.

Thank you for your consideration.

(The resolution and proposed amendments referred to are as follows:)

RESOLUTION

Whereas the national health bill, S. 1620, authorizes increased Federal subsidies to the States to support the furnishing of a broader scope of medical care under the maternal and child welfare and public health titles of the Social Security Act; and

Whereas said bill authorizes Federal subsidies to the States for building and maintenance of public hospitals and health centers, and for State systems of providing medical care generally (including compulsory health insurance systems), and for State systems of temporary disability compensation; and

Whereas said bill requires that the States shall submit plans for furnishing the medical and institutional care involved under the titles thereof in the respective States, and requires that said plans shall provide such methods for establishing and maintaining standards of the medical and institutional care and of remuneration for such care, as the respective Federal administrative agencies shall consider necessary for the efficient operation of such plans; and

Whereas said bill requires that the respective State plans shall provide for State and professional advisory councils to advise with the State agencies on matters relating to the establishment and maintenance of standards for medical and institutional care and the remuneration therefor, and authorizes the Federal administrative agencies to set up Federal advisory councils composed of representatives of the professions concerned with rendering medical care under the respective titles; and

Whereas the osteopathic profession, legally recognized, licensed and practiced in all the States is concerned with the promotion of maternal and child health, maternity care and care of infants, medical care for children and services for crippled and other physically handicapped children in need of such care, and public health work, and the construction and operation of hospitals and health centers, and the furnishing of medical care to those unable to provide adequate medical care; and

Whereas said bill contains no provision safeguarding the right of representation of the osteopathic profession on said State and Federal advisory councils, although said profession is legalized and concerned with the provision of the medical care involved in the respective titles in all the States; and

Whereas said bill contains no provision safeguarding to the recipient of the medical services involved the right to choice from among available practitioners of the healing arts legally licensed to practice in the State in which he resides, including the services of practitioners of osteopathy; and

Whereas said bill contains no safeguards against prescription of standards under State plans which shall impose qualifications in addition to State licensure.

for participation in rendering the medical services involved, and which shall discriminate between recognized schools of practice of the healing art: Now therefore be it

Resolved, That the house of delegates of the American Osteopathic Association, representing the State osteopathic societies of the respective States, in forty-third annual convention assembled at Dallas, Tex., this 29th day of June, 1939, hereby does petition and memorialize the Congress of the United States that the aims and purposes of the national health bill, S. 1620, now pending before Congress, require that said bill be revised and amended to expressly safeguard freedom of choice of physician and school of practice to persons entitled to the medical care to be provided, and to expressly provide for osteopathic representation on any Federal and State advisory councils which may be involved, and expressly safeguard the right of osteopathic physicians to participate in the provision of medical care to beneficiaries entitled thereto under the provisions of State plans within the scope of their practice as defined by State law; and be it further

Resolved, That copies of this resolution be transmitted to the Senate and House of Representatives of the United States Congress.

AMERICAN OSTEOPATHIC ASSOCIATION,
R. C. McCaughan, D. O.,
Executive Secretary.

PROPOSED AMENDMENTS TO S. 1620

Pages 2, line 9; 8, line 15; after the word "of", insert "needy".

Pages 3, line 16, after the word "health"; 10, line 10, after the word "children"; 18, line 9; and 36, line 2, after the word "problems", add the words "including the quantity and quality of medical care available: *Provided*, That any rules and regulations which may be prescribed by the (Federal Administrative Agency) shall provide that licensed practitioners of osteopathy shall be eligible to render the medical services herein referred to within the scope of their practice as defined by State law."

Pages 4, line 20; 12, line 8; 19, line 14; 37, line 4, after the word "establish"; and 41, line 26, after the word "basis", add "*Provided*, That such methods of establishing standards of medical care shall recognize and prescribe that licensed practitioners of osteopathy shall be eligible to render the medical care included in said State plan within the scope of their practice as defined by State law."

Pages 4, line 22; 12, line 10; 19, line 16; 28, line 25; and 37, line 6, strike out the word "professions", and insert in lieu thereof the words "various legalized professions of the healing art."

Pages 7, line 19; 15, line 16; 22, line 22; 33, line 4; and 40, line 10, strike out the word "professions", and insert in lieu thereof the words "various professions of the healing art which are legalized in all the States."

Page 47, after line 10, insert a new subsection (b) and re-letter the succeeding subsections, subsection (b) to read as follows: "(b) Subsection (a) of section 1101 of the Social Security Act is amended by adding a new clause 7, as follows: (7) the term 'medical services' means the services of the legalized professions of the healing art within the scope of their practice as defined by State law."

AMERICAN OSTEOPATHIC ASSOCIATION,
R. C. McCaughan, D. O.,

Secretary.

Senator MURRAY. Dr. Edward A. Ward will be the next witness. Dr. Ward, will you state your name and whom you represent?

STATEMENT OF EDWARD A. WARD, D. O., SAGINAW, MICH.

Dr. WARD. My name is Edward A. Ward, Saginaw, Mich., and my connection with this study is shown in this prepared statement.

Senator MURRAY. You may proceed and follow your statement if you so desire.

Dr. WARD. It was my privilege to head the department of public affairs of the American Osteopathic Association, including the bureau of public health and education, from 1930 to 1936, the period during

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which economic despondency and desperation in this country reached its depths and the Social Security Act was conceived and born. During 1938 I was chairman of the association's committee to study health insurance, and I am here to discuss this bill chiefly in relation to that project.

In my opinion title XIII as it appears in this bill is a direct design for the establishment of health-insurance systems in the various States. I have read reports that such is not the case. I shall begin by relating to the committee a few of the reasons which have persuaded and determined the policy of the organized osteopathic profession in regard to this feature of the bill, based on its inclusion of health-insurance promotion. The history of the bill is to us conclusive.

In the early part of June 1934 the President informed Congress of the desirability of legislation furthering the security of the citizen and his family through social insurance, and a few weeks later the President established by Executive order a Committee on Economic Security to study the problems of economic security of individuals and report to him. Within 3 months after its establishment, that committee published a preliminary report rating illness as an important hazard to economic security, and a progress report issued in October 1934, by the committee's executive director, pointed out that its studies of health insurance was causing considerable ferment among the doctors. He said a number of medical societies had expressed concern because the committee was ignoring the medical profession. To quiet these complaints, according to the report, the committee formed a Medical Advisory Committee to receive the views of the medical profession regarding health insurance. I should like to mention at this time that no representative of the osteopathic profession was invited to membership on that committee.

Speaking at a national conference on economic security in Washington during November 1934, President Roosevelt said he intended to recommend the enactment of unemployment legislation to the next Congress; then referring to health insurance, he said:

There is also the problem of economic loss due to sickness—a very serious matter for many families with or without incomes, and therefore, an unfair burden upon the medical profession. Whether we come to this form of insurance soon or later on, I am confident that we can devise a system which will enhance and not hinder the remarkable progress which has been made and is being made in the practice of the professions of medicine and surgery in the United States.

In making the report to the President, January 15, 1935, the Committee on Economic Security said, among other things, with respect to the problem of enabling self-supporting families of small and moderate means to budget against the cost of medical services needed, that the nature of the problem and the nature of the risks involved called for application of the insurance principle to replace the variable and uncertain costs, but, said the committee, more time is necessary to study the problem. The committee did, however, indicate certain broad principles which it considered fundamental to the design of a sound plan of health insurance. I desire to call to your attention two or three of those principles. Said the committee:

In the administration of the services (that is, health and medical services to the insured population and their families) the medical professions should be accorded responsibility for the control of professional personnel and procedures and for the maintenance and improvement of the quality of service; practitioners should have broad freedom to engage in insurance practice, to accept or reject

patients, and to choose the procedure of remuneration for their services; insured persons should have freedom to choose their physicians and institutions, and the insurance plan shall recognize the continuance of the private practice of medicine and of the allied professions.

The administration of health and medical services should be designed on a State-wide basis, under a Federal law of a permissive character.

The role of the Federal Government is conceived to be principally, (a) to establish minimum standards for health-insurance practice, and (b) to provide subsidies, grants, or other financial aids or incentives to States which undertake the development of health-insurance systems which meet the Federal standards.

Two days later, on January 17, 1935, the first draft of the Economic Security Act, as it was then called, was introduced in the House of Representatives, containing a provision directing the Social Insurance Board, which came to be known as the Social Security Board, to study and make recommendations

as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age insurance, unemployment compensation, accident compensation, health insurance and related subjects.

Considerable significance was attached to the fact, however, that the language of that section as it appeared in the reported print of the bill, and as it became a law, was intact with the notable exception that the subject of health insurance, as a required subject of study and investigation by the Board, had been deleted. Nevertheless, the fact that the Board was directed to study subjects related to those that had been retained, was interpreted by the Board to include the duty of investigating health insurance, and to that end a special Division on Health Studies was established in the research department of the Board.

Soon after the Social Security Act became a law, the President appointed in the summer of 1935 an Interdepartmental Committee to Coordinate Health and Welfare Activities. That committee set up a Technical Committee on Medical Care, which in February 1938, brought in such a graphic report of the need for a national health program that the President suggested the calling of a National Health Conference.

Such a National Health Conference was called by the Interdepartmental Committee to meet in Washington in July 1938, and the American Osteopathic Association was invited to send a delegate. I was privileged to be the osteopathic delegate in attendance, and I would like to say again how much the American Osteopathic Association appreciated Miss Roche's invitation to take part in the deliberations of that conference. The Technical Committee on Medical Care submitted recommendations to the conference which furnished the subject-matter of the conference. I call your attention to the fact that one of those recommendations was for Federal grants-in-aid to the States for the costs of a more general medical care program. It proposed that the States have the option of implementing such a program either by a system of public medical services afforded by general taxation or by a system of health insurance contributions.

Title XIII of the national health bill authorizes assistance to the States to extend and improve medical care, including all services and supplies necessary for the prevention, diagnosis, and treatment of disability. It does not limit Federal assistance to State plans which serve merely the indigent or the low-income groups. It would provide Federal assistance for State programs implementing medical care

to the entire population of the State, whether the State system be supported by general taxation or a system of health insurance contributions, or otherwise, so long as the program is State-wide and the State bears part of the cost and meets certain other standards set up in the Federal act. Practically speaking, there is nothing inconsistent between the recommendations of the Technical Committee on Medical Care and title XIII of this act. This act provides that the States must set up methods of administration such as the Social Security Board considers "necessary for the efficient operation of the plan." The Social Security Board would be recreant in its duty if it did not advise and encourage the States to set up plans which would accomplish the desired results in the best and most efficient manner. The contention of the technical committee is that the best method for implementing the medical care involved is by health insurance. The Chairman of the Social Security Board was a member of the President's Interdepartmental Committee which espoused the recommendations of the Technical Committee on Medical Care regarding health insurance as the most desirable means, and the chief of the Division of Health Studies of the Board, Dr. I. S. Falk, perhaps the foremost exponent of health insurance in the country, was a member of the technical committee that made the recommendation.

Now, gentlemen, there may be room for difference of opinion on the import and purport of title XIII as contained in this bill, but so far as we are concerned, there is no doubt in our minds, that title XIII is a design for establishing health insurance systems in every State.

Senator ELLENDER. Dr. Ward, do you suggest language to the committee that would negative your apprehension of that?

Dr. WARD. Understand, the statement is not a criticism, it is an observation.

Senator ELLENDER. I understand—but are you in favor, then, of health insurance?

Dr. WARD. We are not adverse to health insurance if it is properly directed and if the patient is given free choice of physician and our institutions are properly recognized.

Senator ELLENDER. You are not saying that, then, in criticism?

Dr. WARD. Not in criticism.

Senator ELLENDER. Very well.

Dr. WARD. We think the history of the provision definitely points in that direction and we find nothing in the act to the contrary. That is why it is so important to the osteopathic profession throughout these United States that this Federal design shall include in the pattern which it prescribes clear and unequivocal provisions safeguarding to the people their freedom of choice of physician, and safeguarding to the physicians their right to participate or not in the program.

In making its report the Technical Committee on Medical Care for the Interdepartmental Committee made the statement that—

the insurance procedure is entirely compatible with freedom of all practitioners to participate in the plan, and with free choice of physician by the patient, and with wide latitude left to the physicians as to the method of their remuneration.

Section 1303 of the act as provided in this bill would require State plans to set up methods of establishing and maintaining standards of medical and institutional care and of remuneration for such care.

If, as the technical committee says, even the insurance procedure is entirely compatible with freedom of all practitioners to participate

in the plan and with free choice of physician by the patient, then why not make that a cardinal principle and requirement for embodiment in all State plans that bid for the approval of and receive the aid from the Federal Government. Dr. Falk, of the technical committee, in his book on Security Against Sickness, makes the statement that refusing a doctor admission to the panel of participating physicians is equivalent to depriving him of his livelihood. We are a minority school of medicine, but we are licensed and practicing in all the States and the people have a right to our services, and we have a right to furnish our services, as individual patients and individual physicians. We want those rights preserved in any system or superstructure that may be erected whereby the Government establishes or aids in the establishment of means implementing medical care.

The bill requires that the State health agency shall be the administrative agency for State plans under title XIII. That means the State health officer. We have no quarrel with that, but we do desire in that connection to call your attention to certain conditions already existing under the Social Security Act due to the actions of State health officers as Social Security administrators.

In June 1935 in anticipation of the passage of the Social Security Act making available allotments by the Public Health Service to State health officers for the training of public-health personnel in the States, a conference of State and Territorial health officers met with the Surgeon General and made certain recommendations to themselves regarding the basic educational requirements which should be exacted for the positions of local health officers. Among those basic qualifications, leading all the others, was the requirement of the degree of doctor of medicine. All the others could be met by osteopathic physicians, but the requirement of the degree of M. D. as the sine qua non of qualifications was tantamount to disqualifying all osteopathic physicians as trainees, inasmuch as such physicians have the degree of doctor of osteopathy in the place of the degree of doctor of medicine.

Now, there are many osteopathic physicians serving as city health officers and county health officers, and there are a number of osteopathic physicians who are members of State, county, and city boards of health. As a matter of fact, some States require that an osteopathic physician shall be a member of the State board of health. Although we recited those facts to the Surgeon General and to the conference of State and Territorial health officers, and requested them to remove the disqualification of osteopathic physicians, the recommendation persists in its original form. As a result, not a single osteopathic physician serving as a health officer or desiring an appointment as health officer has been appointed as a trainee to receive the public health instruction, the funds for which are provided by the Federal Government under the Social Security Act.

I addressed a communication which was brought to the attention of the Surgeon General in April 1936, in which I pointed out that the Attorney General of my own State of Michigan had specifically ruled that osteopathic physicians in Michigan meet the requirement of "well-educated physician" set out in the State law as prerequisite to appointment as health officers. A number of attorneys general and even the courts in some States have held the same thing. The Surgeon General's reply was that it was not the Public Health Service that

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made the recommendation, but rather the conference of State and Territorial health officers that made it. But there was misunderstanding in the States as to the source of authority of the recommendation. Not even all the personnel of the Public Health Service understood the authority or lack of authority behind the recommendations. Some Federal Public Health personnel specifically referred to the recommendation as having been adopted by the United States Public Health Service as minimum standards. Now, although the Surgeon General had placed the responsibility for these recommendations entirely upon the conference of State and Territorial health officers, and had said that the individual health officers were free to disregard the recommendation in making their selection of trainees, under the circumstances it is not difficult to understand why no State health officer has selected an osteopathic trainee. It has been suggested that since the State health officers adopted the recommendations themselves, they are therefore morally bound, at least, to comply with them. We suggest that the question of morality was involved in the making of the recommendations, rather than now, because as servants of the State and bound by the letter and the spirit of the laws of the States which they represented, they could not properly bind themselves morally or otherwise to policies which emasculate those laws by denying assistance to communities whose health personnel, though meeting all the requirements of State and local law, fail to satisfy some extra-territorial criterion that has no standing whatever under any law.

We observe that according to this bill it is no longer necessary for the Public Health Service to consult with a conference of State and Territorial health officers as a condition precedent to the making of regulations by the Surgeon General. We approve that change. The Surgeon General has been under the duty of calling a conference of State and Territorial health officers annually every year since 1910, for general cooperative purposes. We think that is a wise provision because it is fitting and proper that the Surgeon General should advise with the chief health authorities of the respective States. But to make it necessary for him to advise with them before he can proceed to carry out a Federal law seems unnecessary, and could stalemate the law in case the State officer should refuse to advise.

However, as I have stated, the law has required an annual conference of State and Territorial health officers since 1910. In 1935 they adopted a recommendation which had the effect of disqualifying osteopathic physicians as Social Security trainees for local health officers. Under title XIII as included in this bill, the same State health officers are made the administrative agency for the medical care programs. There is nothing to prevent them recommending the disqualification of osteopathic practitioners as participants in the medical-care program, and therefore, becoming morally bound to see that they don't participate.

As has been pointed out, we seek only the proper safeguards for freedom of opportunity on the part of the people to obtain, and on the part of the osteopathic profession to supply, osteopathic services, and we request this committee to favorably consider the amendments which we offer today and which are calculated to that end. We approve this bill provided those safeguards are expressly made a part of it.

Senator MURRAY. Thank you, Doctor.

The next witness, Dr. Ralph Fischer, of Philadelphia.

STATEMENT OF DR. RALPH L. FISCHER, PHILADELPHIA, PA.

Dr. FISCHER. For a number of years I have been professor of practice and director of clinics at the Philadelphia College of Osteopathy. I was formerly secretary of the Associated Hospitals of Osteopathy, now known as the American Osteopathic Hospital Association, which is allied with the American Osteopathic Association, at whose instance I am appearing here.

This bill, as I understand it, provides for the extension of the medical and hospital facilities provisions of the present Social Security Act, and adds in addition a provision authorizing Federal funds for the construction of additional public hospitals where necessary. There can be no doubt that the hospital facilities of the country are not being availed of to capacity. There is also no doubt that there are areas where adequate hospital facilities are not available. If additional public hospitals are to be built under the impetus and with financial assistance derived from this bill, it ought certainly to be understood that they will not be located in areas where private and charitable hospital facilities are not now being used to capacity.

There are some 150 osteopathic hospitals licensed and operating in the several States, approximately 75 percent of which are general hospitals doing general surgery and obstetrical work, the remainder of which are institutions for nervous and mental diseases and other specialties. In the general hospitals there are in excess of 2,500 beds. On the basis of four and one-half beds per thousand population, that represents hospital facilities for a population of some 641,000.

Twenty-three osteopathic hospitals are formally approved after inspection by the American Osteopathic Association as institutions for training of internes. Others are qualifying according to fixed standards. A number of the State practice laws require internship of osteopathic applicants before examination for license. Internships at these 23 institutions are accredited by the State examining boards.

The American Osteopathic Hospital Association, in common with the American Hospital Association, the Catholic Hospital Association, and the Protestant Hospital Association, has accepted and agreed with the Federal Compensation Commission to provide services to Federal employees at prescribed rates. Prior to the osteopathic amendment of the United States Employees Compensation Act, which became a law May 31, 1938, services and supplies furnished by osteopathic hospitals were not recognized by the Federal Compensation Commission. Under the osteopathic amendment, the law was revised so as to specifically include osteopathic practitioners within the term "physician" and likewise to expressly include services and supplies by osteopathic practitioners and hospitals within the term "medical, surgical, and hospital services and supplies," within the scope of osteopathic practice as defined by State law.

If the amendments to this bill offered by the American Osteopathic Association are adopted by this committee and enacted into law, the services and supplies of osteopathic hospitals will be made available to needy mothers and children and persons unable to provide adequate care from their own means. I speak from personal knowledge when

I say that the Philadelphia Osteopathic Hospital and clinic is overburdened with charity cases, and I call your attention to the fact that the Philadelphia hospital is a non-profit charitable hospital and it, like the other osteopathic hospitals with the exception of the osteopathic unit of the Los Angeles County Hospital, is supported by private funds. All general osteopathic hospitals are public health assets, and perform public health services each day. The Philadelphia Osteopathic Hospital, I happen to know, is listed by the United States Public Health Service as an approved institution for treatment of venereal diseases.

At the invitation of the President's Interdepartmental Committee a delegation from the American Osteopathic Association met with the technical committee on medical care, with regard to the national health program, and submitted excerpts from the catalogs of three representative osteopathic colleges, which described the special departments of their curricula dealing with preventive medicine, bacteriology, hygiene, and sanitation. Those college courses include modern cultural and serological methods, immunization reagents, vaccines, biologicals, arsenicals, quarantine and sanitation and other public health subjects. There are six osteopathic colleges operating in the United States which have been approved as meeting the requirements of the American Osteopathic Association. I should like to refer to the osteopathic leaflet, which is one of the series of guidance leaflets published by the United States Office of Education, which describes the course of study in those osteopathic colleges as follows:

The subject of medical therapeutics, and the practice of medicine are covered in osteopathic colleges by courses in osteopathic therapeutics and the practice of osteopathy. Surgery and pharmacology are taught in all of the six approved osteopathic colleges.

The first 2 years of work cover the basic sciences which include anatomy (descriptive, histology, embryology, dissection), physiology, chemistry, pathology and bacteriology, supplementary therapeutics (toxicology, pharmacology, anesthesia, narcotics, antiseptics), biological therapeutics (vaccines, serums, anti-toxins, etc.).

The last 2 years cover hygiene and sanitation, practice of osteopathy, surgery, obstetrics, gynecology, etc., and include eye, ear, nose, and throat, nervous and mental diseases, public health, etc.

Upon graduation the doctor of osteopathy degree is conferred. Candidates for graduation in all approved colleges must be 21 years of age, and have given a minimum number of osteopathic treatments.

For graduation a student must cover 4 years (60 weeks each) of training in a recognized college which offers about 4,668 hours according to the standard curriculum of the American Osteopathic Association. Some States require additional training in surgery and internship.

Excerpts from that leaflet show that the States require high-school graduation and college work as a prerequisite for entrance to the osteopathic colleges; while this requirement is not specifically mentioned in some States, it is implied by the fact that students must graduate from approved colleges, and these colleges require high-school graduation and at least 1 year of college work for entrance. Four of these colleges now require 2 years of college work of a prescribed nature, and beginning with the fall of 1940 all will require 2 years of preprofessional college work.

While a number of States and the District of Columbia give licenses granting all privileges of physicians and surgeons to osteopathic physicians, in six States the use of surgery is not included, and eight States do not permit the prescription or administration of any drugs.

All six of the recognized osteopathic colleges maintain standard departments in obstetrics and pediatrics and orthopedic surgery and general surgery. They are inspected annually by the Bureau of Professional Education and Colleges of the American Osteopathic Association.

Laboratory and clinical research is sponsored in the colleges and hospitals, and in addition by the American Osteopathic Association. That research is supported entirely by private funds. Among the fields in which osteopathic physicians are engaged in research is that of cancer. I am glad to see that this bill authorizes additional appropriations for the control of that disease which is the scourge of humanity. The osteopathic profession will continue in research on this problem and the osteopathic institutions have every desire to cooperate and collaborate with Government research centers. I should also like to commend the bill for its inclusion of assistance for further pneumonia control. As chairman of the committee on pneumonia control of the American Osteopathic Association, I had the pleasure of collaborating with the Surgeon General in launching his drive for public health education and increased cooperation among physicians for the control of pneumonia.

On behalf of my colleagues who have preceded me in presenting the views of the osteopathic profession here today, and on my own account, I wish to thank this committee for the most considerate attention which has been accorded us.

Senator ELLENDER. Doctor, could you furnish for the record the number of doctors practicing your profession in the various States, and the names of the States wherein you are permitted to practice?

Dr. FISCHER. I should be glad to furnish that, I don't have it available at the present time.

Senator ELLENDER. I understand that. If you will send that in to the committee we will see to it that it is placed in the record at this point in your testimony, that is following your statement.

Dr. FISCHER. Thank you, and in addition, Senator, I would like to place in the record this very short brochure, written by the United States Department of Education, describing osteopathy.

Senator ELLENDER. That will be perfectly all right.

(The documents referred to are printed in the record at this point.)

OSTEOPATHY ¹

(By Walter J. Greenleaf, specialist in occupational information and guidance, United States Office of Education)

[Leaflet No. 23, U. S. Department of the Interior, Office of Education, 1939]

(Leaflet of a series on counseling and advising for occupations; what the occupations are; what preliminary education is required; where professional training is offered; length of training; student budgets; and selected references. The series is designed for the use of high-school and college students, orientation classes, guidance committees, counselors, teachers, and parents.)

OSTEOPATHY AS A CAREER

Osteopathy is a system of treatment based on the theory that disease is chiefly due to deranged mechanism of the bones, muscles, nerves, blood vessels, and other tissues, and can be remedied by therapeutics majoring in manipulations. Osteopathy is the outgrowth of two theories: (1) That the normal living body makes its own remedies to combat any affection which may attack it; and (2) the body is a machine, which can make and distribute these remedies to the best

¹ This leaflet has the approval of the American Osteopathic Association.

advantage only when it is in correct adjustment. Its treatment is largely manipulative, although it teaches and applies surgery, use of drugs, electrical devices, etc. As a healing art it has had legal recognition since 1896, when Vermont first passed a law legalizing the practice; all States now regulate the practice of osteopathy.

The beginnings of osteopathy date from its founder, Dr. Andrew Taylor Still (born 1828), who in 1892 opened at Kirksville, Mo., a school "to improve our system of surgery, midwifery, and treatment of general diseases * * * the adjustment of the bones is the leading feature of this school." This course covered 20 months, was extended in 1904 to 3 years, and again in 1916 to 4 years. The course of study in the accredited colleges, of which there are now six, includes the therapeutic procedures used in medical science, such as surgery, drugs, vaccines, serums, diet, etc.

CENSUS

The 1939 edition of the directory of the American Osteopathic Association shows that there are 9,386 osteopathic physicians in the United States, including 10 in Hawaii and Puerto Rico. This represents an increase of 1,620 names over the 1930 edition of the same directory. Principal increases occurred in California, Maine, Michigan, Missouri, New Jersey, and Oklahoma. The majority of osteopathic physicians are located in these States with the addition of Illinois, Iowa, Kansas, Massachusetts, New York, Ohio, and Pennsylvania. There are almost twice as many practitioners in California as in any other State. There is in the United States 1 osteopathic physician to every 18 doctors of medicine, and 1 per 13,800 population.

COMPENSATION

A Nation-wide survey of the incomes (1929-37) of practicing osteopathic physicians, conducted by the national income section of the Bureau of Foreign and Domestic Commerce with the cooperation of the American Osteopathic Association and the assistance of the Works Progress Administration, shows that the average income derived only from professional services, based on 1,472 returns, was \$2,584 (net income) in 1937 as compared with an average income of \$3,620 (net income) in 1929. Net income, not to be confused with gross income, means receipts after expenses are deducted.

Incomes rise rapidly during the early years of practice to a peak in the 20th to 24th year of practice, and decline thereafter. The maximum level of income with respect to age is in the forties. Osteopathic physicians in places of less than 25,000 population receive the lower average net incomes. In places above the 25,000 population level there is little relationship between the size of city and average net incomes.

LICENSE TO PRACTICE

A student upon graduation from an osteopathic college is required to take State board licensing examinations to practice osteopathy in the State of his choice. The licensing examinations are given in 29 States and Hawaii by a State board of osteopathic examiners; in other States and Puerto Rico by the medical examining boards, 14 of which provide osteopathic members. In 12 States (14 in 1943) all applicants who intend to practice any of the healing arts are required to take an examination in the basic sciences preliminary to the professional examination. While a number of States and the District of Columbia give licenses granting all privileges of physicians and surgeons to osteopathic physicians in 5 States the use of surgery is not included, and 6 States do not permit the prescription or administration of any drugs.

TRAINING REQUIRED

There are six osteopathic colleges operating in the United States which have been approved as meeting the requirements of the American Osteopathic Association. Every State requires high-school graduation and college work as a prerequisite for entrance to the osteopathic colleges; while this requirement is not specifically mentioned in some States, it is implied by the fact that students must graduate from approved colleges, and these colleges require high-school graduation and at least 1 year of college work for entrance. Four of these colleges now require 2 years of college work of a prescribed nature, and beginning with the fall of 1940 all will require 2 years of preprofessional college work. If the

candidate intends to practice in the District of Columbia, Idaho, Indiana, New Jersey, New York, Puerto Rico, Rhode Island, or Virginia, he must present 2 years of college training with specific preosteopathic subjects before entering an osteopathic college. If he intends to practice in Iowa, Kentucky, Mississippi, New Hampshire, or New Jersey, he must present 2 years' training in an accredited liberal arts college. If he intends to practice in California, Connecticut, or Pennsylvania, he must have 1 year of college training in physics, chemistry, and biology.

TIME REQUIRED FOR PROFESSIONAL TRAINING

For graduation a student must cover 4 years (36 weeks each) of training in a recognized college which offers about 4,000 hours according to the standard curriculum of the American Osteopathic Association. Some States require additional training in surgery and internship.

COURSE OF STUDY

The subject of medical therapeutics and the practice of medicine are covered in osteopathic colleges by courses in osteopathic therapeutics and the practice of osteopathy. Surgery and pharmacology are taught in all of the six approved osteopathic colleges.

The first 2 years of work cover the basic sciences, which include anatomy (descriptive, histology, embryology, dissection), physiology, chemistry, pathology and bacteriology, supplementary therapeutics (toxicology, pharmacology, anesthesia, narcotics, antiseptics), biological therapeutics (vaccines, serums, anti-toxins, etc.).

The last 2 years cover hygiene and sanitation, practice of osteopathy, surgery, obstetrics, gynecology, etc., and include eye, ear, nose and throat, nervous and mental diseases, public health, etc.

Upon graduation the doctor of osteopathy degree is conferred. Candidates for graduation in all approved colleges must be 21 years of age, and have given a minimum number of osteopathic treatments.

State requirements for license of osteopathic physicians

State	Number of osteopathic physicians in United States, January 1939	Educational requirements		Nature of board of examiners				Scope of practice				
		Preliminary (HS=high school; col=college)	Professional (osteopathic college) in years	Osteopathic board	Medical board with osteopathic member	Medical board	Basic science board	Does not include		Includes		As taught in osteopathic colleges
								Surgery	Drugs	Surgery	Obstetrics	
1	2	3	4	5	6	7	8	9	10	11	12	13
Alabama	6	HS										
Arizona	18	HS	4									
Arkansas	26	HS	4			X						(C)
California	1,497	HS-1 col	4	X	X		X	(C)	(C)	(C)	(C)	
Colorado	170	HS	4	X								
Connecticut	80	HS-1 col	4		X					(C)	(C)	
Delaware	15	HS	4	X			X					
District of Columbia	28	HS-2 col	4			X						(C)
Florida	175	HS	4		X							
Georgia	62	HS	4	X			X					
Hawaii	9	HS	4	X								
Idaho	55	HS-2 col	4	X								X
Illinois	513	HS	3	X								X
Indiana	126	HS-2 col	4					(C)	(C)	(C)	(C)	
Iowa	404	HS-2 col	4		X			X	X			
Kansas	346	HS	4	X								
Kentucky	45	HS-2 col	4	X			(C)	X	(C)	(C)	(C)	
Louisiana	27	HS	4		X							(C)
Maine	213	HS	3	X						X	X	
Maryland	22	HS	4	X				X	(C)	(C)	(C)	
Massachusetts	323	HS	4	X				X	X	X	X	(C)
Michigan	569	HS	4		X					X	X	
Minnesota	142	HS	4	X			X			X	X	
Mississippi	13	HS-2 col	4	X			X			(C)	(C)	(C)
Missouri	845	HS	4			X		X	(C)	(C)	(C)	(C)
Montana	81	HS	4	X								X
Nebraska	147	HS	4	X						X	X	X
Nevada	10	HS	4	X								
New Hampshire	21	HS-2 col	4	X						X	X	X
New Jersey	346	HS-2 col	4			X				X	X	X
New Mexico	57	HS	4		X					X	X	X

For footnotes see end of table.

State requirements for license of osteopathic physicians—Continued

State	Number of osteopathic physicians in United States, January 1939	Educational requirements		Nature of board of examiners				Scope of practice				
		Preliminary (HS = high school; col = college)	Professional (osteopathic college) in years	Osteopathic board	Medical board with osteopathic member	Medical board	Basic science board	Does not include		Includes		As taught in osteopathic colleges
								Surgery	Drugs	Surgery	Obstetrics	
1	2	3	4	5	6	7	8	9	10	11	12	13
New York	461	HS—2 col.	4									
North Carolina	55	HS	4	X	X			(1)	(3)			
North Dakota	23	HS	4	X					X			
Ohio	478	HS	4									
Oklahoma	225	HS	4				(1)X		(3)			
Oregon	73	HS	4	X								
Pennsylvania	666	HS—2 col (1941)	4	X	X		X					
Puerto Rico	1	HS—2 col.	4									
Rhode Island	97	HS—2 col (1940)	4				X	(3)	(3)			
South Carolina	14	HS	4		X			(3)	(3)			
South Dakota	73	HS	4	X				(3)	(3)			
Tennessee	71	HS	4	X				(3)	X			
Texas	282	HS	4	X				(3)	X			
Utah	21	HS	4		X							
Vermont	39	HS	4	X								
Virginia	32	HS—2 col.	4	X								
Washington	148	HS	4	X	X			(3)	(3)			
West Virginia	84	HS	4	X								
Wisconsin	129	HS	4		X							
Wyoming	18	HS	4		X							
Total, United States	9,386	Col.—15		10	14	7	16	5	6	2	38	12

¹ With exceptions.

² Not defined.

³ Two types of licenses.

⁴ Does not apply to D. O.'s or M. D.'s.

⁵ Manipulation only.

⁶ In 1941 and thereafter.

⁷ College registered by medical board.

⁸ In 1943 and thereafter.

STUDENT EXPENSES

Tuition averages \$232 in the six osteopathic colleges and \$36 (average) is collected in fees. Board and room is estimated at \$318, and varies from \$234 to \$360 per year, according to the school and location. Books may cost about \$60 annually. Other personal expenses which vary with individual taste and pocket-books should be added.

Colleges of osteopathy—Approved by the American Osteopathic Association

Institution and location	Tuition first year	Fees all students pay	Board and room	Enrollments 1938-39	Degrees D. O. 1938
1	2	3	4	5	6
CALIFORNIA					
College of Osteopathic Physicians and Surgeons, Los Angeles.....	\$270	\$15	\$360	203	50
ILLINOIS					
Chicago College of Osteopathy, Chicago.....	210	51	270	213	22
IOWA					
Des Moines Still College of Osteopathy, Des Moines	254	.....	360	186	43
MISSOURI					
Kansas City College of Osteopathy and Surgery, Kansas City.....	200	32	360	160	50
Kirksville College of Osteopathy and Surgery, Kirksville.....	150	80	234	784	190
PENNSYLVANIA					
Philadelphia College of Osteopathy, Philadelphia ...	310	40	324	351	76
Total.....	232	36	318	1,957	431
Averages.....	232	36	318	1,957	431

AMERICAN OSTEOPATHIC ASSOCIATION

The American Osteopathic Association, 540 North Michigan Avenue, Chicago, Ill., was established to promote the public health, and the art and science of the osteopathic school of practice of the healing art, by stimulating research, elevating the standards of osteopathic education, advancing osteopathic knowledge, etc. The association is a federation of divisional societies organized within the States. Members shall be graduates of recognized colleges of osteopathy and licensed practitioners. It publishes a code of ethics, a yearbook, and a journal.

REFERENCES

- Directory, 1939, American Osteopathic Association, Chicago.
 Information: Director of statistics and information and committee on public relations. American Osteopathic Association, 540 North Michigan Avenue, Chicago.
 The Journal of the American Osteopathic Association. (Monthly publication of A. O. A.)
 Catalogs of the six osteopathic colleges.
 Incomes of Dentists and Osteopathic Physicians. United States Department of Commerce. Herman Lasken, Survey of Current Business, April 1939.

EXCERPTS FROM ABSTRACT OF LAWS COVERING THE PRACTICE OF OSTEOPATHY
COMPILED BY THE AMERICAN OSTEOPATHIC ASSOCIATION

Osteopathy is legalized, licensed, and practiced in all the States

United States.—Employees' Compensation Act, as amended by act of Congress approved May 31, 1938, provides: "The term 'physician' includes surgeons and osteopathic practitioners within the scope of their practice as defined by State law.

The term 'medical, surgical, and hospital services and supplies' includes services and supplies by osteopathic practitioners and hospitals within the scope of their practice as defined by State law."

Alabama.—Board—doctors of medicine. Scope of practice—osteopathy "by means of mechanotherapy according to the methods taught in (school of osteopathy)," but not including major surgery or prescribing or administering drugs.

Arizona.—Board—composite, osteopathic member. Scope of practice—no restrictions. Registration under Harrison narcotic law.

Arkansas.—Board—doctors of osteopathy. Scope of practice—minor surgery, obstetrics and toxicology allowed; use of drugs as remedial agents excluded. Registration under Harrison narcotic law.

California.—Board—doctors of osteopathy. Scope of practice—osteopathic physician's and surgeon's license, unlimited; drugless practitioners' license excludes drugs or medical preparations, and surgery except severance of umbilical cord, includes obstetrics. Registration under Harrison narcotic law.

Colorado.—Board—composite, two osteopathic members. Scope of practice—unlimited. Registration under Harrison narcotic law.

Connecticut.—Board—doctors of osteopathy. Scope of practice—as taught in osteopathic colleges, except that surgery requires a special examination of certificate by medical board in surgery and materia medica. Registration under Harrison narcotic law.

Delaware.—Board—doctors of medicine. Scope of practice—unlimited. Registration under Harrison narcotic law.

District of Columbia.—Board—composite, osteopathic member. Scope of practice—unlimited. Registration under Harrison narcotic law.

Florida.—Board—doctors of osteopathy. Scope of practice—all rights and duties of other practitioners except use of drugs not taught in standard colleges of osteopathy; major surgery to graduates of 4-year course or equivalent. Registration under Harrison narcotic law.

Georgia.—Board—doctors of osteopathy. Scope of practice—as taught and practiced in reputable osteopathic colleges, including surgery and obstetrics. (Opinion of State attorney general.) Registration under Harrison narcotic law.

Idaho.—Board—doctors of osteopathy. Scope of practice—undefined. Supreme court decision prohibits internal medication and surgery; attorney general gave opinion that the supreme court decision did not cover minor surgery and that the law permits its practice and use of narcotics. Registration under Harrison narcotic law.

Illinois.—Board—doctors of medicine, osteopathic member. Scope of practice—the treatment of human ailments without the use of drugs or medicine and without operative surgery; obstetrics requires special examination.

Indiana.—Board—composite, osteopathic member. Scope of practice—includes surgery and obstetrics, and use of antiseptics, anesthetics, and narcotics. Registration under Harrison narcotic law.

Iowa.—Board—doctors of osteopathy. Scope of practice—osteopathic physician's and surgeon's license includes major surgery; osteopathic physician's license includes the use of antidotes, biologics, and drugs for minor surgery and obstetrics and simpler remedies for temporary relief, but excludes internal medicine as curative measures. Registration under Harrison narcotic law.

Kansas.—Board—doctors of osteopathy. Scope of practice—as taught and practiced in reputable osteopathic colleges, except drugs as curative measures and surgery. Registration under Harrison narcotic law.

Kentucky.—Board—composite, osteopathic member. Scope of practice—two forms of license formerly issued. For the practice of osteopathy, not including the use of drugs or the practice of surgery with the knife, one was not examined in materia medica and the practice of medicine. For unlimited practice (the only type now issued) the examination includes principles and practice of osteopathy in addition to the complete examination given physicians of other schools. Registration under Harrison narcotic law.

Louisiana.—Board—doctors of osteopathy. Scope of practice—osteopathy, without the use of drugs or medicine, except antiseptics and anodynes locally applied. Registration under Harrison narcotic law.

Maine.—Board—doctors of osteopathy. Scope of practice—as taught and practiced in recognized osteopathic colleges, including the use of such drugs as are necessary in the practice of surgery and obstetrics. Registration under Harrison narcotic law.

Maryland.—Board—doctors of osteopathy. Scope of practice—manipulation only; no surgery.

Massachusetts.—Board—composite, osteopathic member. Scope of practice—unlimited. Registration under Harrison narcotic law.

Michigan.—Board—doctors of osteopathy. Scope of practice—as taught in recognized osteopathic colleges. Registration under Harrison narcotic law.

Minnesota.—Board—doctors of osteopathy. Scope of practice—excludes major surgery and giving or prescribing of drugs for internal use, except anesthetics, and narcotics in minor surgery and obstetrics, antidotes, and antiseptics. Registration under Harrison narcotic law.

Mississippi.—Board—doctors of medicine. Scope of practice—not defined; no surgery nor obstetrics.

Missouri.—Board—doctors of osteopathy. Scope of practice—as taught in osteopathic colleges. Registration under Harrison narcotic law.

Montana.—Board—doctors of osteopathy. Scope of practice—all general practice, including obstetrics and minor surgery; to practice major surgery an applicant with a Montana osteopathic license must have had 2 years premedical work and a year's internship, and pass the M. D. board in surgery.

Nebraska.—Board—doctors of osteopathy. Scope of practice—as taught in osteopathic colleges. Registration under Harrison narcotic law.

Nevada.—Board—doctors of osteopathy. Scope of practice—unlimited. Registration under Harrison narcotic law.

New Hampshire.—Board—doctors of medicine. Scope of practice—unlimited. Registration under Harrison narcotic law.

New Jersey.—Board—composite, osteopathic member. Scope of practice—licenses under the present law include the practice of the healing art in all its branches; licenses under former laws exclude drugs (for internal use) and surgery.

New Mexico.—Board—doctors of osteopathy. Scope of practice—as taught in approved osteopathic colleges, including major surgery. Registration under Harrison narcotic law.

New York.—Board—composite, osteopathic member. Scope of practice—excludes drugs and surgery, except includes minor surgery and the use of anesthetics, antiseptics, narcotics, and biological products. Registration under Harrison narcotic law.

North Carolina.—Board—doctors of osteopathy. Scope of practice—treatment of disease without the use of drugs, as taught in osteopathic colleges recognized by State society; minor surgery.

North Dakota.—Board—doctors of osteopathy. Scope of practice—as taught in osteopathic colleges, except major surgery, but including obstetrics and the drugs required therein. Registration under Harrison narcotic law.

Ohio.—Board—doctors of medicine, osteopathic examining committee. Scope of practice—excludes prescription or administration of drugs except anesthetics and antiseptics; includes surgery and obstetrics. Registration under Harrison narcotic law.

Oklahoma.—Board—doctors of osteopathy. Scope of practice—osteopathic physician's and surgeon's license includes major surgery; osteopathic physician's license includes minor surgery, obstetrics, also antitoxin, vaccine and serum therapy, but excludes use of any drug the nature of which is not taught in recognized osteopathic colleges. Registration under Harrison narcotic law.

Oregon.—Board—composite, osteopathic member. Scope of practice—unlimited. Registration under Harrison narcotic law.

Pennsylvania.—Board—doctors of osteopathy. Scope of practice—osteopathic physician's and surgeon's license includes major surgery and the use of narcotics "as taught and practiced in osteopathic colleges"; osteopathic physician's license includes practice as taught and practiced in colleges of osteopathy (except major surgery), and use of narcotics for minor surgery and obstetrics. Registration under Harrison narcotic law.

Rhode Island.—Board—composite, osteopathic member. Scope of practice—osteopathy in all its branches as taught and practiced in recognized colleges of osteopathy, except the writing of prescriptions for drugs for internal medication and the practice of major surgery. The license for general surgery may be granted after 1 year's internship in an approved hospital. Registration under Harrison narcotic law.

South Carolina.—Board—doctors of osteopathy. Scope of practice—not defined, includes minor surgery and obstetrics.

South Dakota.—Board—doctors of osteopathy. Scope of practice—as taught in osteopathic colleges, except major surgery. Registration under Harrison narcotic law.

Tennessee.—Board—doctors of osteopathy. Scope of practice—as taught in standard osteopathic colleges. Registration under Harrison narcotic law.

Texas.—Board—composite, osteopathic members. Scope of practice—no distinction as to school of therapy. Registration under Harrison narcotic law.

Utah.—Board—doctors of osteopathy. Scope of practice—osteopathic physician and surgeon: "In accordance with tenets of the professional schools of osteopathy recognized by the department of registration"; osteopathic physician: "Without operative surgery, in accordance with the tenets of the professional schools of osteopathy recognized by the department of registration." Registration under Harrison narcotic law.

Vermont.—Board—doctors of osteopathy. Scope of practice—not defined, includes minor surgery. Registration under Harrison narcotic law.

Virginia.—Board—composite, osteopathic member. Scope of practice—osteopathic physician's and surgeon's license, unlimited; osteopathic physicians "may be exempted from taking the examination of the regulars on practice of medicine, materia medica and therapeutics. A license * * * shall not permit the holder thereof to administer drugs or practice surgery unless he has qualified himself to do so by examination before the board." Registration under Harrison narcotic law.

Washington.—Board—doctors of osteopathy. Scope of practice—osteopathic physician's and surgeon's license, unlimited; osteopathic physician's license, as taught in osteopathic colleges, except surgery. Registration under Harrison narcotic law.

West Virginia.—Board—doctors of osteopathy. Scope of practice—unlimited. Registration under Harrison narcotic law.

Wisconsin.—Board—composite, osteopathic member. Scope of practice—osteopathy, surgery, and obstetrics. Registration under Harrison narcotic law.

Wyoming.—Board—composite, osteopathic member. Scope of practice—not defined. Registration under Harrison narcotic law.

Senator MURRAY. Dr. Thorkelson is our next witness.

STATEMENT OF DR. JACOB THORKELSON, REPRESENTATIVE IN CONGRESS, BUTTE, MONT.

Dr. THORKELSON. Mr. Chairman, may I extend these remarks in the record?

Senator MURRAY. You may.

Dr. THORKELSON. Mr. Chairman, I am not going to discuss this act from the medical angle except to say that we have sufficient medical facilities today.

About 100 years ago the average life was about 20 years. Today the average life is supposed to be about 60. Now that in itself is sufficient evidence that the people are receiving sufficient medical care. It is generally conceded when a child is born today that such child will live until it is about 58 or 60, so this act cannot in any sense provide better medical care. The purpose of this act, of course, is not to provide such care. It is, instead, to organize and socialize medicine.

On the face of the act itself, it doesn't come within the right of Congress to pass an act of this sort because there is no provision for it in the Constitution. Congress has no right to pass any act or engage in any activities in business which is in direct competition with private industry. It is quite true that the United States Government has the right, of course, to look after its own personnel in the Army or Navy, there is no question about that, but it also has the right to look after the health activities such as in the examination of ships when they come into quarantine, and other general health conditions throughout the country because it concerns the people as a whole.

But when it steps out of that particular category and steps into private business, then it has reached a little beyond the point where it has a right to go.

Senator ELLENDER. How about the present Social Security Act?

Dr. THORKELSON. That comes within the same category.

Senator ELLENDER. So that ought to be thrown out of the window too, according to your views?

Dr. THORKELSON. I don't say that it should be thrown out of the window. I think we should provide some sort of a plan to take care of people that need aid, of course. You know I am not opposed to those things, but I am speaking on this thing here, if you don't mind, I am speaking on this thing here simply from a purely business viewpoint.

Senator MURRAY. You think that the aid should come by voluntary action on the part of other citizens and not by the Federal Government, that the Government shouldn't intrude itself?

Dr. THORKELSON. On private business, no. I do not believe that the Government should compete with private industry. You can readily see that the purpose of this act—

Senator MURRAY. Your position appears to be in conflict with the American Medical Association in the pending indictment wherein it contends that it is a learned profession and not a business or an industry. Do you think that medicine should be regarded as a private industry?

Dr. THORKELSON. I do.

Senator MURRAY. And that it should conduct that industry under its own supervision and control and that the Government shouldn't make any interference?

Dr. THORKELSON. Under its own supervision and control, just like any other private industry. It is subject to the same laws and regulations that any private industry may be, for it is all private industry.

There seems to be a fatal tendency, there has been for a number of years, for the Members in Congress—pardon me for making that statement—by special acts to create industries that are directly competitive with business itself. Now, then, we must bear this thing in mind, that there are certain powers delegated to Congress, and those powers are clearly set out in the Constitution, and article X reserves the remaining powers that are not mentioned in the Constitution, to the people, to the States and to the people themselves.

And it further states that if there is any question of doubt as to whether we may be right or wrong about these things, then we must give the benefit of the doubt to the people, not to the Government.

But we have reversed that procedure.

You can readily see in building hospitals directly competitive with institutions of that sort that exist today, that it cannot but help to destroy those structures or hospitals. It is easy enough for the Government to take the taxpayers' money, take the earnings from the hospitals in taxes, and take the earnings from other activities concerned with medicine, and use that money in building or hospitalizing a structure. It doesn't cost the Government anything, but the point we must bear in mind is that money is produced by the taxpayers in the United States, and when the Government engages in private industry, directly competitive with such private industries, it is destroying the very source from which it receives the money to build those structures. And that is the point that I contend is clearly unconstitutional in this act.

There is no provision, and there is no one that can show me or anyone else a provision, wherein power is delegated to any body of Congress to pass this legislation, or the Reorganization Act for that matter. We might just as well be fair about it, because the way I feel about those things is that in the end the responsibility is going to rest upon this Congress of the United States, and that is clearly evident in all the legislation that is passed. We see it every day. Permission is requested of Congress to allow certain things to be done, certain powers that someone desires. We pass that by legislation, we give it to them, and also the use of that power. But if they misuse the power, who is to blame? It is we who sit here in Congress of the United States, and that is the reason I object to an act of this sort.

The medical profession has been built up for hundreds of years. It is now to a point where the average life is about 60, and there are adequate medical facilities for everyone. There is no question about that. And the Government also has its own hospitals and it has its health service at the present time. So there is no reason in the world why the Federal Government itself should step in and reach into private industry again, and there is another point to which I want to call your attention here.

When the Federal Government reaches into private business and private families, as they will if an act of this sort is passed, it simply means that we will be subject to the same things that have happened here for the past 6 or 7 years.

Senator ELLENDER. Doctor, would you say the same argument applies to States, that is that tax funds shouldn't be used in order to aid the indigent?

Dr. THORKELSON. That is not the question. I do know the indigent must be cared for.

Senator ELLENDER. Do you mean to say to the committee that everybody in every section of the country is receiving adequate medical attention?

Dr. THORKELSON. I have not seen anyone that has not received adequate medical attention.

Senator ELLENDER. You haven't traveled much, or you have closed your eyes to it.

Dr. THORKELSON. Maybe I haven't, but I have traveled all around this world four times.

Senator ELLENDER. I have too, I have seen quite a lot of it myself, and I wish you would come down South.

Dr. THORKELSON. I lived in South Carolina, in Florida, and North Carolina, and have been in Georgia. I don't know where you are from.

Senator ELLENDER. I am from Louisiana, and I want to tell you this, that we in Louisiana have today six hospitals that are State-maintained from every angle, and if it weren't for those hospitals, if it weren't for the fact that the State of Louisiana is spending several millions of dollars per year to aid the indigent, I don't know where they would go for aid.

Do you believe in that kind of work?

Dr. THORKELSON. I believe the indigent should be taken care of, under some sensible plan.

Senator ELLENDER. Have you ever been through the State of Mississippi?

Dr. THORKELSON. No, I haven't.

Senator ELLENDER. Alabama?

Dr. THORKELSON. No, I have not. I have been down in Texas and Arizona.

Senator ELLENDER. Have you been through South Carolina?

Dr. THORKELSON. Yes.

Senator ELLENDER. And do you mean to say that some of the people in South Carolina don't need medical aid?

Dr. THORKELSON. Well, I have traveled in South Carolina, I used to be captain of a ship one time—

Senator ELLENDER (interposing). You must have visited the coast cities, you didn't go into the interior.

Dr. THORKELSON. Yes; I have been up in the swamps where they cut the cypress timber, and I have seen people that are very very poor, but in no place have I seen any one suffer for the lack of medical care.

Senator MURRAY. Doctor, in our home State you are familiar with the silicosis situation out there?

Dr. THORKELSON. I am.

Senator MURRAY. Would you say that the silicosis victims have always received adequate care and attention?

Dr. THORKELSON. Well, Mr. Chairman, silicosis of course is a deposit of silica or calcium carbonate in the lungs of individuals. Now there is no person living today that isn't somewhat affected with silicosis, because if we stand on the street down here and inhale a mouthful of dust, it settles in the lungs, and it stays there after that. So there is a potential case of silicosis.

Now, then, of course, what you refer to is the miners that work in the mines in Butte. In the past, of course, they inhaled considerable of the dust in the mines and it settled in their lungs, but after it is deposited in the lungs, there is nothing to be done, for there is no treatment for that. It will remain there as long as those people live.

Senator MURRAY. Then you don't think that after a miner in the Butte mines incurs silicosis that any further consideration can be paid to him, that he should be discharged?

Dr. THORKELSON. Yes; I think the man ought to be taken care of, I think we ought to have some insurance plan whereby a working man may be retired when he is 55 years old, or 60, preferably 55, so that he may live comfortably on such income.

Senator MURRAY. But you don't think that he should be accorded any medical treatment or care, hospitalization?

Dr. THORKELSON. Mr. Chairman, there is no medical treatment for silicosis.

Senator MURRAY. Then you think that the silicosis hospital there at Galen, Mont., is a waste of time and funds?

Dr. THORKELSON. Mr. Chairman, that is not a silicosis hospital, that is a tuberculosis hospital.

Senator MURRAY. I mean where they send victims of silicosis.

Dr. THORKELSON. Mr. Chairman, they send victims suffering from tuberculosis to that hospital.

Senator MURRAY. I understand, but don't they also send victims of silicosis?

Dr. THORKELSON. No; because that would be an injustice to those suffering from tuberculosis. Tuberculosis is amenable to treatment

and may be cured. If you fill a hospital up with a number of people suffering from silicosis, you are leaving the people that ought to have care outside, and for that reason the hospitals do not take cases of silicosis as such.

Senator MURRAY. Do you know they are building an addition to the institution over there now, and that the purpose of it is to take care of silicosis victims of the Butte mines?

Dr. THORKELSON. Mr. Chairman, the purpose of the building is for tuberculosis patients. It is not for the silicosis victims in a medical sense. Now then, if one who happened to suffer from silicosis upon which tuberculosis was superimposed, naturally he would also be treated there—not for the silicosis, but for tuberculosis.

Senator MURRAY. Then, assuming that it is for tuberculosis, don't you think that it is a proper function of the Government to provide an institution of that kind for the people infected or afflicted with that disease, which of course is contagious, where they are unable to take care of themselves, and haven't the means to secure aid and medical attention?

Dr. THORKELSON. Mr. Chairman, I believe it is the duty of the State to provide those institutions and not the Federal Government.

Senator MURRAY. Well, where the State is unable by reason of the financial condition of the State to do so, don't you consider it a proper function of the Federal Government to render assistance to those States that are so situated?

Dr. THORKELSON. I don't, for this reason. The Federal Government has no right to take the money from the gentleman's State who is sitting on the left of you there, from Louisiana, and use that to build a hospital in Montana. The people in Montana, themselves ought to be able to look after themselves, and they are able to look after themselves, and the chairman knows this.

Senator ELLENDER. Doctor, in that connection, that would probably be true if our laws and our methods of doing business were not such that a corporation located in the State of New York, one located in Pittsburgh, one located in Philadelphia, can take the cream of the crop out of Montana and not pay to the State of Montana its just proportion of taxes. Federal taxes are paid on the income, it is true, but Montana gets little or no credit by way of cash—then I say that something ought to be done whereby the Federal Government is to aid.

Take Louisiana, for instance. We are third in the country in oil resources and our people are poor, as such.

Dr. THORKELSON. I understand that.

Senator ELLENDER. The moneyed people from other sections come down there and get the cream, and what we are trying to do right now is to retrieve a little bit of it by way of the Federal Treasury.

Dr. THORKELSON. May I say to the gentleman that that is precisely the attitude that Congress has assumed for a number of years.

Senator ELLENDER. And it is going to keep on assuming that same attitude, I hope.

Dr. THORKELSON. Maybe, it all depends on the people.

Senator ELLENDER. Unless the Republicans win and do what they did in the past.

Dr. THORKELSON. I wish the gentleman wouldn't call attention to the Republicans, because I have been a good Democrat—

Senator ELLENDER (interposing). You know the difference between the Republicans and the Democrats—the Republicans have been,

during all the time that they have been in power, taking care of the few, the privileged, whereas the Democrats try to take care of the masses of the people. That is the only difference between the two parties.

Dr. THORKELSON. Since the gentleman mentioned that, let me call your attention to this. There is a condition existing in the United States today that has never existed before, and there is a small group of bankers that now own and control \$15,500,000,000 that belongs to the people, if you please, and that is something that never happened under any Republican administration.

Senator ELLENDER. Oh, my God!

These few bankers accumulated all this money under a Republican regime, that is just the point, and what we are trying to do is to force it in the channels of commerce.

Dr. THORKELSON. Yes; but you are not doing that, because the gold certificates are held by interests outside of the Treasury of the United States, if you please. Uncle Sam has no control of it whatsoever, and your President and your Secretary of the Treasury is holding \$2,000,000,000 of gold, and unconstitutionally, because you will find that section 9 of the Constitution provides that money appropriated from the Treasury must be accounted for in the proper manner, and receipts and expenditures published from time to time. In the Gold Reserve Act there is a provision that the President shall not give any accounting to public officials or any officers in the Government, as to what he has done with the \$2,000,000,000? Now, don't tell me anything about what the Democrats have done with the money, because I can tell you plenty about it.

Senator ELLENDER. You evidently don't believe that all that the New Deal did in 1932 is helping out business?

Dr. THORKELSON. Let me inform you of this. I am not interested in what the Republicans or the Democrats have done. Neither one of them has done right. I am not upholding the Republican Party, and I am not upholding the Democratic Party. I simply wish to present this point here, that the Federal Government itself has no right constitutionally—and you cannot show me—that they have any power whatsoever to engage in competition with private industry. And this is private business.

Now, then, if you will read my remarks, I will be very glad to leave them with you. I am very sorry, but I did not want to get into an argument.

Senator MURRAY. Getting back to the bill and the subject that we have under consideration, don't you know that there has been a long waiting list of miners in Butte suffering with silicosis who have been unable to secure treatment, and that the Miners' Union there has petitioned the State government and the Federal Government with reference to that situation?

Dr. THORKELSON. Mr. Chairman, there is a long list of unfortunate individuals waiting to be admitted into the State Tuberculosis Hospital, Galen, but they are waiting to be admitted because they have tuberculosis. I have examined many of those myself. I know when it is a typical case of silicosis the patient is not admitted to Galen when tuberculosis is superimposed upon silicos.

Senator MURRAY. Do you contend that there is no treatment whatever for silicosis?

Dr. THORKELSON. There is none; no, sir.

Senator MURRAY. No care can be given?

Dr. THORKELSON. No care, except the general care of food and sunlight and the things that all of us need, of course. They need care and healthful food, but there is no medical care for silicosis, because calcium carbonate is insoluble, and when it reaches the lung it remains there.

Senator MURRAY. Doctor, in other sections of the country are there not great stretches of the country where people are unable to secure medical care and attention and hospitalization?

Dr. THORKELSON. Well, in the Southern States, of course they have the Negro element, which is not a problem in the North.

Senator ELLENDER. If the State cannot help those people, don't you think it is the duty of the Federal Government to do so?

Dr. THORKELSON. I think it is for the State.

Senator ELLENDER. If they cannot, and they have not got the money, what then?

Dr. THORKELSON. That should be provided for by every State.

Senator ELLENDER. But how? If they have not got the money?

Dr. THORKELSON. That is up to the State. Huey Long in your own State spent a lot of money.

Senator ELLENDER. Sure, and that is what we did with our money.

Dr. THORKELSON. That is fine.

Senator ELLENDER. That is what we have done and are now doing with our money, but we have not enough of it to do the work as it should be done.

Dr. THORKELSON. That is no reason why Montana and New York should furnish money to Louisiana. There are 48 States, each a sovereign government, within itself, which must according to the Constitution, regulate the business within the State and care for those who cannot care for themselves.

Senator MURRAY. Doctor, your principal objections are legal and constitutional?

Dr. THORKELSON. Yes; because it interferes with private business, and I think we ought to stop doing that.

Senator MURRAY. You are a doctor and not a lawyer, are you not?

Dr. THORKELSON. I am a doctor, and not a lawyer, but I happen to be able to read the Constitution.

Senator MURRAY. I see. And you think that the bill should be not enacted at all—

Dr. THORKELSON. I don't think it should be.

Senator MURRAY (continuing). Because there is no basis for it in the Constitution.

Dr. THORKELSON. I think it should not be enacted because it is clearly unconstitutional like many other measures adopted during the past 10 years, which we must stop sooner or later or something will happen.

Senator ELLENDER. What?

Dr. THORKELSON. Let me give you a book here and you look it over.

(At the request of the witness, and by direction of Senator Murray, the witness extended his remarks, as follows:)

When Senator Wagner said, "I introduced a bill of widespread interest" he was right. The bill (S. 1620) or the National Health Act of 1939, is and will be a bill of national interest. It is a national disgrace, no different than its brother, the Reorganization Act of 1939, of which I am informed it was once a part.

Now what is the bill for? Is it to bring about better health? Of course not. A child born today is conceded by medical men to have a life expectancy of 62 years or over, and to reach such age it must enjoy reasonably good health, and this condition is prevalent at the present time. Can it in fairness be said that our people lack adequate medical care? I believe any fair-minded person would say "no," for we have plenty of hospitals, an oversupply of doctors, fast transportation by airplane, by automobile, by automobile ambulances, and by train service. In the winter when the roads are closed because of snow, I have used an airplane on skis, landing in the streets of small communities so as to provide medical care for those who could not reach a hospital. So the purpose of the bill cannot be for the lack of services and facilities. Is it to provide greater care in maternity cases? It may again be said, "No." It is not for that purpose, for such cases are receiving adequate care today. Is it for prevention and control of disease? No, it is not, for prevention and control of disease is very well developed. We now have preventive inoculation for typhoid, diphtheria, cholera, tetanus, and many other diseases, including vaccination for smallpox.

Before this bill is considered by the House, I shall briefly describe to the members the present status of medicine, the causes of deterioration, the end results, and the real purpose of this act.

We have in the United States today, I believe, the best medical facilities in the world. We have a medical organization that is functioning not as a corporation or a trust, but instead as individuals, such as the doctors engaged in private practice, the small private clinics, and the large private clinics. We have public and private hospitals with free clinics. These institutions serve those in need with free medicine and treatment. Some of these hospitals furnish free hospital service up to certain limits, and many of them even extend charitable hospitalization aid to the point where it hurts the institution.

We have large research and teaching centers such as The Rockefeller Institute, private laboratories, and medical schools including the efforts and observations of individuals and groups, which are collected, reported, and published with free interchange of ideas, experiences, and research. This wide experience and collaboration of knowledge is the result of individual interest by the people engaged in the science of medicine. It is on a highly competitive basis, where pride and prestige is the honor for which they strive.

Medical science and its success therefore depend upon personal ambitions, and can never be a monopoly because each doctor is a complete business within himself. Knowledge cannot be monopolized as long as it remains within the doctor himself.

Medicine cannot be considered mercenary or monopolistic until it becomes commercialized or socialized. The wide experiences and collaborations of medical knowledge is the result of individual interests and cannot in any sense be considered a monopolistic plan on a parallel with federally owned private corporations now so destructive to our national life.

The most destructive blow to medicine is contract practice. Such practice lowers the standard of medicine, and will, I believe, end in retardation as compared with past progress. Socialization now contemplated in this bill takes a step backward, because it will destroy personal ambition, pride, and interest which has been so conspicuous in establishing proper, adequate and efficient medical care.

Many men now engaged in medicine, and I am one of them, will never lift a scalpel under a socialized regime. I shall never operate under the instructions of those who do not understand medicine. I shall never allow myself to be led by the nose by those who are now running around in the Federal Government, as mentally incompetent as many who are confined in asylums. I shall instead let those responsible pay for their own mistakes. I shall heap coals on the fire to accelerate the conflagration, so as to restore sanity within our Nation. There are two ways to learn, and if we are bent upon selecting the hard way—I want to hurry it so we can be finished and begin again as we did 151 years ago.

What is the real purpose of bill S. 1620, the National Health Act of 1939? It is for one purpose—the same that this administration has pursued for the past 6 years, i. e., to socialize and communize the Government for the greater glory of someone within the structure itself, who is not interested in the perpetuation of a sound Republican form of government as the Constitution provides for, but is instead bent upon the destruction of it. If the majority of this Congress desires to go hand in hand with this destruction, the voice of one cannot stop it. It is however my desire to advise the Democratic majority that House Resolution

4425, the Reorganization Act of 1939, is a step well toward the end. It will receive greater momentum by passing S. 1620, and it is positively assured by increasing our national indebtedness. You have made a mistake, and you are responsible when the structure falls upon your heads. It will be such a grand ending to 8 years of an overwhelming Democratic control of Congress.

This bill, as the Senator said, "will be of widespread interest," because it already carries appropriations over a half a billion dollars. This money, of course, will be borrowed on the credit of the United States on Government tax-exempt securities. The interest on these bonds if held by foreigners will be payable in gold.

I would not even attempt to estimate the ultimate cost of the administration of this bill without one iota of medical aid. I venture to say if adopted, it will cost over half a billion dollars a year in its administration alone. The total cost to the Nation after it is in full operation no doubt will be more than the spending cost of the Federal Government should be. That is an angle which should interest every one of us, because it concerns itself with money—and borrowed money, if you please.

The object of the bill is for one purpose, and it is not of health. It is instead to establish a complete centralized control of the United States and to open the door of every private home to un-American propaganda—the same propaganda that has been passed out by the many Federal publicity bureaus for the past 6 years.

The House passed the reorganization bill, which is in itself a most flagrant invasion of the constitutional rights of the people. This bill if passed will be subjected to the same bizarre shifting about and regulation as are all activities, under the reorganization bill.

Playing cards were invented to amuse Charles the Fourteenth, and the Nation's departments to amuse someone in the Federal Government. I live in continual dread of this most abnormal and dangerous attitude of Congress, which seems to be bent upon destroying sound constitutional government.

I wonder if the people throughout the land realize what is happening to the American Nation. I cannot understand how they can be ignorant of the happenings here in Washington but if they are, I hope those who read this little chat will pass the information along for their own sake, and so help to safeguard the life of the Republic.

Let us analyze S. 1620, the National Health Act of 1939.

First. We want to know who drafted the bill, and what particular power is interested in passing this legislation. It is, of course, unnecessary and uncalled for, so what Congress should look into is the objective. The fact that it is highly desirable legislation for someone is evident in the fact that the weapon for enactment of this legislation may be found in sympathetic appeal for public support. The benefactors who propose this measure pretend to give something to the public free of charge, and in this particular case it is medical care. It will, of course, end up in the building of hospitals with the ultimate destruction of those which are now operating with private capital. No doubt it will end in the control of the dental profession as well as the medical profession. It will extend even further than that, for it will include drug stores and all appliances and supplies connected with the medical and dental professions. It can easily be seen that this plan is far reaching, and it is for no other purpose than to bring these professions under the control of the Secretary of Labor, the Chief of the Childrens Bureau, and the Surgeon General of the United States. It promises nothing but regulation, and is for the sole purpose of gaining greater control in order to destroy constitutional government.

In order to clarify my statement, I shall quote a part of this bill, and discuss briefly the headlines of the different paragraphs, so that you may have a clearer understanding of it.

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

"PART 1—MATERNAL AND CHILD HEALTH SERVICES

"SEC. 501. For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and in areas suffering from severe economic distress, to extend and improve services, supplies and facilities for promoting the health of mothers and children, and medical care during maternity and infancy, including medical, surgical and other related services and care in the home or in institutions, and facilities for diagnosis, hospitalization, and after care: and to develop more effective measures for carrying out the purposes of this part of this title, including the training of personnel."

This is the same old appeal. It opens the flood gates to the lachrymal glands, and starts the majority of Congress weeping. It instills fear in their hearts that they might not be reelected to Congress if the bill is not passed.

I shall now quote from the bill itself, so that you may know that it is for no other purpose except to build up a putrid political machine.

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

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

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

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

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

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

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

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

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

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

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

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

"SEC. 507. Rules and Regulations. 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."

This is only a very small part of the regulations. I shall not mention them all because there are pages of them. The people who are concerned in this are the Secretary of Labor, whom you all know of, the Chief of the Children's Bureau, and the Surgeon General of the United States. These three individuals are best known for their political activities.

Will the States get any money out of this? In section 502 (a) and (b) no mention is made of it except by intimation.

I shall quote section 504, "Payments to States," so that you may have a better idea of the plans.

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

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

In section 511, \$73,000,000 is appropriated which shall be paid to the State if approved by the Chief of the Children's Bureau. Out of this \$73,000,000, we find in section 512 that \$38,000,000 is set aside for certain care of children, the allotments to be determined by rules and regulations prescribed by the Chief of the Children's Bureau, to be approved by the Secretary of Labor.

Section 513 concerns itself with rules for approval of State plans, a mass of planning which has been so fatal for the past 6 years. Our Nation has turned into a madhouse filled with insane planners, who in my opinion as a medical man belong within the walls of some of the sanitariums they expect to build.

In section 514, entitled "Payments to States" no specific sum is mentioned. There is only a paper transaction.

The next paragraph concerns itself with the operation of State plans. Section 516 concerns Federal Advisory Councils, and section 517 takes up rules and regulations.

Section 541 concerns itself with Administration. In this paragraph, \$2,500,000 is set aside for administering the Children's Bureau, which also concerns itself with investigations, demonstrations and various other regulations.

This brings us to title 6, "Public Health Work and Investigations." The first paragraph, section 601, sets aside \$100,000,000 for various activities. The sums authorized under this section shall be used in making payments to States which have capitulated to the Surgeon General of the Public Health Service.

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

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

This gives you a general idea of how the system works. One hundred million is appropriated, but they have not the slightest idea how it shall be allotted. It is an imaginary flight of warped mentality.

Section 603, entitled "Approval of State Plans," is also a mass of regulations which finally ends under the supervision of the Surgeon General of the United States.

"SECTION 603. (a) A State plan to effectuate the purposes of this title shall—

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

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

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

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

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

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

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

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

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

Section 605 is entitled "Operation of State Plans," section 606, "Federal Advisory Councils," and section 607, "Rules and Regulations." But when you come to section 608, entitled "Administration," \$1,500,000 is set aside to pay administration expenses for 1 years. You can readily see from this, Mr. Taxpayer, that these Federal spendthrifts do not deny unto themselves your money.

In section 611, part 2 concerns itself with investigations, and to pay for such investigations a sum of \$10,500,000 is set aside. This is to pay for allowances and travel expense of regular and reserve officers of the Public Health Service.

Section 1201, "Appropriations," sets aside \$158,000,000, and in section 1202, entitled "Allotment to the States," nothing is said about how it shall be allotted, but the Surgeon General of the Public Health Service is the commanding officer for the whole country.

In section 1203, entitled "Approval of State Plans," I want to call your attention to the fact that paragraph 1 provides again for financial participation by the State.

The State should not forget as it sells itself into Federal slavery—it does not only furnish the money which is used by the Federal Government, but it is actually compelled to raise and furnish money within the State to provide greater and more complete destruction of itself. It is certainly a wonderful and great plan to bring about a totalitarian state or a dictatorial government by kidding the people into committing national suicide.

Section 1204, entitled "Payment to the States," mentions \$450 as allotment for beds; \$300 is for a bed in a hospital and \$150 for a bed in a mental hospital. There is, of course, a distinction in the two beds, the cheaper going to those who cannot

complain. I wonder how many taxpayers sleep in \$300 or \$150 beds? It would be interesting to know.

Section 1205 is entitled "Operation of State Plans."

Section 1206 is "Federal Advisory Councils."

Section 1207 concerns itself with "Rules and Regulations," but in section 1208, entitled "Administration," these noble boys appropriate \$1,000,000 for their expenses. I don't want you to overlook this, Mr. Taxpayer. These noble boys do not overlook payment to themselves.

Title XIII concerns "Grants to States for Medical Care." In section 1301, "Appropriations," \$35,000,000 is set aside, and in 1302, "Allotment to the States," no money is mentioned, but again it deals with regulations and problems. Section 1303, entitled "Approval of State Plans," provides again for financial participation by the States. It strikes me that the boys who are going to run this roost are not much different from our Shakespearean Shylock.

Section 1305, "Operations of State Plans," section 1306, "Federal Advisory Councils," and section 1307, "Rules and Regulations," are like the others. Under section 1308, "Administration," \$1,000,000 is set aside to defray expenses.

Section 1401, entitled "Appropriations" sets aside another \$10,000,000, which may be paid to the States which have submitted and been approved by the Board.

Section 1402 states, "State Temporary Disability Compensation Plans," but this paragraph concerns itself with nothing but regulations.

Section 1404 headed "Administration," sets aside \$250,000 for salary and expenses.

Section 1405 graciously supplies the reader with definitions. In the end of this paragraph, the highest amount is to be expended in the poorest State, that is 66½ percent, and 16½ percent to the State with the highest financial resources. It is, therefore, a sort of a socialistic plan in which an attempt is made to penalize the industrious State at the expense of another. I do not believe Senator Wagner's own State would like that very much, because I believe the State of New York will be classed as one with the highest financial resources.

I shall now quote the last paragraph regarding appropriations:

"The new appropriations authorized in the first year for all phases of the program, including administrative costs, aggregate approximately \$80,000,000, exclusive of amounts which may be appropriated in the discretion of Congress for aiding the States in the construction of needed tuberculosis and mental hospitals. This sum will be gradually increased over a 10-year period and will be available to match sums appropriated by the States toward the cost of their respective programs. No new Federal pay-roll taxes are authorized.

"In order to make the available funds serve the interest of those localities and States which are in greatest need of the services, the bill authorizes grants on a variable matching basis, depending on the relative financial resources of the several States, as determined by the per capita income of their inhabitants. For the various programs of public health services and hospital construction the authorized Federal grants will vary from 33¼ to 66¾ percent of the total sums expended by the States; for general programs of medical care the matching ratio varies from 16¾ to 50 percent of total State expenditures. In this way the bill will raise the general level of health protection throughout the country, while reducing the existing wide variations among the States, and especially as between rural and urban areas."

We can therefore come to only one conclusion, that this bill is for no other purpose than to build up a political machine. It is an invasion of States' rights, and destructive to business itself. It will destroy private hospitals. It will destroy the medical profession, the dental profession, and in the end, it will include drugs and drug stores. It is the final milestone toward a communistic, socialistic, controlled government.

The CHAIRMAN. That will conclude the testimony for the day, and it also concludes the hearings.

The Chair will direct that certain communications and statements received in relation to this bill shall be incorporated in the record at the conclusion of today's hearings.

(Whereupon, at 11:55 a. m. the hearings were concluded.)

THE MASSACHUSETTS MEDICAL SOCIETY,
EXECUTIVE OFFICES,
Boston, Mass., May 29, 1939.

Senator JAMES E. MURRAY,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: I want to thank you for the sympathetic hearing you gave me in my presentation of the material concerning the Wagner health bill. At the very beginning I made one technical error in connection with the answering of Senator Ellender's questions that might have been misconstrued by him, Senator Wagner, and yourself, and might get me in wrong with the medical society back home. When Senator Ellender asked me in regard to the divided vote of our committee as to where the minority stood, I answered with a flat statement they are against the bill which is perfectly correct. I, however, should have gone on to explain that our division of opinion was not on the matter of whether to oppose this bill but whether to take a position identical to that of the American Medical Association or whether we should admit as I did, and as the majority wanted me to, that the bill had some good features and we might consider supporting the bill if sufficient features we felt harmful are corrected.

Our society has its annual meeting next week. This whole matter will be gone over then and following the meeting I will let you know at once whether the position I expressed has been endorsed by the society or repudiated. In either case I will communicate to you any resolutions or suggestions that come out of the meeting.

I wish you would let Senator Wagner and Senator Ellender see this letter and thank them for me.

Sincerely yours,

CHARLES C. LUND, M. D.,
Chairman, Committee on State and National Legislation.

THE MASSACHUSETTS MEDICAL SOCIETY,
EXECUTIVE OFFICES,
Boston, Mass., June 8, 1939.

Senator JAMES E. MURRAY,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: You may be interested to know that my statement to the subcommittee concerning the Wagner bill was presented to the council of the Massachusetts Medical Society, which is our legislative body, and unanimously endorsed yesterday. At the same time the council adopted a resolution urging the American Medical Association to prepare and have introduced in Congress suitable legislation along the same line that is covered by the Wagner bill. In due course following the meeting you will receive an official statement from the secretary of the society concerning these two resolutions.

Thanking you again for your kind consideration at your hearing.

Sincerely yours,

CHARLES C. LUND, M. D.,
Chairman, Committee on State and National Legislation.

UNITED STATES SENATE,
COMMITTEE ON THE JUDICIARY,
June 14, 1939.

HON. JAMES E. MURRAY,
United States Senate.

DEAR SENATOR: Recalling our conversation in which you advised me that a witness appearing before your committee had pointed out that the Carrie Tingley Hospital in New Mexico was an example of the building of hospitals where they are not needed, I contacted the chairman of the board of directors of the hospital, who has prepared a statement on what has been accomplished in the hospital. I am enclosing this statement in the hope you can have it inserted in the hearings.

From this statement you will observe that approximately 500 cases have been admitted and treated since the hospital was opened. There remain several hundred, in fact available figures disclose 800 or 900, children in New Mexico yet to be treated. When all these cases are treated, 1,400 or 1,500 children will have received treatment at this hospital which they would not have otherwise received. The witness who testified may think that spending approximately \$900,000 for

building and equipping the hospital is waste, but restoring 1,500 children to health seems to me to justify the cost of the entire project, even if there are no more children treated. Of course it is intended that the hospital will be used for the treatment of children from States other than New Mexico.

I, myself, have every confidence in the Carrie Tingley Hospital and believe it has served a worthwhile and useful purpose. I trust you can insert the statement of Dr. Colvard in the committee hearings.

Sincerely yours,

CARL A. HATCH.

DR. COLVARD'S STATEMENTS

The Carrie Tingley Hospital was constructed at Hot Springs, N. Mex., by Works Progress Administration labor as a project which was approved, and cost the Federal Government approximately \$900,000 for building and equipment. This includes the State's share of construction cost, and the hospital was opened to receive patients September 1, 1937. A survey conducted by the Department of Public Welfare examined children for crippling conditions, including children from birth to the age of 21. These clinics have shown approximately 1,400 of the State who are eligible for and have been recommended to the hospital board for admission to date. Since the opening of the hospital approximately 500 cases have been admitted and treatment started. Obviously some of these patients will have to receive treatment over a period of months but a large number have been discharged as cured. The incidence of infantile paralysis has been found to be approximately 33 $\frac{1}{2}$ percent as a basic cause for the physical defects found. A large amount of tuberculosis of the bone, it is believed, can secure more beneficial treatment productive of permanent cure at this hospital than in most orthopedic hospitals, due to the excessive sunshine found in the State of New Mexico, which is quite a factor in the successful treatment of bone tuberculosis. It will be seen from the above figures that between 800 and 900 children are yet to be treated, and it is my belief that within the next 3 to 5 years this accumulated State load of patients will have been taken care of. Subsequent to that time it is probable that the normal occurrence of crippling conditions in the State will not be sufficient to justify the full-time operation of this hospital, and it is believed that some national foundation can be interested in utilizing its services and steps have already been taken and the foundation laid for such utilization. During the past 3 months the facilities of the hospital have been inspected by a representative of one of the large foundations and an entirely favorable report made regarding such benefits for this institution.

The physical equipment of this hospital is unique in that all services required in the treatment and care of these various crippling conditions can be cared for under one roof. In many of the larger institutions, surgery, braces or one of the facilities we offer have to be obtained from some other institution. The advantage of these facilities all being available at the hospital during the child's one stay there, or one period of stay there, is obvious.

The degree of disablement of the child has varied from complete inability to walk or stand erect to permanent deformities, such as hare-lip and cleft palate. Of these 1,400 children we believe that a large percentage can be restored to useful citizenship and to at least a semblance of normal physical makeup.

The Legislature of the State of New Mexico in 1937 appropriated approximately \$10,000 per month to operate this hospital, which was supplemented with funds from the Crippled Children's Bureau of the Federal Department of Public Welfare. The legislature of 1939 has appropriated \$105,000 per annum for the next biennium for operation of the hospital. The operative control of the hospital is under a board of three directors appointed by the Governor for terms of 2, 4, and 6 years, respectively.

GEORGE T. COLVARD, M. D.,
Chairman, Board of Directors of Carrie Tingley Hospital.

PHILADELPHIA BOARD OF TRADE,
Philadelphia, May 23, 1939.

Hon. JAS. J. DAVIS,
United States Senate, Washington, D. C.

MY DEAR SENATOR: I enclose you herewith certified copy of a memorial adopted by the Philadelphia Board of Trade protesting enactment of S. 1620

(to be known as the National Health Act), and would appreciate your having this presented and referred to the proper committee.

Very truly yours,

H. W. WILLS, *Secretary.*

PHILADELPHIA BOARD OF TRADE,
Philadelphia, May 22, 1939.

To the Honorable the Senate and House of Representatives, in Congress Assembled:

This memorial of the Philadelphia Board of Trade respectfully represents:

That the executive council of the Philadelphia Board of Trade has carefully considered the provisions of Senate bill 1620 (to be known as the National Health Act) and which proposes that the several States shall make more adequate provisions for public health, disease-preventive service, maternal and child-health services, maintenance and construction of hospitals, health services, etc., including disability insurance as well as amendment of the Social Security Act, and emphatically urges your unfavorable action thereon.

That our national economy requires retrenchment in Federal disbursements and abandonment of the current paternalistic program; it is the people's business to support the Government—not the Government to support the people.

That practical experience and an acquaintance with the principles of democratic government as established under the Constitution of the United States have led this board of trade to the conviction that the proposal submitted in this bill would demonstrate a socially and economically unwise function on part of the Federal authority.

That the proposed expenditure of not less than \$439,000,000 drawn from the United States Treasury and distributed among the several States according to the financial resources of each, promises a political gratuity which invites wanton waste of public funds at the same time blazing a new avenue in the violation of what we have so long recognized as the rights of the individual States.

That while we recognize the humane ideals which ostensibly motivate such proposed legislation we most respectfully urge that such a program as that proposed would initiate under a partial disguise a system of "State medicine" with all the perversions and iniquities which such a paternal policy would encourage and therefore Congress must shun the temptation of partisan political aggrandisement in the sincere advancement of human welfare by refusing to promote such a system as that now submitted, being confident that by proper educational methods the essential facilities may be provided by the individual States as their respective financial resources may permit and that thus sound and practical economy may be conserved and a more responsible service secured for the proper care and development of the public health, morally and physically.

Therefore, for the reasons hereinbefore cited, the executive council of the Philadelphia Board of Trade urgently represents that your honorable body disapprove enactment of S. 1620, to be known as the National Health Act.

THE PHILADELPHIA BOARD OF TRADE,
GEO. L. MARKLAND, Jr., *President.*

H. W. WILLS, *Secretary.*

[SEAL]

Attest:

(The following was requested to be furnished for the record. See p. 275, pt. 1.)

STATE, COUNTY, AND MUNICIPAL WORKERS OF AMERICA

Affiliated with C. I. O. New York District

Senator JAMES E. MURRAY,

Chairman Subcommittee on Education and Labor, Washington, D. C.

MY DEAR SENATOR MURRAY: May I take this opportunity to express my appreciation for the courteous treatment accorded me at the hearings before your committee on the 12th of May?

Attached please find information regarding New York State and city hospitals, which was requested by a member of the committee.

Sincerely and respectfully yours,

MARY LUCIEL MCGORKEY, R. N.,
*Chairman, New York State Industrial Union Council,
Congress of Industrial Organizations.*

NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE HOSPITALS

Patients		Patients	
Binghamton.....	2, 800	Marcy.....	2, 400
Brooklyn.....	2, 700	Middletown.....	3, 300
Buffalo.....	2, 200	Pilgrim.....	8, 600
Central Islip.....	6, 800	Rochester.....	3, 100
Creedmoor.....	4, 500	Rockland.....	6, 700
Gowanda.....	2, 200	St. Lawrence.....	2, 100
Harlem Valley.....	4, 500	Utica.....	1, 650
Hudson River.....	4, 400	Willard.....	2, 900
Kings Park.....	5, 700		
Manhattan.....	3, 000	Total.....	69, 550

STATE SCHOOLS AND CRAIG COLONY

Patients		Patients	
Letchworth Village.....	3, 700	Wassalo.....	4, 000
Newark.....	2, 300	Craig Colony.....	2, 250
Rome.....	3, 400		
Syracuse.....	1, 050	Total.....	16, 700

The daily patient population within these institutions is 86,250. The cost to the State per patient, per day, is estimated at \$1. The cost per meal per patient 6 cents.

All the above figures were taken from the official report of the State Department of Mental Hygiene.

MUNICIPAL HOSPITALS IN NEW YORK CITY

There are 28 municipal hospitals in New York City, with a total bed capacity of 18,836. There were 266,892 patients hospitalized during the year ending December 31, 1937. There were 2,628,253 clinic visits made to these hospitals during the same period. The average per-capita cost for in-patients was \$3.58 per day. Our city hospitals function at 98-percent capacity at all times, thus making it difficult and in some instances impossible to maintain sanitary conditions.

Submitted by:

MARY LUCIEL MCGORKEY,
Chairman, New York State Industrial Union Council,
Congress of Industrial Organizations.

THE AMERICAN ASSOCIATION OF MEDICAL SOCIAL WORKERS, INC.

Chicago, Ill.

NEW YORK SCHOOL OF SOCIAL WORK,
New York, N. Y., May 25, 1939.

Re Wagner national health bill (S. 1620).

Hon. JAMES E. MURRAY,
Chairman, Subcommittee of the Senate Committee on Education and Labor,
United States Senate, Washington, D. C.

MY DEAR SENATOR MURRAY: The President of the American Association of Medical Social Workers, Miss Agnes Schroeder, has authorized me to send you a brief statement summarizing the reasons which medical social workers have for supporting the Federal Government's health program.

Medical social workers are employed in hospitals and in community health and welfare organizations.

Those in hospitals know from first-hand experience of the difficulties encountered by both institution and patient in meeting the costs of adequate medical care. They know of and often take part in the admission of patients, which means also the exclusion of ineligible, and, when hospitals assume responsibility for seeing that refused applicants are advised where else to seek help it is often the social worker who gives this advice as to resources available. They know of the long waiting lists of institutions for care of chronic invalids and

defectives, of the crowded wards of many public hospitals, and of the total lack of some special facilities even in the better-supplied communities.

In the services outside of hospitals, medical social workers are attempting to aid in case-finding and in the coordination and use of all existing health agencies. To workers in this field the lack of both curative and preventive facilities is a constant and an urgent problem. The beginning already made under Social Security and State initiative is showing the need to be greater than we know.

The following summary is made from reports from a number of workers in city, State, and Federal health and welfare services.

Rural communities show the greatest lack of facilities for medical care. Need is reported for the expansion of public-health services, maternal and child care, construction of hospitals and clinics, and a better general medical program. There are areas in which there is no doctor, nurse, or hospital, and whole States in which treatment centers are few. "There are many people who get no medical service at all." There is also the problem of transportation. "Because of mountain topography, funeral expenses, instead of hospital bills, are sometimes paid."

In one State the diagnostic clinics set up under the crippled children's program have found more than 2,000 children in need of treatment; only a fraction of them can be cared for unless there is an expansion of present facilities and expenditures. Long waiting lists are reported, of children needing surgical treatment of various kinds. In some places the provision for care for adults is even less than that for children.

A report from a medical social worker who has observed health work in 18 States says that in clinics for crippled children in rural areas a great number of illnesses are revealed besides the orthopedic handicap. "These clinics which have been set up for specialized service represent the first opportunity of numbers of families to consult any physician." The need for general diagnostic and treatment resources is thus revealed by the partial program made possible by the Social Security grant.

We think the investment would be good, even in terms of money. One State initiated a hospital and clinic program in which dentistry is featured, because social workers found that more than three-fourths of the relief recipients had bad teeth. It is said that during the first 3 months over 9,000 persons were treated, and that 110 families were known to have been removed from relief rolls, returned to health and employment through dentistry.

Differences in procedure are noted when medical care is the sole responsibility of counties. Many counties cannot pay for doctors' services and so omit even such important measures as care of syphilis, even though the State may offer free laboratory tests and drugs.

There is everywhere emphasis upon the need for a balanced and a general program, both because of administrative practicability and economy, and because of the danger of diverting money and interest into certain services at the expense of others equally necessary.

Yours very-sincerely,

ANTOINETTE CANNON.

VETERANS' ADMINISTRATION,
Washington, June 1, 1930.

HON. JAMES E. MURRAY,
United States Senate, Washington, D. C.

MY DEAR SENATOR MURRAY: I have been informed that at a hearing held before the subcommittee of the Senate Committee on Education and Labor, of which you are chairman, Dr. Heyd, of New York, made the statement that "In the Veterans' hospitals it takes 29 days to take out tonsils and discharge the patient. In civilian hospitals it takes 3 to 4 days."

I think that Dr. Heyd's statement was made without full knowledge of the facts in this matter. The average period of hospitalization for tonsillectomy in facilities of the Veterans' Administration conforms to that in civilian hospitals of the better class. When this average period of hospitalization for tonsil operation is exceeded, it is because of complications in the individual case or because the patient is retained in hospital for associated treatment of some other disorder, or to accomplish a general physical examination, the report of which is to be used in the adjudication of a claim for disability compensation, pension, insurance, etc.

Very truly yours,

FRANK T. HINES, Administrator.

THE NATIONAL BOARD OF THE YOUNG WOMEN'S CHRISTIAN ASSOCIATIONS OF THE
UNITED STATES OF AMERICA

600 Lexington Avenue

NEW YORK, N. Y., April 13, 1939

Statement from the National Board of the Young Women's Christian Associations
on the need for Federal aid for improving health conditions in the United States

The Public Affairs Program adopted at the 1938 National Convention of the Young Women's Christian Associations of the United States of America, includes under the heading, "Public Health," the following: "To encourage and support Government and other agencies in the establishment of adequate low-cost medical care; protection of maternal and infant welfare; * * * equalization of health coverage among the various elements in our population * * *." This convention also endorsed the principle of social insurance.

The promotion of physical health is one of the objectives included in the purpose of the Y. W. C. A. Since the beginning of the Y. W. C. A. movement there has been an active health program in practically every local Y. W. C. A. in the United States. This long experience has given us an intimate knowledge of health needs.

In a study of budgets of business girls in the Y. W. C. A., made in 1931 and 1932, it was discovered that with a drop in income which occurred for a large percentage of the group during the second year, the first item in the budget to be drastically reduced was medical care.

Within the Negro groups of our membership, health is a matter of major concern. In communities where the local Y. W. C. A.'s have made studies of civil rights of Negroes, the membership concerned has never failed to register the restricted access Negroes have to hospitals, medical training, doctors, and public-health service.

Our farm membership reports the acute problems which rural families face because of lack of adequate or available hospital and medical facilities.

This experience within the Y. W. C. A. membership itself, in health education departments, in the business and industrial girls' clubs, among our Negro members, among our rural associations, all points to the fact that the present system of private practice, voluntary group practice and Government help for the indigent, is not sufficient to cover the needs of our population for medical care.

It was this conviction which led the 1938 convention to advocate Government aid for low cost medical care and for the equalization of health coverage for all parts of the population, and support of legislation for a system of social insurance.

[s] MARY N. G. FRENCH,
Mrs. JOHN FRENCH, *President.*

THE OHIO SOCIETY OF OSTEOPATHIC
PHYSICIANS AND SURGEONS,
Marietta, Ohio, May 7, 1939.

Senator ROBERT TAFT,
United States Senate, Washington, D. C.

HONORABLE SENATOR: Enclosed is a copy of the resolution adopted by the Ohio Society of Osteopathic Physicians and Surgeons, May 6, 1939.

Your careful consideration of the same will be appreciated.

Yours very truly,

THE OHIO SOCIETY OF OSTEOPATHIC
PHYSICIANS AND SURGEONS,
H. L. BENEDICT,
Dr. H. L. BENEDICT, *President.*

[s]

THE OHIO SOCIETY OF OSTEOPATHIC
PHYSICIANS AND SURGEONS,
Marietta, Ohio.

RESOLUTION OF OHIO SOCIETY OF OSTEOPATHIC PHYSICIANS AND SURGEONS

Whereas the American Osteopathic Association, a democratic and representative federation of State osteopathic societies, by its house of delegates assembled in forty-second annual session at Cincinnati, Ohio, in July 1938, resolved to

cooperate "with employers and employees, with representatives of lay organizations, with other medical organizations, and with those departments of Government interested in the program, in working out a program of care (which will include, for the individual, the option of free choice of physician) for those not now receiving adequate medical care because of medical indigency;" and

Whereas osteopathy is recognized, regulated, and licensed in the State of Ohio and osteopathic physicians are engaged in the practice of their profession in said State; and

Whereas osteopathic physicians in this State are concerned with the promotion of maternal and child health, maternity care, and care of infants, medical care for children and services for crippled and other physically handicapped children in need of such care, and public health work, and the construction and operation of hospitals and health centers, and the furnishing of medical care to those unable to provide adequate medical care; and

Whereas the national health bill, S. 1620, purports to extend and multiply the medical care provisions of the Social Security Act and to that end authorizes the Federal administrative agencies to set up Federal advisory councils composed of representatives of the professions concerned, and requires the State administrative agencies to do likewise; and

Whereas said national health bill makes no provision for the representation of the osteopathic profession on said Federal and State advisory councils: Now, therefore, be it

Resolved by the Ohio Society of Osteopathic Physicians and Surgeons, representing the osteopathic profession in said State, That the United States Senators from this State, the author of said bill, and the Senate Committee on Education and Labor, and the President of the Senate, the Vice President of the United States, be informed by transmittal of copies hereof that the aims and purposes of said bill require amendments expressly preserving freedom of choice of physician and school of practice to persons entitled to medical care, and expressly providing for osteopathic representation on said Federal and State advisory councils to the end that the osteopathic profession in this State and in the United States may be enabled to cooperate in implementing the medical-social security program of said bill.

NASHVILLE, TENN., May 12, 1939.

SENATOR JAMES E. MURRAY,
Chairman of Subcommittee on Education and Labor,
United States Senate.

Greatly appreciate your invitation to appear as a witness at the hearing on national health bill but find it impossible to appear in person this afternoon. However, would appreciate very much the privilege of having the statement which I am sending you made a part of the record.

HORTON CASPARIS, M. D.

VANDERBILT UNIVERSITY, SCHOOL OF MEDICINE,
Nashville, Tenn., May 12, 1939.

SENATOR JAMES E. MURRAY,
Chairman, Subcommittee on Education and Labor,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: Confirming my telegram, I do appreciate very much the invitation extended me to appear before the subcommittee of the Senate Committee on Education and Labor holding hearings on the national health bill, S. 1620. Since the committee was somewhat rushed and since it was practically impossible for me to appear in person on Friday afternoon, May 12, I am sending a statement of my interest and position covering that aspect of the bill about which I feel qualified to have an opinion namely, that part concerning maternal and child health. I hope it will be possible to have this made a part of the record for I think my statement represents fairly well the attitude of a number of my colleagues concerning this matter.

Sincerely,

HORTON CASPARIS, M. D.,
Professor of Pediatrics.

CASPARIS' STATEMENT

In being given the opportunity through invitation to make a statement to your committee holding hearings on the national health bill, it is probably appropriate in the first place for me to identify myself and explain my interest in this matter. I happen to be chairman of the public relations committee of the American Pediatric Society. This society is an organization which has been in existence more than 50 years. Its membership is made up largely of those physicians throughout the country who are in the main associated with the better medical schools, and who are responsible for much of the teaching, preparation, and guidance of young physicians, practicing physicians, nurses, health officers, and lay groups and organizations interested in the care of and promotion of health in children.

Since the health of children is indissociably linked with the health of mothers, I feel qualified to speak to that part of the national health bill only which concerns maternal and child health. And, while I cannot speak officially for the American Pediatric Society, I do feel the membership is deeply interested in any sane efforts looking to the promotion of maternal and child health, since at its annual meeting on April 27-29, 1939, the society passed the following resolution:

"Resolved, That the American Pediatric Society approves in principle the provisions for the promotion of maternal and child health as contemplated in S. 1620."

Having been professor of pediatrics at the Vanderbilt University Medical School, Nashville, Tenn., for the past 14 years, I have had a rather unusual privilege and opportunity to see and work with thousands of children in the South, especially, children in various stages of health and disease, and children in all social and economic levels. Also I have had intimate contact with many individual physicians, physicians in small and large groups, health officers, nurses, lay groups, and organizations chiefly throughout the South, but also in most other sections of the country.

Out of all of these opportunities for intimate and actual experience with children on the one hand, and physicians on the other, this definite conclusion has become very clear in my mind. That although we still have much to learn concerning the care of children, most of our trouble today results from lack of general application of available medical knowledge. To secure widespread application of available medical knowledge we have two problems or two angles of approach.

The first is to get this working knowledge more generally into the hands of doctors caring for mothers and children. The medical schools certainly must assume responsibility for adequate teaching and training of their students, and likewise there must be developed means of devoting intensive efforts to keep practicing physicians abreast of the times through various methods of post-graduate education, because medical care can never be any better than the preparation of the doctors who give it.

The second problem or approach is to make good medical care as widely secureable and usable as possible. This aspect of the problem concerns not only the economic status of the patient, but also, and probably just as important as the first, his education to see the advantage of good medical care and to seek it. In other words, making the services of good doctors available to the people, doesn't mean that the people will use these services. We too often see examples of lack of use of good available facilities, especially among those who need medical care most. We have found that often it requires a good deal of effort to teach people to take advantage of good medical care, but through doing so, they gradually learn to appreciate its value and slowly tend to seek it. People in general so easily get accustomed to and even satisfied with the quality of medical care available regardless of its level.

As I see it, then, improving the ability of physicians to give good medical care, and teaching the people, largely through demonstration the advantage of good medical care, as well as making it possible from the economic standpoint for them to secure it, are the basic needs, and cover the purpose of the proposed amendment to section V of the Social Security Act.

With this purpose in mind I hardly see how any of us responsible for the promotion of maternal and child health could do anything except approve heartily of any efforts in this direction, provided they were guided more by common sense rather than sentiment, and provided they took into consideration the fact that this problem is educational with respect to doctor and patient, as well as economic with respect to patient and doctor, and its solution therefore must move forward slowly and gradually under the supervision of those properly qualified.

HORTON CASPARIS, M. D.

NATIONAL DENTAL ASSOCIATION,
Washington, D. C., June 1, 1930.

Hon. JAMES E. MURRAY,
Chairman, Subcommittee on Education and Labor,
United States Senate.

SIR: I regret very much that the representative of the National Dental Association was not permitted to appear in person before the Subcommittee on Education and Labor studying the Wagner health bill, S. 1620.

By request of your committee, I am enclosing a written statement of the public relations committee of the National Dental Association for inclusion in the record of the hearings to be published by the committee.

Respectfully yours,

NATIONAL DENTAL ASSOCIATION,
By [s] WM. O. CLAYTOR,
WILLIAM O. CLAYTOR, D. D. S.,

Cochairman, Public Relations Committee, and State Vice President, for
District of Columbia, for the President.

STATEMENT OF THE NATIONAL DENTAL ASSOCIATION COMPOSED OF OVER 2,000
NEGRO DENTISTS, COMMENTS BY REQUEST OF THE SUBCOMMITTEE ON EDUCATION
AND LABOR CONSIDERING THE WAGNER HEALTH BILL, S. 1620, TO BE
PRINTED IN THE RECORD OF THE HEARINGS

NATIONAL DENTAL ASSOCIATION—WHY ARE DENTISTS INTERESTED IN THE
NATIONAL HEALTH BILL?

Modern dental science has revealed that many systemic diseases, if not caused by diseased teeth, are greatly aggravated by them. Notable are statistics showing that the highest death rate is caused by heart disease. A Mayo clinic report issued not over 5 years ago shows that a number of their cases of heart disease could be traced to disease teeth and gums from which infectious organisms are carried to the heart by the bloodstream. Many other systemic diseases, according to a report by Dr. John Opple McCall, of New York, were summed up as rheumatism, heart disease, certain kidney ailments, neuritis, neuralgia, certain types of headaches, dizziness, excessive fatigue, certain serious eye diseases, nervous prostration, and St. Vitus' Dance are the result of diseased teeth and gums as either primary or secondary cause. Consequently, any health program which leaves out the dental services is entirely inadequate.

We would emphasize as most important a thorough system of dental health education in agreement with the plan set forth by the American Dental Association and that there may be a more effective and understanding knowledge adequately presented by the dentists themselves to the general public in order that the public be made fully aware of the importance of proper dental care.

CITATIONS OF ITEMS IN S-1620

Page 2, line 15: " * * * including the training of personnel * * * ." The National Dental Association is particularly interested in the training of its members and asks that they be accorded proportionate representation in those States and political subdivisions for which training facilities are established. Lack of admission to hospital staffs and present clinical institutions has prevented the proper training and experience of the majority of the members of our association. We urge that the Surgeon General of the Public Health Service and the Chief of the Children's Bureau insist that due consideration be given to the training of members of the professions among the minority groups before approving State plans for grants or funds.

Page 4, lines 14, 15, and "16 * * * methods relating to the establishment and maintenance of personnel standards on a merit basis * * * ." We call attention to the merit system for employed personnel which is provided in the bill. The past experiences of Negro persons properly qualified and eligible, reveal there has been discrimination in their recognition and selection for employment under the civil service. The mere fact that the photograph is required contributes to possible rejection even if the colored applicant merits the appointment. It is necessary, therefore, that certain specifications be included in the fundamental law of this national health bill to assure equitable participation of Negro trained personnel.

Page 4, lines 21 to 25: "* * * 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 * * *."

The members of the various professions and agencies which are placed on these councils should be representative of all groups in the State regardless of race, creed, or color. The obvious reason for this is to give the members of the professions of the minority groups an opportunity to safeguard their interests in the very inception of the plan itself, not only regarding the present agencies but the proposed facilities as well.

Whereas, over 95 percent of the hospitals and health institutions use no discriminatory practices in the acceptance and treatment of Negro patients, either indigent or otherwise, Negro doctors are excluded from these same health institutions. The few remaining facilities open to the Negro doctors are those operated primarily by and for Negroes only.

SUMMARIZATION

(1) Endorsement of the general objectives of the national health program.

The National Dental Association, composed of Negro dentists who observe and treat the millions of Negro men, women, and children, is cognizant of the great need for adequate and efficient dental care and, therefore, subscribes to the proposal, based on reliable data of pertinent surveys, that ways and means should be provided for the benefits that dental science and dental education have made possible, but which the constituted authorities and agencies in the related fields of health, economics, and social welfare have not made available to the people who need them.

(2) Endorsement of the American Dental Association's qualifications of the provisions of the national health program.

The National Dental Association has maintained intelligence of the discussions, resolutions, and editorial comments of the American Dental Association, qualifying the provisions of the national health program with the view of protecting the proper rights and interests of the American dentists while agreeing to reasonable and judicious participation in the plan, and it is the sense of the National Dental Association that the recommendations of the American Dental Association are clearly and wisely stated.

(3) Qualifications proposed by the National Dental Association.

Formerly, many unfavorable, unwise, and sometimes unfair attitudes and practices in the provision of public benefits have denied both the Negro doctors and their patients, actual or potential, an equitable share of the public funds and professional opportunities.

Therefore, the National Dental Association is constrained to petition the administrators of both the Federal and the State phases of the national health program to consciously consider and justly provide for the Negro dentists and the Negro people in the operation of the national health program if and when it becomes effective.

CONCLUSION

Representing as we do the largest minority group in our American Democracy, which also constitutes the largest pro rata of indigent and near indigent, the National Dental Association submits this petition to the effect that provisions of the national health bill will require administrators of both the Federal and State phases of the national health program to consciously and adequately include the Negro members of the dental profession.

Respectfully yours,

NATIONAL DENTAL ASSOCIATION,
PUBLIC RELATIONS COMMITTEE,
CHARLES W. DORSEY, D. D. S., *Chairman*.
By (s) WM. O. CLAYTOR,
William O. Claytor, D. D. S., *Cochairman*,
and *State Vice President for District of Columbia*.

NATIONAL ASSOCIATION OF COLORED GRADUATE NURSES, INC.,

New York City, June 20, 1939.

Mr. CHARLES A. MURRAY,

*Secretary to Senator James E. Murray,
Committee on Education and Labor,**United States Senate, Washington, D. C.*

DEAR MR. MURRAY: Enclosed is the statement from the National Association of Colored Graduate Nurses which you requested in your letter of May 23.

Sincerely yours,

MABEL K. STAUPERS, R. N.

STATEMENT PRESENTED TO THE SENATE COMMITTEE ON EDUCATION AND LABOR ON THE WAGNER HEALTH BILL, S. 1620, BY THE NATIONAL ASSOCIATION OF COLORED GRADUATE NURSES.

I. Fundamental position:

Favor passage of bill provided certain safeguards against discrimination are included in the bill.

II. Safeguards made necessary by present practices of public-health agencies whose services the act proposes to extend:

A. In States where separate public-health facilities are maintained for separate races, provide for a just and equitable apportionment of such funds to carry out the purposes of each part of each title of the act for minority races without reduction of the proportion of State and local moneys expended during the fiscal year ended in 1938 for such health services.

Supporting data for this contention:

1. Field of maternal and child welfare: In Mississippi in the year of 1936, 85 percent of all Negro babies born were born without the aid of doctors, a condition hard to believe in a civilized country, as against 10.4 percent of all white babies born under similar conditions. Needless to say, if there was no doctor in these instances, neither was there a nurse. Only 1.5 percent of all Negro births in Mississippi in this year were in hospitals as against 13.6 percent of all white births. Contrast this last figure with hospital births in the State of New York in this same year—79.8 percent for Negroes, 76.6 percent for whites—and you will get some idea of the medical aid available to Negro mothers in these two States. In Mississippi the outstanding need for increased health service is in the Negro group and the bill must specifically provide that increased facilities on a just and equitable basis will be extended to this group.

2. In those areas specified under title VI of bill S. 1620 we use one illustration: The death rate per 100,000 persons in 10 Southern States in the period from 1931 to 1933 where the cause of death was respiratory tuberculosis was 137.48 for Negroes as against 48.49 for whites. If we did not know how to reduce the death rate from tuberculosis this statement of fact would be indeed tragic, but we do know a great many things to do and in the face of our knowledge this condition is criminal. Proper food, rest, nursing service, and medical care intended to be provided under this act will go a long way to change the picture, but only if the funds under the act are placed at the point of need and are expended fairly for all people.

3. Title VII: Here the purpose is to extend hospital facilities. We quote from Trevor Bowen's study made under the Institute of Social and Religious Research: "There is 1 hospital bed available for every 2,000 Negroes in this country, as compared with 1 bed for every 150 of the white population." And we give one

instance which happened in Atlanta, Ga.: A Negro was taken critically ill on the street. Showing no visible signs of color, he was taken to the white side of the city hospital. While receiving care, a relative, showing color, arrived. Treatment was stopped, a sheet thrown across the patient, and he was carried through the rain across the street to the colored wing. It is unnecessary to say that the exposure and delayed treatment took their toll on the life of the Negro patient. It is this sort of existing practice that makes our support of the bill rest on safeguards written into the text of the act itself.

4. Title XIII—"To improve medical care, including all services and supplies necessary for prevention, diagnosis, and treatment of illness and disability."

To insure this being done this portion of the act, as some of the other sections, carries a provision for "training of personnel." Those who know what a share efficient nursing service has had in reducing illness and unnecessary deaths know what a determining factor adequate training of nurses has been. Yet what are the conditions a Negro nurse meets when she tries to prepare herself for adequate and efficient service? Many nursing schools are closed to her. Others maintained for Negroes often offer inferior training facilities. Administration of funds now available for nurses' training under the Social Security Act savor of discrimination and leave us distrustful of ever being treated justly under general clauses.

B. Federal and State advisory councils must have members from sizeable minorities present in the area served by the council. This provision gives Congress some assurance that administration of the act will be just.

C. No discrimination in the salary and wages of personnel in the same classification and doing the same work or equal work shall be made on account of sex, creed, race, or color.

Table I: Health Department and Public Health Nursing Association employing Negro nurses and salary paid Negro nurses as compared with salaries paid white nurses. Compiled by Estelle Massey Riddle, president of National Association of Colored Graduate Nurses, Journal of Negro Education, July 1937, page 487:

Place	Agency	Nurses employed		Salary of Negro nurses	
		Negro	White	Same	Lower
Virginia:					
Lynchburg	City health department	1	(?)		X
Newport News	Board of education	1	(?)		X
Norfolk	City health department	1	(?)		X
Suffolk	City and city health department	1	(?)		X
North Carolina:					
Charlotte	City health department	4	9		X
Greensboro	do.	4	(?)		X
Georgia:					
Albany	County health department	2	(?)		X
Atlanta	City health department	4	15		X
Macon	County health department	3	(?)		X
Savannah	do.	2	(?)		X
Florida:					
Clearwater	City health department	1	(?)		X
Miami	do.	1	3	X	
West Palm Beach	do.	1	1		X
Kentucky:					
Lexington	Public health center	1	8		X
Louisville	Public health nurses association	3	31	X	
Tennessee:					
Knorrville	do.	2	6		X
Memphis	City health department	13	26		X
Nashville	Public health nurses council	5	18	X	
Alabama: Birmingham	City health department	5	11		X
Louisiana: New Orleans	Child welfare association	2	27	X	
Oklahoma: Oklahoma City	Public health nursing bureau	2	12	X	
Texas:					
Houston	City health department	3	6		X
San Antonio	City board of health	1	5	X	

Table I is self-explanatory. Existing public health agencies are now paying Negroes less for the same work than they pay white workers. Yet everyone knows that the grocery clerk charges a Negro as much for his staples as he does a white person. Furthermore, everyone knows that rents in Negro neighborhoods are higher for services rendered than rents in white neighborhoods. There

is simply no excuse for such differentials. One further thing, however, must be noted in this table: Some public health agencies do pay the same wages for the same work and some of the public health agencies are southern agencies. So it can be done because it is being done.

We end by adding that the above will not be realities without (1) Proper definitions of "minority races" and "just and equitable distribution of funds," we favor those given by Dr. Louis T. Wright in his testimony before this committee; and (2) provision in the act that there be full publicity of any proposed change in the administration of the act by each State before such a change is made and that the accounts of all expenditures be such that adequate check on just and equitable distribution can be made by Federal agencies disbursing funds.

NEW YORK STATE DEPARTMENT OF HEALTH,
Albany, N. Y., July 20, 1939.

AUGUST 6, 1939.

STATEMENT SUBMITTED BY THE COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC.

PROPOSALS FOR AMENDMENT OF THE WAGNER BILL S. 1620

The national movement for improvement of health services and provision of better medical care for the people, which has been gaining force in the last years, has now reached the point where legislation is pending. Hearings before the Senate subcommittee have been held on the Wagner bill which was the subject of the last statement issued by the committee on May 5, 1939. The bill has received the general support of consumer groups (labor, farm, women's organizations, etc.) and has been subjected to criticism, sympathetic and otherwise, by professional groups of all kinds. The subcommittee of the Senate Committee on Education and Labor, before which these hearings were held, has submitted a report. In this report it is stated that "the committee will continue its study of S. 1620 so that a definitive report on the proposed legislation can be submitted soon after the beginning of the next session of Congress." In addition, to quote from another section: "We do not at this time have solutions for all of the problems which have developed in the study of the bill, but we are confident that solutions will be found as we proceed with our study and as we continue to receive critical advice and assistance which we welcome from public and professional groups and individuals who have assured us of their cooperation." In the light of these hearings and this report it is not only possible but necessary to take a more concrete position on this bill and other legislation which may be proposed.

The Committee of Physicians wishes to assert its sympathy with the general purposes of the Wagner bill and with the program of the technical committee, upon which the bill is based. It appreciates the attitude with which the Senate subcommittee conducted the hearings, the interest and receptiveness which its members displayed, the lack of prejudice which characterizes their analysis of the problem under the consideration and the evidence which was presented to them, and the intelligent open-mindedness of the comments and conclusions of their report. The Committee of Physicians recognizes certain compromises were made in this first legislative draft to meet objections that had been raised against the technical committee's program and to bring its proposals into conformity with the existing complex Federal machinery entrusted with the administration of health. The hearings have demonstrated that these compromises have achieved no useful purposes and that they may jeopardize some of the most desirable aims of health legislation, especially the continuous improvement of the quality of medical care. The Committee of Physicians, therefore, recommends that the Wagner bill (S. 1620) be amended or redrafted in conformity with the suggestions presented in this statement.

GENERAL PRINCIPLES

1. There can be no doubt of the fact that good medical care is not now available to a large portion of the population of the United States. This has been satisfactorily established by repeated surveys, including that of the United States Public Health Service, which were the basis of the technical committee's report before the National Health Conference. It has been supported by the testimony of representative members of the medical profession as given in the American Foundation's report "American Medicine," 1937. The existence of this medical

need was not challenged in the National Health Conference held in July 1938 under the auspices of the interdepartmental committee.

2. There can be no doubt that if good medical care is to be given to the people of this Nation, the government (local, State, and Federal) must assist in devising programs and sharing the expense. Many of the States are likely to be unable successfully to finance improved medical care for their people. Experience has demonstrated that Federal participation can best be effected by grants-in-aid to the States, carefully protected by the establishment of standards which must be met by the States in order that they may qualify for the receipt of grants. Although for the sake of coordination and to prevent abuses, these prerogatives should be retained by the Federal Government, responsibility for the institution and administration of programs should reside in the States as the Wagner bill provides. In utilizing these two principles, the Wagner bill is sound.

3. The provision of moneys by the Federal Government to assist in medical care at once involves the Government in the setting up of suitable machinery to see that the moneys so appropriated are expended in such a way as not only to improve the medical care offered to the people but to maintain and improve the standards of the institutions and individuals participating in this care. Only by insistence upon this principle can the prudent use of public moneys be guaranteed. Although provisions for this purpose are included in every title of the Wagner bill, there are certain features in these titles and in the bill as a whole that militate against the achievement of these objectives, namely:

I. Divided control in the planning and execution of the program is incompatible with any sound program for national health. There should be unified Federal health authority.

II. As a corollary to this there should also be a General Health Council. This Council should have authority to establish and enforce professional standards in order to insure a good quality of medical care. The constitution of the Council should be defined in the bill.

III. The establishment of the unified health authority and the General Health Council should be the first step taken in connection with the institution of a national health program.

IV. Although special measures such as those contained in titles V, VI, and XII,² of the Wagner bill may be expedient, the objective should be to provide in every community a unified program of health service and medical care which will meet the standards approved by the General Health Council.

V. The lack of provision for support of medical education and research may cut the ground from under good medical practice. The achievement and maintenance of high standards of medical education and research require additional funds.

SPECIFIC PROPOSALS

1. There must be a unified Federal authority responsible for the institution and execution of all parts of the health program.

Professional bodies and experts who have testified before the Senate subcommittee, have, with one accord, protested against the divided authority proposed in the bill.

(a) Not only does the Wagner bill fail to recognize the need for consolidation of the present agencies, it further dissipates the administration of health and medical services in the Federal Government by creating a new agency under the Social Security Board for the administration of medical care under title XIII "including all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability" and the subcommittee report suggests the possibility of another title (XV) under the Department of Labor dealing with industrial hygiene.

(b) The authority for a general health program is properly the United States Public Health Service. It is impossible to separate for administrative purposes measures for the prevention from measures for the treatment of disease. Some labor organizations and the United States Department of Labor have asked that industrial hygiene be separated or kept separate under the Federal and State Departments of Labor by the addition of still another agency. The Senate subcommittee in its report suggests the introduction of an additional title for this purpose. Fear has been expressed that the able personnel and efficient work of the Children's Bureau of the Department of Labor or of the Public Health Service or both may suffer if the identity of either organization is lost by merger. Some formula must

² Title V, maternal and child health; Title VI, public-health work; Title XII, hospitals and health centers.

be devised by which the Federal agencies dealing with various aspects of the same problem may be coordinated and consolidated without impairing their efficiency. Reorganization must recognize the varied professions and agencies involved in a comprehensive program and provide that the interests of each are safeguarded in order that full advantage may be taken of the expert services of all who may contribute to the success of the program.

2. A General Health Council should be established which shall have the power to define and supervise standards of medical education, research and care whenever it is proposed to make Federal grants-in-aid and these shall not be made without its approval.

The appropriation and expenditure of Federal moneys for the purpose of extending the provision of medical care without assuring good quality can accomplish no useful purpose and may even do harm. The problems involved in establishing the necessary standards for medical education, medical research, and medical care are highly technical and can be satisfactorily determined only by experts in these fields. It is of first importance that, as the Federal Government increases its assistance in these fields, standards and supervision should be established and carried on by some impartial body of experts with knowledge, experience, and wisdom.

(a) The Surgeon General of the United States Public Health Service should be the Chairman and executive officer of the General Health Council.

(b) Appointments to the General Health Council should be made by the President with the advice and consent of the Senate in such a manner that representation of special interests should be subordinated to the more important point of assembling outstanding persons with imagination, intelligence, critical judgment, and expert knowledge in public health and medicine.³

(c) The Council should be composed of eight persons in addition to the executive officer, a majority of whom should hold degrees of doctor of medicine.

(d) The term of office should be sufficiently long to permit members of the Council to look upon their membership as a career. If the term of office is specified, it should be provided that members may be reappointed when their terms expire.

(e) Members of the General Health Council should give full-time service. Remuneration for these services must therefore be generous enough to attract persons of the highest quality.

(f) The Council will be charged with defining and supervising the standards of all institutions and services aided by Federal grants.

No Federal funds should be made available to the States through grants-in-aid unless the Council has certified to the Surgeon General that the standards set up by the Council have been complied with by the States requesting Federal aid.

(g) Whenever the Council finds, after reasonable notice and opportunity for hearing to the State agency concerned, that there has been failure on the part of such agency to comply substantially with any requirements of the Council, the Council shall recommend no further payments to such State for that purpose until it has been satisfied that there is no longer any such failure to comply.

(h) Scientific and technical subcommittees covering the several fields for which the General Health Council is responsible, should be constituted under the authority of the Council to aid in its task of defining and supervising standards.

There should be provisions for paying members of the subcommittees for specific periods of temporary service.

3. Within a reasonable period of time, the several services provided under the bill should be consolidated in one State health agency. Pending this consolidation, the State department of health in every State should be the clearing agency for the Federal grants-in-aid made available upon recommendation of the General Health Council.

(a) This principle is partly recognized in the Wagner health bill. Although, within the standards set by the General Health Council, the States should have the greatest freedom in developing and administering their own programs, ultimate centralization of authority seems a minimum requirement in the interests of efficiency. With the present organization of health and welfare services in some States, certain aspects of the State health plan may be delegated to agencies other than the State department of health. However, provision should be made

³ For the purposes of this draft, the terms "medicine" and "medical care" shall be defined as including preventive medical services; medicine and surgery with all specialties; dentistry and other similar ancillary specialties; industrial medicine and other organized forms of medical endeavor; premedical sciences, such as anatomy, physiology, physiological chemistry, pharmacology, pathology, immunology, and bacteriology; hospital administration; nursing; social service and public welfare activities essential to the proper administration of medical services.

for consolidation and unification of health services under a single State health agency after an interval of not less than 5 nor more than 10 years.

(b) While the individual States should be given freedom to set up whatever coordinating organizations seem best fitted for their needs, it is suggested that a State health council, following the pattern prescribed for the Federal Health Council would be most effective.

4. Under the supervision of the General Health Council, provisions should be made to continue present Federal health activities, to expand specific activities of proved merit, and to coordinate and merge all such activities into a future general program of health service and medical care.

(a) Titles V and VI provide for expansion of maternal and child health programs under the Children's Bureau of the Department of Labor and for the development of medical care programs for these groups. Since machinery exists for the continuation of the activities of the Children's Bureau and the Public Health Service and they have proved their utility, their reasonable expansion is warranted. The personnel and facilities involved should, however, be incorporated in the reconstituted Federal health agency and their activities subjected to review by the General Health Council. Public health and medical care should not be separated, and the care of children and expectant mothers should be integrated with that of the rest of the population.

(b) Construction of new hospitals and health centers with the aid of the Federal Government may be a prerequisite, for the institution of an adequate program for medical care in some areas. It should not, however, be regarded as a separate project as title XII of the Wagner bill proposes but as part of the general health program. Grants-in-aid for construction of these facilities should be given to the States only upon the advice of the General Health Council through the central Federal health authority which should establish principles and standards of qualification of both equipment and personnel for receipt of such grants-in-aid.

It might be advisable to incorporate certain basic principles in the health legislation.

(1) Hospitals or health centers must not be constructed to meet a temporary local condition in a manner or place that will not serve the ultimate purpose of a comprehensive program.

(2) They should not be constructed where there are existing facilities, public or private, that are not utilized to their effective capacity provided that these facilities can be made available at a reasonable cost and provided that these facilities do or can be made to conform to the standards established by the General Health Council.

(3) Provision should be made, with proper safeguards for the Government, for the rehabilitation of existing public and private facilities provided that they do or can be made to conform to the standards established by the General Health Council.

(4) It is not consistent with good medical practice to deny a large group of physicians access to facilities essential for the practice of good medicine.

As stated in the committee's last statement, May 5, 1939: "The hospitals must be staffed by qualified physicians and surgeons and no person should be allowed to assume professional obligations for which he has not demonstrated competence. Standards similar to those of the American Boards for Certification of Physicians as Specialists might be established. If standards of competence are established as qualifications for appointment to the staff of these hospitals and centers, every effort should be made to permit those who can meet these qualifications to participate in the activities of these hospitals and centers and to utilize their facilities. Under the present system, in many communities throughout the country, highly competent young surgeons and specialists are excluded from the local hospitals which, although presumably quasi-public, philanthropic institutions are controlled by small groups of physicians and surgeons, virtually as personal vested interests. This tends to impair their educational value, to deter physicians from taking full advantage of their facilities, and discourages highly trained men from establishing themselves in practice in these communities." (III E-2, 3.)

5. Certain general principles which must govern the constitution of general programs for medical care should be incorporated in the bill.

(a) If a program to provide care of the medically needy is to function, it must be predicated upon the total population requiring service, with payment estimated on a per capita basis.

In the words of our last statement of May 5, 1939: "If expenditures are contingent upon illness, there will be a tendency to reduce services to a minimum and to impose obstacles to qualification. The objective should be to provide care

for all those that require it, not merely for those who demand it. There is evidence that much of the unmet medical need among the poorer members of the population arises from the unwillingness of these individuals to submit themselves, unless they are seriously ill, to the administrative delays to which they are often subjected. Some system will have to be devised for the registration of those entitled to tax-supported care. But methods must be found whereby they may be qualified with expedition and without indignity." (III-B.)

(b) No arbitrary limitations should be placed upon the States in determining the groups of the population that may be included in these programs nor the methods that may be employed to finance these programs.

(c) The committee is agreed, however, on the general principle that the proportion of Federal assistance should be greater to those States and those areas within the several States in which the greatest need exists for the services contemplated under the bill, and that the amount of Federal assistance in no instance should be in excess of clearly demonstrated need.

(d) An integrated program of health service and medical care should include—

- (1) Adequate public health services under competent control;
- (2) The services of an individual physician, including office and home care;
- (3) Coordinated services of specialists and consultants with reference to the patient;
- (4) Availability of modern diagnostic and therapeutic facilities, including hospitalization when needed.

Complete medical services, including prevention, are no longer obtainable through the individual practitioner alone. The rapid development of modern medical science has made it impossible for the individual doctor to provide all the facilities needed for modern scientific medical care. Good medical care now requires the integrated services of the individual doctor, the laboratory, and the hospital.

This naturally means that provisions must be made for the utilization of existing hospitals and other institutions and facilities, public and private, as well as the continued development of such facilities. There appears to be some doubt whether title XIII will meet these objectives.

6. Federal grants-in-aid to States for disability benefits should be made contingent upon the establishment of satisfactory provisions for the medical care of the beneficiaries. But the power to pass upon the adequacy of the medical services available to minimize disability among those covered in a State plan and to make allotments of grants-in-aid must rest with the Federal health authority acting under the direction of the General Health Council, and not with any other board.

7. It is imperative that provisions be made in a special title of the bill for general medical education and research. Grants for these activities should be made by the General Health Council upon direct application from universities, other educational or research institutions, and individual investigators to Federal authority.

To effect a real improvement in medical care, not only the distribution of medical care but also the quality of medical care must be continually improved. At the present time services that are rendered on the whole fall far short of the actual values that medicine has to offer. The intellectual equipment and technical proficiency required to understand and apply the new weapons that science has given us to combat disease have grown as rapidly or more rapidly than the physical appurtenances. The educational background that was adequate a decade ago is quite insufficient today. Knowledge becomes obsolete as rapidly as apparatus. Greater opportunity must be given, not only for the initial training of physicians and other professional workers but also for their continuous education. Already, however, medical education is more expensive and time-consuming than any other kind of education. Medical schools and other educational institutions cannot meet their full obligations to the students, interns, and residents entrusted to their charge; much less can they assume the burden of continuing education for physicians. Philanthropy is quite as incapable, although the value of extended education has been demonstrated by experiments conducted under philanthropic auspices. Any comprehensive health program will increase the demand for competent men and further overload the already burdened educational machinery. It will avail us little to establish standards of merit and competence if no efforts are made to enable men to meet these standards. In fact, the practicable level of quality in our medical services will ultimately depend upon the educational system. Investigation must also be fostered in order that our means of combating sickness and disability may be

enhanced. Society cannot afford to neglect measures that will curtail or eliminate disability, to save the larger sums that it would otherwise be called upon to spend in support of the results of this disability.

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