

# NATIONAL HEALTH PROGRAM

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## HEARINGS

BEFORE THE

COMMITTEE ON EDUCATION AND LABOR

UNITED STATES SENATE

SEVENTY-NINTH CONGRESS

SECOND SESSION

ON

**S. 1606**

A BILL TO PROVIDE FOR A NATIONAL  
HEALTH PROGRAM

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PART 1

APRIL 2, 3, 4, 5, 9, 10, 11, AND 16, 1946

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# CONTENTS

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	Page
<b>Altmeier, Arthur J., Chairman, Social Security Board:</b>	
How healthy are we?-----	169
Barriers to adequate medical care-----	170
Budgeting for medical costs-----	170
Borrowing to pay for medical care-----	171
Adequacies of medical care, facilities and personnel-----	171
The need for protection against sickness costs-----	172
Voluntary insurance-----	172
Method of doctor remuneration-----	176
Selection of physician-----	177
Effect of bill on voluntary plans-----	178
Freedom of choice under the bill-----	179
Health insurance in other countries-----	180
Financing the plan-----	183
Attitudes of medical associations-----	189
Compulsory insurance-----	196
Voluntary plans are not democratic-----	196
Public-opinion polls on health insurance-----	196
Advantages of a national system-----	200
Title I of S. 1606-----	200
Title II of S. 1606-----	202
Coverage-----	202
Scope of the benefits provided-----	203
Costs and financing-----	204
Administering a health insurance program-----	206
<b>Anderson, Joseph P., executive secretary, American Association of Social Workers:</b>	
The American Association of Social Workers-----	445
Endorsement of S. 1050-----	446
Barriers to adequate medical care-----	447
Public health services-----	448
Medical care-----	448
<b>Butler, Dr. Allan M., associate professor of pediatrics, Harvard Medical School:</b>	
Inevitable changes in patterns of medical care-----	410
Importance of group practice-----	411
Present medical care too expensive-----	412
Voluntary medical plans inadequate-----	413
Physician support of the Bill-----	415
Prompt action is imperative-----	416
Independent citizens committee of the arts, sciences, and professions-----	418
The AMA bureaucracy-----	423
Income of the AMA-----	431
The National Physicians Committee-----	432
<b>Cobb, Dr. W. Montague, the national medical committee of the National Association for the Advancement of Colored People:</b>	
Endorsement of S. 1606-----	500
Health problems of the Negro-----	501
Title I of S. 1606-----	504
Title II of S. 1606-----	504
Attitude of the AMA-----	505
Summary-----	507
<b>Dingell, Hon. John D., representative from Michigan:</b>	
Opposition of American Medical Association-----	64
Public opinion polls-----	66
Inadequacies of voluntary health insurance-----	81
The plan is not radical-----	84
The plan does not regiment doctors-----	85

	Page
Foreman, Dr. Clark, president, Southern Conference for Human Welfare:	
Endorsement of the bill.....	353
More sickness in the South.....	353
The causes.....	365
Voluntary Health Insurance not the answer.....	366
National Health Insurance is essential.....	367
Medical Advisory Council.....	368
The Southern Conference for Human Welfare.....	369
Attitude of the American Medical Association.....	373
Financing National Health Insurance.....	376
Bill collecting under existing system.....	383
The problem of the South.....	390
Fichter, Joseph W., chairman, joint subcommittee on health of the National Planning Association:	
The National Planning Association.....	309
Tuberculosis campaign.....	310
Annual costs of tuberculosis.....	311
Costs for a 10-year campaign.....	314
The hospital program.....	317
Green, William, president, American Federation of Labor:	
A. F. of L. program for social security.....	463
Endorsement of National Health Insurance.....	464
Workers dissatisfied with present health levels.....	465
Selective-Service rejection figures.....	465
Unpredictability of illness.....	466
Neglect of illness.....	467
Voluntary insurance plans.....	467
Coverage of S. 1606 is adequate.....	469
Quality of medical care would be improved.....	469
Existing services would be utilized.....	469
Freedom of choice.....	470
The bill provides for democratic administration.....	470
Maternal and child health services.....	471
Proposed amendment to title I.....	471
Medical care for the needy.....	472
Source of opposition funds should be investigated.....	472
Constitutionality of S. 1606.....	472
Financing of S. 1050.....	474
Selective-service rejections.....	478
Free choice of doctor.....	480
Survival of our system depends upon economic security.....	484
Workmen's compensation.....	486
S. 1606 is not socialistic.....	488
Voluntary health insurance.....	489
Supplementary statement on estimated costs.....	518
Hall, Helen, director, Henry Street Settlement, appearing for National Federation of Settlements:	
Health insurance is overdue.....	320
Two rusty cliches.....	321
Risks and services.....	322
Both out of work and sick.....	322
A Texas experience.....	324
Medicine's capital city.....	324
Settlement studies.....	326
Some wartime lessons.....	327
Free choice of a doctor.....	328
Health insurance and unemployment insurance.....	331
Free choice of doctors.....	333
Exemption for Christian Scientists.....	340
Imposition of fees to prevent abuses.....	341
Ickes, Harold L., executive chairman of the Independent Citizens Com- mittee of the Arts, Sciences, and Professions:	
Conservation of the Nation's health.....	393
Selective-service rejections.....	394
United States is not the healthiest nation.....	394
Hospital construction under the PWA.....	396
Specialized medical care by industry undesirable.....	397
Comparison to old-age insurance.....	398

	Page
<b>LaGuardia, Fiorello H., former president of the United States Conference of Mayors:</b>	
Appropriations for title I are low.....	285
Health insurance most important legislation ever before Congress....	286
Hospitals and medical research in New York City.....	287
Financial burden of illness.....	288
National insurance better than local plans.....	288
The bill does not regiment doctors.....	289
Importance of group practice.....	290
Plan should be put into effect gradually.....	291
Hospital construction.....	295
Gradual introduction of the plan.....	295
Hospital plans in New York.....	300
Medical education.....	301
Professional incentive under health insurance.....	302
Why not leave it to the States?.....	303
Attitude of the American Medical Association.....	304
Freedom of choice of doctor.....	304
<b>Lawless, Dr. Theodore K., Congregational Christian Churches:</b>	
Inadequacy of health care.....	440
Weaknesses of voluntary plans.....	440
Inadequate local facilities.....	441
The issue of regimentation.....	441
Advantage of the national health bill, S. 1606.....	441
Health is a government responsibility.....	442
<b>Linder, Leo J., National Lawyers Guild:</b>	
Report on the National Health Act:	
The medical care and education program.....	230
Grants to States for health services and for medical care for needy persons.....	236
The need for national health insurance.....	240
Constitutionality of S. 1606.....	242
Appraisal of American Bar Association Report.....	243
Freedoms under the bill.....	244
Financial needs for medical care.....	254
Voluntary insurance is not adequate.....	256
No freedom of choice today.....	257
Relationship between doctor and patient.....	259
The right of judicial review.....	266
Health insurance is in the American tradition.....	274
The National Lawyers Guild.....	276
Constitutionality of S. 1606.....	280
<b>Martin, William Logan, American Bar Association:</b>	
American Bar Association report on S. 1161.....	209
Appraisal of S. 1606.....	215
Political attitude of American Bar Association.....	220
Blue Cross plans.....	224
<b>McMichael, Rev. Jack R., executive secretary, Methodist Federation for Social Service:</b>	
The Methodist Federation for Social Service.....	452
Comparison to crusade for free education.....	452
Public opinion polls.....	453
Freedom from disease.....	453
The need for medical care.....	454
Voluntary plans inadequate.....	455
Private charity cannot do the job.....	456
Health insurance must be national.....	457
Coverage should be extended.....	458
Doctor-patient relationship.....	458
S. 1606 will improve quality of medical care.....	458
Democratic administration of the bill.....	459
Amendments to title I.....	459
<b>McPeck, Rev. Francis W., chairman, legislative committee, council for social action, Congregational-Christian Churches:</b>	
The Congregational-Christian Churches.....	437
Endorsement of S. 1606.....	438

	Page
Miller, Watson B., Federal Security Administrator:	
Endorsement of the bill.....	121
Public health grants.....	122
Prepaid health services.....	123
Safeguards to personal freedoms.....	123
Decentralization of administration.....	124
Coverage of the bill.....	124
Letter to chairman of committee.....	126
Is the bill socialistic?.....	131
Advantages of bill to business.....	132
Mountin, Dr. J. W., Medical Director, United States Public Health Service:	
Introductory remarks.....	134
Objectives of the bill.....	135
Extension of public health services.....	138
Suggested public health service amendments.....	138
Grants for medical research.....	138
Medical education.....	139
Cost barriers to adequate medical care.....	139
Maldistribution of medical services.....	140
Voluntary insurance plans.....	140
Advantages of a national program.....	141
Universal coverage proposed.....	142
Need for comprehensive services.....	142
Problems of administration.....	142
Safeguards to freedom.....	143
Endorsement of bill.....	144
Proposed amendment.....	149
Relation between administrative agencies.....	150
Importance of research.....	152
The philosophy of health insurance.....	155
Hospital construction.....	156
Voluntary health insurance.....	158
Safeguards under the bill.....	162
Murray, Hon. James E., Senator from Montana, and chairman of the Committee on Education and Labor:	
The President's health message.....	1
The national health bill, S. 1606.....	9
Correspondence between President Truman and Senator Murray.....	31
Federal agency reports on national health bill.....	34
Legislative background.....	44
Plans for hearings.....	46
Washington Post editorial.....	47
Newman, Pauline M., National Women's Trade Union League of America:	
Endorsement of S. 1606.....	509
The Union Health Center.....	509
Health care is prohibitively expensive at present.....	510
Public health clinics inferior.....	511
Importance of health education.....	511
Voluntary health agencies not equal to the task.....	512
The opposition to S. 1606.....	512
Pepper, Hon. Claude, Senator from Florida:	
Work of Subcommittee on Wartime Health and Education.....	87
The Nation's health problem.....	102
Economic burdens in illness.....	103
Voluntary health insurance plans.....	107
Only compulsory insurance can meet the problem.....	111
The public supports a national plan.....	112
Summary on health insurance.....	112
Maternal and child care.....	114
Wagner, Hon. Robert F., Senator from New York:	
A national health bill is essential.....	52
Health insurance is not socialized medicine.....	53
Freedom of choice safeguarded.....	54
Voluntary plans aided.....	55
Financing health insurance.....	55
Summary of Wagner-Murray-Dingell National Health Bill.....	56
Personal health service benefits available under the National Health Act.....	57

	Page
<b>Wagner, Hon. Robert F., Senator from New York—Continued</b>	
Why voluntary health-insurance plans can't do the job.....	58
What the National Health Act would mean to the medical profession.....	59
What the National Health Act would mean to hospitals.....	60
What the National Health Act would mean to veterans.....	60
What the National Health Act would mean to farmers.....	61
What the National Health Act would mean to businessmen.....	62
What the National Health Act would mean for maternal and child care.....	63
<b>Ware, Caroline F., American Association of University Women:</b>	
Endorsement of the bill.....	344
The need for health insurance.....	348
Popular demand for health insurance.....	349
Grants-in-aid.....	350
The insurance principle.....	350
Voluntary plans.....	351
Why the plan must be national.....	351
<b>Statements from organizations:</b>	
American Federation of Labor.....	518
American Association of Medical Social Workers, Inc.....	520
American Federation of Labor.....	526
American Federation of Women's Auxiliaries of Labor.....	499
American Public Health Association.....	527
American Veterans Committee.....	531
American Society for Research in Psychosomatic Problems.....	531
Atlanta Federation of Trades.....	498
Building Service Employees' International Union.....	497
Central Trades and Labor Council.....	534
Citizens Political Action Committee.....	534
Citizens' Public Affairs Committee.....	534
Connecticut Federation of Labor.....	496
Connecticut Independent Citizens' Committee.....	534
Farmers Educational and Cooperative Union of America, Bowling Green Local 22.....	535
Girls' Friendly Society, United States of America.....	535
Kansas State Federation of Labor.....	495
Kentucky State Federation of Labor.....	492
Medical Society of the State of Pennsylvania.....	536
Minnesota State Federation of Labor.....	537
North Platte Valley Central Labor Union.....	498
West Virginia State Federation of Labor.....	497
<b>Statements from individuals:</b>	
Angell, W. Randolph.....	539
Berger, Malcolm.....	539
Berke, Carl.....	539
Bricker, Melvin.....	540
Donaldson, Beatrice A.....	540
Finkelstein, E.....	540
Gifford, Cuthbert G.....	540
Governale, J.....	540
Green, John W.....	542
Longaker, Daniel.....	542
Machlis, S.....	543
McLean, Edward H.....	543
Platt, Bernard.....	544
Ritey, Hector.....	544
Rubin, Samuel.....	544
Sartori, M.....	546
Schwartz, Arthur H.....	546
Schwarz, S.....	546
Sohn, Herman H.....	547
Wender, Mrs. Luba.....	547



# NATIONAL HEALTH PROGRAM

TUESDAY, APRIL 2, 1946

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

The committee met at 10 a. m., pursuant to call, the Honorable James E. Murray (chairman) presiding.

Present: Senators Murray, Thomas, Pepper, Wagner, Taft, and Smith.

Also present: The Honorable John D. Dingell, a Representative in Congress from the State of Michigan.

The CHAIRMAN. The hearing will come to order.

I am very sorry that we do not have a larger committee room for this meeting this morning, but owing to the use of the larger rooms by other important committees we have been compelled to take this room. I hope that we may be able to get a larger room before the hearings have ended.

First, I wish to insert in the record of the hearings the President's health message, the national health bill, S. 1606, copies of correspondence between President Truman and myself relative to certain amendments proposed by Mr. William Green, president of the American Federation of Labor, and, fourthly, reports on the national health bill from a number of Federal agencies, including the Bureau of the Budget, the Federal Security Administrator, and the Secretary of Commerce.

(The documents above referred to are as follows:)

[H. Doc. No. 380, 79th Cong., 1st sess.]

## MESSAGE FROM THE PRESIDENT OF THE UNITED STATES, TRANSMITTING HIS REQUEST FOR LEGISLATION FOR ADOPTION OF A NATIONAL HEALTH PROGRAM

*To the Congress of the United States:*

In my message to the Congress of September 6, 1945, there were enumerated in a proposed economic bill of rights certain rights which ought to be assured to every American citizen.

One of them was "the right to adequate medical care and the opportunity to achieve and enjoy good health." Another was the "right to adequate protection from the economic fears \* \* \* sickness \* \* \*."

Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.

The people of the United States received a shock when the medical examinations conducted by the Selective Service System revealed the widespread physical and mental incapacity among the young people of our Nation. We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently in terms which all of us can understand.

As of April 1, 1945, nearly 5,000,000 male registrants between the ages of 18 and 37 had been examined and classified as unfit for military service. The number of those rejected for military service was about 30 percent of all those examined. The percentage of rejection was lower in the younger age groups and higher in the higher age groups, reaching as high as 49 percent for registrants between the ages of 34 and 37.

In addition, after actual induction, about a million and a half men had to be discharged from the Army and Navy for physical or mental disability, exclusive of wounds; and an equal number had to be treated in the armed forces for diseases or defects which existed before induction.

Among the young women who applied for admission to the Women's Army Corps there was similar disability. Over one-third of those examined were rejected for physical or mental reasons.

These men and women who were rejected for military service are not necessarily incapable of civilian work. It is plain, however, that they have illnesses and defects that handicap them, reduce their working capacity, or shorten their lives.

It is not so important to search the past in order to fix the blame for these conditions. It is more important to resolve now that no American child shall come to adult life with diseases or defects which can be prevented or corrected at an early age.

Medicine has made great strides in this generation, especially during the last 4 years. We owe much to the skill and devotion of the medical profession. In spite of great scientific progress, however, each year we lose many more persons from preventable and premature deaths than we lost in battle or from war injuries during the entire war.

We are proud of past reductions in our death rates. But these reductions have come principally from public health and other community services. We have been less effective in making available to all of our people the benefits of medical progress in the care and treatment of individuals.

In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future unless government is bold enough to do something about it.

People with low or moderate incomes do not get the same medical attention as those with high incomes. The poor have more sickness, but they get less medical care. People who live in rural areas do not get the same amount or quality of medical attention as those who live in our cities.

Our new economic bill of rights should mean health security for all, regardless of residence, station, or race—everywhere in the United States.

We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation.

There are five basic problems which we must attack vigorously if we would reach the health objectives of our economic bill of rights.

1. The first has to do with the number and distribution of doctors and hospitals. One of the most important requirements for adequate health service is professional personnel—doctors, dentists, public health and hospital administrators, nurses, and other experts.

The United States has been fortunate with respect to physicians. In proportion to population it has more than any large country in the world, and they are well trained for their calling. It is not enough, however, that we have them in sufficient numbers. They should be located where their services are needed. In this respect we are not so fortunate.

The distribution of physicians in the United States has been grossly uneven and unsatisfactory. Some communities have had enough or even too many; others have had too few. Year by year the number in our rural areas has been diminishing. Indeed, in 1940, there were 31 counties in the United States, each with more than a thousand inhabitants, in which there was not a single practicing physician. The situation with respect to dentists was even worse.

One important reason for this disparity is that in some communities there are no adequate facilities for the practice of medicine. Another reason—closely allied with the first—is that the earning capacity of the people in some communities makes it difficult if not impossible for doctors who practice there to make a living.

The demobilization of 60,000 doctors and of the tens of thousands of other professional personnel in the armed forces is now proceeding on a large scale. Unfortunately, unless we act rapidly, we may expect to see them concentrate

in the places with greater financial resources and avoid other places, making the inequalities even greater than before the war.

Demobilized doctors cannot be assigned. They must be attracted. In order to be attracted, they must be able to see ahead of them professional opportunities and economic assurances.

Inequalities in the distribution of medical personnel are matched by inequalities in hospitals and other health facilities. Moreover, there are just too few hospitals, clinics, and health centers to take proper care of the people of the United States.

About 1,200 counties, 40 percent of the total in the country, with some 15,000,000 people, have either no local hospital or none that meets even the minimum standards of national professional associations.

The deficiencies are especially severe in rural and semirural areas and in those cities where changes in population have placed great strains on community facilities.

I want to emphasize, however, that the basic problem in this field cannot be solved merely by building facilities. They have to be staffed; and the communities have to be able to pay for the services. Otherwise the new facilities will be little used.

2. The second basic problem is the need for development of public health services and maternal and child care. The Congress can be justifiably proud of its share in making recent accomplishments possible. Public health and maternal and child health programs already have made important contributions to national health. But large needs remain. Great areas of our country are still without these services. This is especially true among our rural areas; but it is true also in far too many urban communities.

Although local public health departments are now maintained by some 18,000 counties and other local units, many of these have only skeleton organizations, and approximately 40,000,000 citizens of the United States still live in communities lacking full-time local public health service. At the recent rate of progress in developing such service, it would take more than a hundred years to cover the whole Nation.

If we agree that the national health must be improved, our cities, towns, and farming communities must be made healthful places in which to live through provision of safe water systems, sewage-disposal plants, and sanitary facilities. Our streams and rivers must be safeguarded against pollution. In addition to building a sanitary environment for ourselves and for our children, we must provide those services which prevent disease and promote health.

Services for expectant mothers and for infants, care of crippled or otherwise physically handicapped children, and inoculation for the prevention of communicable diseases are accepted public health functions. So, too, are many kinds of personal services such as the diagnosis and treatment of widespread infections like tuberculosis and venereal disease. A large part of the population today lacks many or all of these services.

Our success in the traditional public health sphere is made plain by the conquest over many communicable diseases. Typhoid fever, smallpox, and diphtheria—diseases for which there are effective controls—have become comparatively rare. We must make the same gains in reducing our maternal and infant mortality, in controlling tuberculosis, venereal disease, malaria, and other major threats to life and health. We are only beginning to realize our potentialities in achieving physical well-being for all our people.

3. The third basic problem concerns medical research and professional education.

We have long recognized that we cannot be content with what is already known about health or disease. We must learn and understand more about health and how to prevent and cure disease.

Research—well directed and continuously supported—can do much to develop ways to reduce those diseases of body and mind which now cause most sickness, disability, and premature death—diseases of the heart, kidneys, and arteries, rheumatism, cancer; diseases of childbirth, infancy, and childhood; respiratory diseases; and tuberculosis. And research can do much toward teaching us how to keep well and how to prolong healthy human life.

Cancer is among the leading causes of death. It is responsible for over 160,000 recorded deaths a year and should receive special attention. Though we already have the National Cancer Institute of the Public Health Service, we need still more coordinated research on the cause, prevention, and cure of this disease. We need more financial support for research and to establish special clinics

and hospitals for diagnosis and treatment of the disease especially in its early stages. We need to train more physicians for the highly specialized services so essential for effective control of cancer.

There is also special need for research on mental diseases and abnormalities. We have done pitifully little about mental illnesses. Accurate statistics are lacking, but there is no doubt that there are at least 2,000,000 persons in the United States who are mentally ill, and that as many as 10,000,000 will probably need hospitalization for mental illness for some period in the course of their lifetime. A great many of these persons would be helped by proper care. Mental cases occupy more than one-half of the hospital beds, at a cost of about \$500,000,000 per year—practically all of it coming out of taxpayers' money. Each year there are 125,000 new mental cases admitted to institutions. We need more mental-disease hospitals, more out-patient clinics. We need more services for early diagnosis, and especially we need much more research to learn how to prevent mental break-down. Also, we must have many more trained and qualified doctors in this field.

It is clear that we have not done enough in peacetime for medical research and education in view of our enormous resources and our national interest in health progress. The money invested in research pays enormous dividends. If anyone doubts this, let him think of penicillin, plasma, DDT powder, and new rehabilitation techniques.

4. The fourth problem has to do with the high cost of individual medical care. The principal reason why people do not receive the care they need is that they cannot afford to pay for it on an individual basis at the time they need it. This is true not only for needy persons. It is also true for a large proportion of normally self-supporting persons.

In the aggregate, all health services—from public health agencies, physicians, hospitals, dentists, nurses, and laboratories—absorb only about 4 percent of the national income. We can afford to spend more for health.

But 4 percent is only an average. It is cold comfort in individual cases. Individual families pay their individual costs and not average costs. They may be hit by sickness that calls for many times the average cost—in extreme cases for more than their annual income. When this happens they may come face to face with economic disaster. Many families, fearful of expense, delay calling the doctor long beyond the time when medical care would do the most good.

For some persons with very low income or no income at all we now use taxpayers' money in the form of free services, free clinics, and public hospitals. Tax-supported, free medical care for needy persons, however, is insufficient in most of our cities and in nearly all of our rural areas. This deficiency cannot be met by private charity or the kindness of individual physicians.

Each of us knows doctors who work through endless days and nights, never expecting to be paid for their services because many of their patients are unable to pay. Often the physician spends not only his time and effort but even part of the fees he has collected from patients able to pay, in order to buy medical supplies for those who cannot afford them. I am sure that there are thousands of such physicians throughout our country. They cannot, and should not, be expected to carry so heavy a load.

5. The fifth problem has to do with loss of earnings when sickness strikes. Sickness not only brings doctor bills; it also cuts off income.

On an average day, there are about 7,000,000 persons so disabled by sickness or injury that they cannot go about their usual tasks. Of these, about  $3\frac{1}{4}$  millions are persons who, if they were not disabled, would be working or seeking employment. More than one-half of these disabled workers have already been disabled for 6 months; many of them will continue to be disabled for years and some for the remainder of their lives.

Every year, four or five hundred million working days are lost from productive employment because of illness and accident among those working or looking for work—about 40 times the number of days lost because of strikes on the average during the 10 years before the war. About nine-tenths of this enormous loss is due to illness and accident that is not directly connected with employment and is therefore not covered by workmen's compensation laws.

These then are the five important problems which must be solved, if we hope to attain our objective of adequate medical care, good health, and protection from the economic fears of sickness and disability.

To meet these problems, I recommend that the Congress adopt a comprehensive and modern health program for the Nation, consisting of five major parts, each of which contributes to all the others.

## FIRST. CONSTRUCTION OF HOSPITALS AND RELATED FACILITIES

The Federal Government should provide financial and other assistance for the construction of needed hospitals, health centers, and other medical, health, and rehabilitation facilities. With the help of Federal funds, it should be possible to meet deficiencies in hospital and health facilities so that modern services—for both prevention and cure—can be accessible to all the people. Federal financial aid should be available not only to build new facilities where needed, but also to enlarge or modernize those we now have.

In carrying out this program, there should be a clear division of responsibilities between the States and the Federal Government. The States, localities, and the Federal Government should share in the financial responsibilities. The Federal Government should not construct or operate these hospitals. It should, however, lay down minimum national standards for construction and operation and should make sure that Federal funds are allocated to those areas and projects where Federal aid is needed most. In approving State plans and individual projects, and in fixing the national standards, the Federal agency should have the help of a strictly advisory body that includes both public and professional members.

Adequate emphasis should be given to facilities that are particularly useful for prevention of disease—mental as well as physical—and to the coordination of various kinds of facilities. It should be possible to go a long way toward knitting together facilities for prevention with facilities for cure, the large hospitals of medical centers with the smaller institutions of surrounding areas, the facilities for the civilian population with the facilities for veterans.

The general policy of Federal-State partnership which has done so much to provide the magnificent highways of the United States can be adapted to the construction of hospitals in the communities which need them.

## SECOND. EXPANSION OF PUBLIC HEALTH, MATERNAL AND CHILD-HEALTH SERVICES

Our programs for public health and related services should be enlarged and strengthened. The present Federal-State cooperative health programs deal with general public health work, tuberculosis and venereal disease control, maternal and child-health services, and services for crippled children.

These programs were especially developed in the 10 years before the war and have been extended in some areas during the war. They have already made important contributions to national health, but they have not yet reached a large proportion of our rural areas, and in many cities they are only partially developed.

No area in the Nation should continue to be without the services of a full-time health officer and other essential personnel. No area should be without essential public health services or sanitation facilities. No area should be without community health services, such as maternal and child-health care.

Hospitals, clinics, and health centers must be built to meet the needs of the total population and must make adequate provision for the safe birth of every baby and for the health protection of infants and children.

Present laws relating to general public health and to maternal and child health have built a solid foundation of Federal cooperation with the States in administering community health services. The emergency maternity and infant care program for the wives and infants of servicemen—a great wartime service authorized by the Congress—has materially increased the experience of every State health agency and has provided much-needed care. So, too, have other wartime programs, such as venereal disease control, industrial hygiene, malaria control, tuberculosis control, and other services offered in war essential communities.

The Federal Government should cooperate by more generous grants to the States than are provided under present laws for public health services and for maternal and child health care. The program should continue to be partly financed by the States themselves and should be administered by the States. Federal grants should be in proportion to State and local expenditures and should also vary in accordance with the financial ability of the respective States.

The health of American children, like their education, should be recognized as a definite public responsibility.

In the conquest of many diseases, prevention is even more important than cure. A well-rounded national health program should, therefore, include systematic and widespread health and physical education and examinations, beginning with

the youngest children and extending into community organizations. Medical and dental examinations of school children are now inadequate. A preventive health program, to be successful, must discover defects as early as possible. We should, therefore, see to it that our health programs are pushed most vigorously with the youngest section of the population.

Of course, Federal aid for community health services—for general public health and for mothers and children—should complement and not duplicate pre-paid medical services for individuals, proposed by the fourth recommendation of this message.

#### THIRD. MEDICAL EDUCATION AND RESEARCH

The Federal Government should undertake a broad program to strengthen professional education in medical and related fields and to encourage and support medical research.

Professional education should be strengthened where necessary through Federal grants-in-aid to public and to nonprofit private institutions. Medical research, also, should be encouraged and supported in the Federal agencies and by grants-in-aid to public and nonprofit private agencies.

In my message to the Congress of September 6, 1945, I made various recommendations for a general Federal research program. Medical research, dealing with the broad fields of physical and mental illnesses should be made effective in part through that general program and in part through specific provisions within the scope of a national health program.

Federal aid to promote and support research in medicine, public health, and allied fields is an essential part of a general research program to be administered by a central Federal research agency. Federal aid for medical research and education is also an essential part of any national health program, if it is to meet its responsibilities for high-grade medical services and for continuing progress. Coordination of the two programs is obviously necessary to assure efficient use of Federal funds. Legislation covering medical research in a national health program should provide for such coordination.

#### FOURTH. PREPAYMENT OF MEDICAL COSTS

Everyone should have ready access to all necessary medical, hospital, and related services.

I recommend solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system. This is not socialized medicine.

Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk and to benefit the insured who actually suffers the loss. If, instead of the costs of sickness being paid only by those who get sick, all the people, sick and well, were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately served without overburdening anyone. That is the principle upon which all forms of insurance are based.

During the past 15 years, hospital insurance plans have taught many Americans this magic of averages. Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people's needs. Only about 3 or 4 percent of our population now have insurance providing comprehensive medical care.

A system of required prepayment would not only spread the costs of medical care, it would also prevent much serious disease. Since medical bills would be paid by the insurance fund, doctors would more often be consulted when the first signs of disease occur instead of when the disease has become serious. Modern hospital, specialist, and laboratory services, as needed, would also become available to all and would improve the quality and adequacy of care. Prepayment of medical care would go a long way toward furnishing insurance against disease itself, as well as against medical bills.

Such a system of prepayment should cover medical, hospital, nursing, and laboratory services. It should also cover dental care—as fully and for as many of the population as the available professional personnel and the financial resources of the system permit.

The ability of our people to pay for adequate medical care will be increased if, while they are well, they pay regularly into a common health fund instead of paying sporadically and unevenly when they are sick. This health fund should be built up nationally in order to establish the broadest and most stable basis for spreading the costs of illness and to assure adequate financial support for doctors and hospitals everywhere. If we were to rely on State-by-State action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross State boundary lines.

Medical services are personal. Therefore the Nation-wide system must be highly decentralized in administration. The local administrative units must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions. Locally as well as nationally, policy and administration should be guided by advisory committees in which the public and the medical professions are represented.

Subject to national standards, methods and rates of paying doctors and hospitals should be adjusted locally. All such rates for doctors should be adequate and should be appropriately adjusted upward for those who are qualified specialists.

People should remain free to choose their own physicians and hospitals. The removal of financial barriers between patient and doctor would enlarge the present freedom of choice. The legal requirement on the population to contribute involves no compulsion over the doctor's freedom to decide what services his patient needs. People will remain free to obtain and pay for medical service outside of the health-insurance system if they desire, even though they are members of the system; just as they are free to send their children to private instead of to public schools, although they must pay taxes for public schools.

Likewise physicians should remain free to accept or reject patients. They must be allowed to decide for themselves whether they wish to participate in the health-insurance system full time, part time, or not at all. A physician may have some patients who are in the system and some who are not. Physicians must be permitted to be represented through organizations of their own choosing, and to decide whether to carry on in individual practice or to join with other doctors in group practice in hospitals or in clinics.

Our voluntary hospitals and our city, county, and State general hospitals, in the same way, must be free to participate in the system to whatever extent they wish. In any case they must continue to retain their administrative independence.

Voluntary organizations which provide health services that meet reasonable standards of quality should be entitled to furnish services under the insurance system and to be reimbursed for them. Voluntary cooperative organizations concerned with paying doctors, hospitals, or others for health services but not providing services directly, should be entitled to participate if they can contribute to the efficiency and economy of the system.

None of this is really new. The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have misnamed it "socialized medicine."

I repeat—what I am recommending is not socialized medicine.

Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed.

Under the plan I suggest, our people would continue to get medical and hospital services just as they do now—on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all-important difference: whether or not patients get the services they need would not depend on how much they can afford to pay at the time.

I am in favor of the broadest possible coverage for this insurance system. I believe that all persons who work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employees, Government employees, and employees of nonprofit institutions and their families.

In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies. Increased Federal funds should also be made available by the Congress under the public-assistance programs to reimburse the States for part of such premiums, as well as for di-

rect expenditures made by the States in paying for medical services provided by doctors, hospitals, and other agencies to needy persons.

Premiums for present social-insurance benefits are calculated on the first \$3,000 of earnings in a year. It might be well to have all such premiums, including those for health, calculated on a somewhat higher amount such as \$3,600.

A broad program of prepayment for medical care would need total amounts approximately equal to 4 percent of such earnings. The people of the United States have been spending, on the average, nearly this percentage of their incomes for sickness care. How much of the total fund should come from the insurance premiums and how much from general revenues is a matter for the Congress to decide.

The plan which I have suggested would be sufficient to pay most doctors more than the best they have received in peacetime years. The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists, and nurses for the services they render.

Federal aid in the construction of hospitals will be futile unless there is current purchasing power so that people can use these hospitals. Doctors cannot be drawn to sections which need them without some assurance that they can make a living. Only a Nation-wide spreading of sickness costs can supply such sections with sure and sufficient purchasing power to maintain enough physicians and hospitals.

We are a rich Nation and can afford many things. But ill health which can be prevented or cured is one thing we cannot afford.

#### FIFTH. PROTECTION AGAINST LOSS OF WAGES FROM SICKNESS AND DISABILITY

What I have discussed heretofore has been a program for improving and spreading the health services and facilities of the Nation and providing an efficient and less burdensome system of paying for them.

But no matter what we do, sickness will, of course, come to many. Sickness brings with it loss of wages.

Therefore, as a fifth element of a comprehensive health program, the workers of the Nation and their families should be protected against loss of earnings because of illness. A comprehensive health program must include the payment of benefits to replace at least part of the earnings that are lost during the period of sickness and long-term disability. This protection can be readily and conveniently provided through expansion of our present social-insurance system with appropriate adjustment of premiums.

Insurance against loss of wages from sickness and disability deals with cash benefits rather than with services. It has to be coordinated with the other cash benefits under existing social insurance systems. Such coordination should be effected when other social security measures are reexamined. I shall bring this subject again to the attention of the Congress in a separate message on social security.

I strongly urge that the Congress give careful consideration to this program of health legislation now.

Many millions of our veterans, accustomed in the armed forces to the best of medical and hospital care, will no longer be eligible for such care as a matter of right except for their service-connected disabilities. They deserve continued adequate and comprehensive health service. And their dependents deserve it, too.

By preventing illness, by assuring access to needed community and personal health services, by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic productivity. We shall increase the professional and economic opportunities of our physicians, dentists, and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people.

We need to do this especially at this time because of the return to civilian life of many doctors, dentists, and nurses, particularly young men and women.

Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available. By meeting that demand we shall strengthen the Nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land.

[S. 1606, 79th Cong., 1st sess.]

A BILL To provide for a national health program

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "National Health Act of 1945."*

## TITLE I—GRANTS TO STATES FOR HEALTH SERVICES

## PART A—GRANTS TO STATES FOR PUBLIC HEALTH SERVICES

SEC. 101. Section 314 of the Public Health Service Act (Act of July 1, 1944, 58 Stat. 682) is hereby amended to read as follows:

## "GRANTS AND SERVICES TO STATES

"SEC. 314. (a) To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention, treatment, and control of venereal diseases, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention, treatment, and control of such diseases, including the training of personnel for State and local health work, and to enable him to prevent and control the spread of the venereal diseases in interstate traffic, and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist in carrying out the purposes of this section with respect to the venereal diseases, and to administer this section with respect to such diseases, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subsection.

"(b) To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention, treatment, and control of tuberculosis, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention, treatment, and control of such disease, including the provision of appropriate facilities for care and treatment and including the training of personnel for State and local health work, and to enable him to prevent and control the spread of tuberculosis in interstate traffic, and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist in carrying out the purposes of this section with respect to tuberculosis, and to administer this section with respect to such disease, there is hereby authorized to be appropriated the sum of \$10,000,000, and for each fiscal year a sum sufficient to carry out the purposes of this subsection.

"(c) For each fiscal year, the Surgeon General, with the approval of the Administrator, shall determine the total sum from the appropriation under subsection (a) and the total sum from the appropriation under subsection (b) which shall be available for allotment among the several States. He shall, in accordance with regulations, from time to time make allotments from such sums to the several States on the basis of (1) the population, (2) the size of the venereal-disease problem, and the size of the tuberculosis problem, respectively, and (3) the financial need of the respective States. Upon making such allotments the Surgeon General shall notify the Secretary of the Treasury of the amounts thereof.

"(d) The Surgeon General, with the approval of the Administrator, shall from time to time determine the amounts to be paid to each State from the allotments to such State under subsection (c), and shall certify to the Secretary of the Treasury the amounts so determined, reduced or increased, as the case may be, by the amounts by which he finds that estimates of required expenditures with respect to any prior period were greater or less than the actual expenditures for such period. Upon receipt of such certification, 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, pay in accordance with such certification.

"(e) Money so paid under subsection (d) shall be paid upon the condition that there shall be spent in such State for the same general purpose from funds of such State and its political subdivisions an amount determined in accordance with regulations.

"(f) (1) To enable the Surgeon General to assist, through grants and as otherwise provide in this section, States, counties, health districts, and other political subdivisions of the States to extend and improve public-health work by establishing and maintaining adequate public-health services as rapidly as may be practicable under the conditions in the States, especially by improving such services in rural communities, in economically depressed areas, and in other communities or areas where such services are below nationally accepted standards of adequate public-health services, including grants for demonstrations and for the training of personnel for State and local public-health work, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1946, a sum sufficient to carry out the purposes of this section. Of the sum appropriated for each fiscal year pursuant to this subsection there shall be available an amount, not to exceed \$5,000,000, to enable the Surgeon General to provide demonstrations and to train personnel for State and local health work and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist States in carrying out the purposes of this subsection.

"(2) A state plan to be approved under this subsection must—

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

"(B) 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 services not later than the beginning of the fiscal year ending June 30, 1950;

"(C) provide for extension and improvement of public-health work in the State, in accordance with the purposes of paragraph (1) of this subsection;

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

"(E) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Surgeon General to be necessary for the proper and efficient operation of the plan;

"(F) 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 services;

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

"(H) 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 public-health 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;

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

"(3) The Surgeon General shall approve any plan which fulfills the conditions specified in paragraph (2) of this subsection.

"(4) From the sums appropriated therefor under this subsection, the Secretary of the Treasury shall pay to each State which has an approved plan under this subsection, for each year or part thereof covered by such plan, amounts equal to the Federal proportion of 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 paragraph (5) of this subsection upon the basis of

the financial resources of the State, not counting so much of such total expenditures by the State as are included in any other State plan aided by grants under any other subsection of this Act or any other Act of Congress. The amounts so paid to a State by the Secretary of the Treasury shall be used exclusively for carrying out the purposes of this subsection.

"(5) (A) The financial resources of the several States shall be measured by per capita income accruing to the inhabitants thereof.

"(B) The Federal proportion with respect to any State, for the purposes of paragraph (4) of this subsection, shall be 100 per centum less the non-Federal proportion. The non-Federal proportion for each State whose per capita income is greater than or equal to the per capita income of the continental United States and for the District of Columbia, Alaska, and Hawaii shall be 50 per centum each, and the non-Federal proportion for Puerto Rico and the Virgin Islands shall be 25 per centum each. The non-Federal proportion for each State whose per capita income is less than the per-capita income of the continental United States shall be that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States, except that (i) the non-Federal proportion shall in no case be less than 25 per centum, and (ii) the non-Federal proportion shall be rounded to the nearest whole per centum.

"(C) The percentages representing the Federal proportion of total expenditures under this program shall be promulgated by the Surgeon General between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall for the purposes of this section be conclusive for each of the eight quarters in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Surgeon General shall promulgate such percentages as soon as possible after the enactment of this Act, which promulgation shall be conclusive for the purposes of this subsection for each of the two fiscal years in the period beginning July 1, 1945, and ending June 30, 1947.

"(6) The Surgeon General shall, from time to time but not less often than semi-annually, estimate the amount to be paid to each State for each year or part thereof under the provisions of paragraph (4), 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 period in accordance with the provisions of paragraph (4), and (B) such other data as to such estimated expenditures and such other investigations as the Surgeon General may find necessary. The Surgeon General shall then certify to the Secretary of the Treasury the amount so estimated, reduced or increased, as the case may be, by any sum by which the Surgeon General finds that his estimate for any prior period was greater or less than the amount which should have been paid to the State under paragraph (4) for such period; except that such increases or reductions shall not be made to the extent that such sum has been applied to make the amount certified for any prior period greater or less than the amount estimated by the Surgeon General for such prior period. The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Surgeon General, the amount so certified.

"(g) The moneys so paid to any State under subsections (d) and (f) shall be expended solely in carrying out the purposes specified in subsection (a), or subsection (b), or subsection (f) of this section, as the case may be, and in accordance with plans presented by the health authority of such State and approved by the Surgeon General.

"(h) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the health authority of the State, finds that, with respect to money paid to the State out of appropriations under subsection (a), or subsection (b), or subsection (f), as the case may be, there is a failure to comply substantially with either—

"(1) the provisions of this section;

"(2) the plan submitted under subsection (f) or subsection (g), as may be pertinent; or

"(3) the regulations;

the Surgeon General shall notify such State health authority either that further payments will not be made to the State from appropriations under such subsection (or in his discretion that further payments will not be made to the State from such appropriations for activities in which there is such failure), until he is

satisfied that there will no longer be any such failure. Until he is so satisfied the Surgeon General shall make no further certification for payment to such State from appropriations under such subsection, or shall limit payment to activities in which there is no such failure.

"(i) All regulations and amendments thereto with respect to grants to States under this section shall be made after consultation with a conference of the State health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement of the State health authorities prior to the issuance of any such regulations or amendments.

"(j) Funds appropriated under subsection (a) and funds appropriated under subsection (b), in addition to being available for payments to States, shall also be available for expenditure by the Surgeon General in otherwise carrying out the respective subsections, including expenditures for printing and binding of the findings of investigations, and for pay and allowances and traveling expenses of personnel of the Service engaged in activities authorized by the respective subsections.

"(k) In carrying out the duties imposed upon him, the Surgeon General is hereby authorized and directed, with the approval of the Federal Security Administrator, to enter into such agreements or cooperative working arrangements as may be necessary to insure coordination in the administration of programs and services under this part with those under parts B and C of this title and with those under title II of this Act.

"(l) When used in subsection (f) of this section, the term 'public-health work' includes customary and accepted functions, services, and activities of public-health agencies with respect to: public-health administration; training of personnel; vital statistics; sanitation of the human environment; control of communicable and preventable diseases; laboratory services; protection of health in maternity, infancy, and childhood; public-health education; public-health nursing; research and the performance of demonstrations; medical and related services for prevention or mitigation of sickness or disability and for the prevention of premature death; planning and coordination of health services and activities; enactment and enforcement of necessary standards and regulations; production or procurement, and distribution, of therapeutic and prophylactic preparations; and related matters. The term does not include: construction of hospitals, water supplies, sewerage or other waste-disposal systems, or of other facilities; operation or maintenance of hospitals (except hospitals for persons afflicted with infectious diseases), water supplies, sewerage or other waste-disposal systems; and related matters."

## PART B—GRANTS TO STATES FOR MATERNAL AND CHILD HEALTH SERVICES

### MATERNAL AND CHILD-HEALTH SERVICES

#### Appropriation

Sec. 121. (a) For the purpose of enabling each State to provide and maintain services and facilities for promoting the physical and mental health of mothers and children, by establishing and maintaining adequate maternal and child-health services, and to develop more effective measures for carrying out the purposes of this section, including demonstrations and the training of personnel for State and local maternal and child-health work, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1946, a sum sufficient to carry out the purposes of this section. 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 establishing and maintaining adequate maternal and child-health services.

#### APPROVAL OF STATE PLANS

Sec. 122. (a) A State plan for maternal and child-health services to be approved under this section must—

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

(3) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Chief of the Children's Bureau shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are necessary for the proper and efficient operation of the plan;

(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;

(5) provide for the extension and improvement of local maternal and child-health services and facilities administered by local health units so that the plan will be in effect in all political subdivisions of the State not later than a date ten years after the date of approval of the first State plan approved under this section;

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

(7) provide for the development of demonstration services and for the training of personnel;

(8) provide that as services and facilities are furnished under the plan they shall be available to all mothers and children in the State or locality who elect to participate in the benefits of the program; and

(9) provide that the State agency shall have authority to make and publish such rules and regulations as are necessary for the efficient operation of such services, having special regard for the quality and economy of service.

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

#### SERVICES FOR CRIPPLED CHILDREN

##### Appropriation

SEC. 123. For the purpose of enabling each State to provide and maintain services for locating crippled or otherwise physically handicapped 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 otherwise physically handicapped or who are suffering from conditions which lead to crippling, or physical handicap, and to develop more effective measures for carrying out the purposes of this section, including demonstrations and the training of personnel for State and local crippled children's services, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1946, a sum sufficient to carry out the purposes of this section. 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 establishing and maintaining adequate crippled children's service.

#### APPROVAL OF STATE PLANS

SEC. 124. (a) A State plan for services for crippled and other handicapped children to be approved under this section must—

(1) provide for financial participation by the State;

(2) provide for the administration of the plan by a single State agency or the supervision of the administration of the plan by a single State agency, and for appropriate coordination of the plan with the maternal and child-health program of the State health agency;

(3) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Chief of the Children's Bureau shall exercise no authority with respect to the selection, tenure of office, and compensation of

any individual employed in accordance with such methods) as are necessary for the proper and efficient operation of the plan;

(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;

(5) provide for carrying out the purposes specified in subsection (a) so that the program will be in effect in all political subdivisions of the State, and the services and facilities available to all crippled children not later than a date 10 years after the date of approval of the first plan approved under the section;

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

(7) provide that as services and facilities are furnished under the plan they shall be available to all crippled children in the State who elect to participate in the benefits of the program; and

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

(b) The Chief of the Children's Bureau shall approve any plan for crippled children's services 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. 125. (a) From the sums appropriated therefor under section 121 or 123, the Secretary of the Treasury shall pay to each State which has an approved plan for material and child-health services, or for services to crippled children, respectively, for each year or part thereof covered by such plan, amounts equal to the Federal proportion of the total amount of public funds expended under the respective State plan, during each year or part thereof covered by such plan, as is determined in accordance with section 127 of this title upon the basis of the financial resources of the State, not counting so much of such total expenditures by the State as are included in any other State plan aided by grants under any other section of this part, or any other part of this title, or any other Act of Congress. The amounts so paid to a State by the Secretary of the Treasury shall be used exclusively for carrying out the purposes of the respective sections of this part.

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

(1) The Secretary of Labor shall, from time to time but not less often than semiannually, estimate the amount to be paid to the State with respect to each State plan for each year or part thereof under the provisions of subsection (a) of this section, such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended for each such plan in such period in accordance with the provisions of subsection (a) and (B) such other data as to such estimated expenditures and such other investigations as he may find necessary.

(2) The Secretary of Labor shall then certify to the Secretary of the Treasury the amount so estimated for each State plan, reduced or increased, as the case may be, by any sum by which the Secretary of Labor finds that his estimate for any prior period for such State plan was greater or less than the amount which should have been paid to the State under subsection (a) for such period; except that such increases or reductions shall not be made to the extent that such sum has been applied to make the amount certified for any prior period greater or less than the amount estimated by the Secretary of Labor for such prior period.

(3) The Secretary of the Treasury shall, 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.

## OPERATION OF STATE PLANS

SEC. 126. In case of any State plan for maternal and child-health services, or for services to 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 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 121, or section 123, respectively, to be included in the plan, he shall notify such State agency that further payments will not be made to the State under such plan (or, in his discretion, that further payments will not be made to the State under such plan for services in which there is such failure) 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 plan for such State.

## FEDERAL GRANT PERCENTAGES

SEC. 127. (a) The financial resources of the several States shall be measured by per capita income accruing to the inhabitants thereof.

(b) The Federal proportion with respect to any State, for the purposes of section 125 of this title, shall be 100 per centum less the non-Federal proportion. The non-Federal proportion for each State whose per capita income is greater than or equal to the per capita income of the continental United States and for the District of Columbia, Alaska, and Hawaii shall be 50 per centum each, and the non-Federal proportion for Puerto Rico and the Virgin Islands shall be 25 per centum each. The non-Federal proportion for each State whose per capita income is less than the per capita income of the continental United States shall be that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States, except that (1) the non-Federal proportion shall in no case be less than 25 per centum, and (2) the non-Federal proportion shall be rounded to the nearest whole per centum.

(c) The percentages representing the Federal proportion of total expenditures under these programs shall be promulgated by the Secretary of Labor between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall for the purposes of this section be conclusive for each of the eight quarters in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Secretary of Labor shall promulgate such percentages as soon as possible after the enactment of this Act, which promulgation shall be conclusive for the purposes of this section for each of the two fiscal years in the period beginning July 1, 1945, and ending June 30, 1947.

## STUDIES, INVESTIGATIONS, ADMINISTRATION, RULES AND REGULATIONS, AND ANNUAL REPORT

SEC. 128. (a) The Children's Bureau shall make and aid the financing of such studies, demonstrations, investigations, and research as will promote the efficient administration and operation of this part. In such administration, the Chief of the Children's Bureau shall pursue general policies established by him after consultation with advisory committees composed of professional and public members which he shall appoint (without regard to the civil-service laws), with the approval of the Secretary of Labor, to advise him on matters pertaining to the furnishing of the care and services authorized by this part, and after consultation with a conference of the State health officers with respect to section 121, and a conference of State officers responsible for the administration of State plans with respect to section 123. Insofar as practicable, the Chief of the Children's Bureau shall obtain agreement of these State authorities prior to the issuance of such general policies.

(b) The Chief of the Children's Bureau, with the approval of the Secretary of Labor, shall make and publish such rules and regulations as may be necessary to the efficient administration of this part.

(c) In carrying out the duties imposed upon him by this part, the Chief of the Children's Bureau is hereby authorized and directed, with the approval of

the Secretary of Labor, to enter into such agreements or cooperative working arrangements with the Surgeon General of the Public Health Service and with the Social Security Board as may be necessary to insure coordination in the administration of programs and services administered by him with those under parts A and C of this title and with those under title II of this Act.

(d) The Secretary of Labor shall include in his annual report to Congress a full account of the administration of this part.

#### DEFINITION

SEC. 129. In this part, the term "State" includes Alaska, Hawaii, the District of Columbia, Puerto Rico, and the Virgin Islands.

#### APPROPRIATION

SEC. 130. There is hereby authorized to be appropriated for the fiscal year ending June 30, 1946, the sum of \$5,000,000 for all necessary expenses of the Children's Bureau in administering the provisions of this part of this title, and in developing and promoting effective measures for carrying out the purposes of this part, including studies, demonstrations, investigations and research, the training of personnel for Federal, State, and local services, and the payment of salaries and expenses of personnel detailed at the request of State agencies to cooperate with and assist such agencies in carrying out the purposes of this part of this title; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this part.

### PART C—GRANTS TO STATES FOR MEDICAL CARE OF NEEDY PERSONS

#### APPROPRIATION

SEC. 131. For the purpose of enabling each State to provide medical care, as far as practicable under the conditions in such State, for needy persons, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1946, the sum of \$10,000,000, and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this part. The sums made available under this section shall be used for making payments to States which have submitted and had approved by the Social Security Board (hereinafter referred to as the "Board") State plans for medical care of needy persons.

#### APPROVAL OF STATE PLANS

SEC. 132. (a) A State plan for medical care must—

(1) provide that it shall be in effect in all political subdivisions of the State, and if administered by them, be mandatory upon them;

(2) provide for financial participation by the State, and for such distribution of funds, as to assure meeting in full the need of individuals for medical care throughout the State, as determined in accordance with standards established by the State;

(3) (A) provide for the establishment or designation of a single State public assistance agency to administer or to supervise the administration of the plan for medical care; and (B) provide that there will not be more than one public assistance agency of a local subdivision of the State established or designated to administer the plan for medical care within such subdivision;

(4) provide for granting to any individual, whose claim for medical care is denied, an opportunity for a fair hearing before such State agency;

(5) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Board shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Board to be necessary for the proper and efficient operation of the plan;

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

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan; and

(8) provide that the State agency shall, in determining need for medical care, take into consideration (A) the requirements of individuals claiming medical care under the plan, and (B) any income and resources of an individual claiming medical care under the plan, which must be taken into consideration with regard to an individual claiming assistance under a State plan approved under the Social Security Act, as amended.

(b) The Board shall approve any plan which fulfills the conditions specified in subsection (a), except that it shall not approve any plan which imposes as a condition of eligibility for medical care under the plan any citizenship or residence requirement, or any requirement which excludes any recipient of public assistance under a State plan approved under the Social Security Act, as amended.

#### PAYMENT TO STATES

SEC. 133. (a) From the sums appropriated therefor under section 131, the Secretary of the Treasury shall pay to each State which has an approved plan for medical care, for each year or part thereof covered by such plan, amounts equal to the Federal proportion of 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 section 135, not counting so much of such expenditures for medical care for any individual under the age of eighteen years who at the time of such expenditure is living in a public or private institution, or for any individual who has attained the age of eighteen years and at the time of such expenditure is living in a public institution, and not counting so much of such total expenditures by the State as are included in any other State plan aided by grants under any other part of this title, or any other Act of Congress. The amounts so paid to a State by the Secretary of the Treasury shall be used exclusively for carrying out the purposes of this title.

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

(1) The Board shall, prior to the beginning of each period for which a payment is to be made to the State under subsection (a), estimate the amount to be paid to such State for such period 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 period 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 period, and if the sum of such amount and the estimated Federal grant to be paid the State under subsection (a) is less than the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other data as to such estimated expenditures and such other investigation as the Board may find necessary.

(2) The Board shall then certify to the Secretary of the Treasury the amount so estimated by the Board (A) reduced or increased, as the case may be, by any sum by which it finds that its estimate for any prior period was greater or less than the amount which should have been paid to the State under subsection (a) for such period, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Board, of the net amount recovered during any prior period by the State or any political subdivision thereof with respect to medical care furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior period greater or less than the amount estimated by the Board for such prior period: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Board, the amount so certified.

(4) The period for which estimates and certifications are made under this section shall be a calendar quarter, except that, upon application by a State, the Board may extend the period for such State to not more than four calendar quarters.

## OPERATION OF STATE PLANS

SEC. 134. In case of any State plan for medical care which has been approved by the Board, if the Board, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(a) that the plan has been so changed as to impose any requirement prohibited by section 132 (b), or that in the administration of the plan any prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(b) that in the administration of the plan there is a failure to comply substantially with any provision required by section 132 (a) to be included in the plan;

the Board shall notify such State agency that further payments will not be made to the State under such plan until the Board is satisfied that such prohibited requirement is no longer imposed, and that there is no longer any such failure to comply. Until it is so satisfied it shall make no further certification to the Secretary of the Treasury with respect to such plan for such State.

## FEDERAL GRANT PERCENTAGES

SEC. 135. (a) The Federal proportion with respect to any State, for the purposes of section 133 of this title, shall be 100 per centum less the non-Federal proportion. The non-Federal proportion for each State whose per capita income is greater than or equal to the per capita income of the continental United States and for the District of Columbia, Alaska, and Hawaii shall be 50 per centum each, and the non-Federal proportion for Puerto Rico and the Virgin Islands shall be 25 per centum each. The non-Federal proportion for each State whose per capita income is less than the per capita income of the continental United States shall be that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States, except that (1) the non-Federal proportion shall in no case be less than 25 per centum, and (2) the non-Federal proportion shall be rounded to the nearest whole per centum.

(b) The percentages representing the Federal proportion of total expenditures under this program shall be promulgated by the Board between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall for the purposes of this section be conclusive for each of the eight quarters in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Board shall promulgate such percentages as soon as possible after the enactment of this Act, which promulgation shall be conclusive for the purposes of this section for each of the two fiscal years in the period beginning July 1, 1945, and ending June 30, 1947.

## ADMINISTRATION

SEC. 136. (a) In carrying out the duties imposed upon it by this part, the Board is hereby authorized and directed, with the approval of the Federal Security Administrator, to enter into such agreements or cooperative working arrangements with the Surgeon General of the Public Health Service, and with the Chief of the Children's Bureau, as may be necessary to insure coordination in the administration of programs and services under this part with those under parts A and B of this title and with those under title II of this Act.

(b) Medical care under this part may be provided either (1) by the State or local public assistance agency administering the plan for medical care through (A) money payments to individuals claiming such care, or (B) payments to the persons or institutions furnishing such care or, (C) direct provision of such care; (2) in accordance with agreements (authorized in regulations by the Board) between such State or local agency and other agencies of the State or political subdivision thereof, by such other agencies; or, (3) through arrangements by a State or local public agency with the Surgeon General for services furnished under title II of this Act, on the basis of equitable payments to the Personal Health Services Account established under title II of this Act: or (4) through such combination or modification of (1), (2), or (3) as the Board may approve.

## DEFINITION

SEC. 137. In this part, the term "State" includes Alaska, Hawaii, the District of Columbia, Puerto Rico, and the Virgin Islands.

## TITLE II—PREPAID PERSONAL HEALTH SERVICE BENEFITS

## PRIMARY PERSONAL HEALTH SERVICE BENEFITS

SEC. 201. (a) Every individual, who is currently insured, and has been determined by the Board to be eligible for benefits under this title in a current benefit year, shall be entitled to receive personal health service benefits.

## DEPENDENT'S PERSONAL HEALTH SERVICE BENEFITS

(b) Every dependent (as defined in section 214 (1)) of an individual who is currently insured and who has been determined by the Board to be eligible for benefits under this title in a current benefit year, shall be entitled to receive personal health service benefits, if such dependent is not entitled to receive such benefits under subsection (a) of this section in the current benefit year.

## PERSONAL HEALTH SERVICE BENEFITS FOR RETIRED AND SURVIVOR BENEFICIARIES

SEC. 202. Every individual entitled for any period to monthly benefits under title II of the Social Security Act, as amended, shall be entitled to receive personal health service benefits for the current benefit year, if such individual is not entitled to receive such benefits under section 201.

## ADMINISTRATION

SEC. 203. (a) The Surgeon General of the Public Health Service shall perform the duties imposed upon him by this Act, under the supervision and direction of the Federal Security Administrator, and after consultations with the Advisory Council (hereinafter established) as to questions of general policy and administration, and in consultation with the Board shall also have the duty of studying and making recommendations as to the most effective methods of providing personal health service benefits, and as to legislation and matters of administrative policy concerning health and related subjects.

(b) The Surgeon General is hereby authorized and directed to take all necessary and practical steps, not inconsistent with the provisions of this title, to arrange for the availability of the benefits provided under this title and of services and reports required by the Board for administration under this Act.

(c) In carrying out the duties imposed upon him by this title, the Surgeon General is hereby authorized and directed, after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, to negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any State or political subdivision thereof, and with other appropriate public agencies, and with private agencies or institutions, and with private persons or groups of persons, and with combinations thereof, to utilize their services and facilities and to pay fair, reasonable, and equitable compensation for such services or facilities, and for the Personal Health Services Account (hereinafter referred to as the "Account"), established in accordance with section 212, to receive reimbursements for services rendered with respect to individuals or services under section 209, and to negotiate and periodically renegotiate agreements or cooperative working arrangements for the purchase or availability of supplies and commodities necessary for the benefits provided under this title, and to enter into contracts for such services, facilities, supplies, and commodities (subject to the limitations specified in section 214 (h)).

(d) In carrying out the duties imposed upon him by this title, the Surgeon General is hereby authorized and directed, with the approval of the Federal Security Administrator, to enter into such agreements or cooperative working arrangements with the chief of the Children's Bureau and with the Social Security Board as may be necessary to ensure coordination in the administration of programs and services under this title with those under parts B and C of title I of this Act.

(e) In the administration of this title, the Surgeon General shall, insofar as practicable, give priority and preference to utilizing the facilities and services of State and local departments or agencies on the basis of mutual agreements with such departments or agencies.

(f) The Surgeon General may delegate to any officer or employee of the Public Health Service or of any Federal, State or local cooperating department or agency, such of his powers and duties, except that of prescribing rules and regulations, as he may consider necessary and proper to carry out the purposes of this title.

(g) The Surgeon General, after consultation with the Board, and after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, shall prescribe and publish such rules and regulations and require such records and reports, not inconsistent with other provisions of this Act, as may be necessary to the efficient administration of this title: *Provided*, That when rules and regulations relate to the performance by Federal, State, or local departments or agencies, of functions under mutual agreements made therewith, or to the establishment or determination of local areas for administrative purposes, such rules and regulations shall be made by the Surgeon General after consultation with representatives of such departments or agencies.

(h) The Surgeon General shall periodically notify the Secretary of the Treasury of obligations incurred under arrangements entered into by the Surgeon General in accordance with this section and to whom such obligations obtain and the Surgeon General shall from time to time certify disbursements from the Account to meet such obligations, and such certified disbursements shall be paid from the Account by the Secretary of the Treasury.

(i) Except with respect to States or local areas for which other arrangements have been made, under the provisions of this section, the Surgeon General shall appoint local-area committees to aid in the administration of this title. The members of such local-area committees shall be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical, dental, and nursing services and education and with the operation of hospitals and laboratories and from among other persons, agencies, or organizations informed on the need for or provision of medical, dental, nursing, hospital, laboratory, or related services and benefits. The membership of such local-area committees shall include (1) medical and other professional representatives, and (2) public representatives, in such proportions as are likely to provide fair representation to the principal interested groups that furnish and receive personal health services, having regard for the functions of the local-area committees. Such committees shall be consulted at frequent intervals, and shall be kept informed by the local-area officers of the Public Health Service with respect to arrangements for the availability of benefits under this title and policies to be followed in carrying out the provisions of this title. Such committees are hereby authorized to make annual and special reports, with recommendations, if any, to the local-area officers or to the Surgeon General through his State or regional officers having administrative responsibility for the respective local areas. Such committees, with the same or corresponding functions, shall be appointed by each State or local cooperating department or agency with respect to local areas for which such other arrangements have been made under the provisions of this section.

(j) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1946, and for each fiscal year thereafter, a sum sufficient for all necessary expenses in carrying out the duties imposed upon the Surgeon General, the Board, and the Advisory Council by this title, including the printing of forms and reports, making such studies and demonstrations and such provisions for the training of personnel as may be expected to improve the quality of the services and promote the efficient administration of this title and for the pay, allowances, and traveling expenses of commissioned officers and other personnel assigned to duty in carrying out the purposes of this title in the District of Columbia and elsewhere.

(k) Appointment is hereby authorized in the Public Health Service of such personnel and in such grades as may be necessary for the proper and efficient administration of this title, in accordance with the provisions of the civil-service laws and the Classification Act of 1923, as amended. Such personnel, and commissioned officers of the Regular or Reserve Corps of the Public Health Service, may be assigned to duty in such bureaus, divisions, sections, and other units as the Surgeon General may find it necessary to establish, with the approval of the Administrator, for carrying out the purposes of this title, without regard to

limitations otherwise specified in the Public Health Service Act (Act of July 1, 1944, 58 Stat. 682).

(1) The Surgeon General shall make a full report to Congress, at the beginning of each regular session, of the administration of the functions with which he is charged under this title. Such report shall include a record of consultations with the Advisory Council, recommendations of the Advisory Council, and comments thereon.

NATIONAL ADVISORY MEDICAL POLICY COUNCIL

SEC. 204. (a) There is hereby established a National Advisory Medical Policy Council (herein referred to as the "Advisory Council") to consist of the Surgeon General as Chairman and sixteen members to be appointed without regard to the civil-service laws by the Surgeon General and with the approval of the Federal Security Administrator. The sixteen appointed members shall be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical, dental, and nursing services and education and with the operation of hospitals and laboratories and from among other persons, agencies, or organizations informed on the need for or provision of medical, dental, nursing, hospital, laboratory, or related services and benefits. The membership of the Advisory Council shall include (1) medical and other professional representatives, and (2) public representatives, in such proportions as are likely to provide fair representation to the principal interested groups that furnish and receive personal health services, having regard for the functions of the Advisory Council. The Advisory Council shall meet not less frequently than twice a year and whenever at least four of the members request a meeting. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the terms of office of the members first taking office shall expire, as designated by the Surgeon General at the time of appointment, four at the end of the first year, four at the end of the second year, four at the end of the third year, and four at the end of the fourth year after the date of appointment. Each appointed member shall receive compensation at a rate not to exceed \$25 per day during the time spent in attending meetings of the Advisory Council and for the time devoted to official business of the Advisory Council under this title, inclusive of travel time; and actual and necessary traveling expenses and per diem in lieu of subsistence, allowable in accordance with the Standardized Government Travel Regulations, while away from his place of residence upon official business under this Act. The Advisory Council, and each of its appointed members, shall be provided by the Surgeon General with such secretarial, clerical or other assistants as the Congress shall authorize and provide each year for carrying out the purposes of this section.

(b) The Advisory Council shall advise the Surgeon General with reference to questions of general policy and administration in carrying out the provisions of this title, including—

(1) personal standards of quality to apply to personal health service benefits;

(2) designation of specialists and consultants;

(3) methods and arrangements to stimulate and encourage the attainment of high standards through coordination of the services of general or family practitioners, specialists and consultants, laboratories, and other auxiliary services, and through the coordination of the services of physicians and dentists with those of educational and research institutions, hospitals and public-health centers, and through other useful means;

(4) standards to apply to participating hospitals, to the relations or coordination among hospitals, and to the establishment and maintenance of the list of participating hospitals;

(5) adequate and suitable methods and arrangements of paying for personal health service benefits;

(6) studies and surveys of personal health services and of the quality and adequacy of such services; and

(7) grants-in-aid for professional education and research projects.

(c) The Advisory Council shall establish special advisory, technical regional, or local committees or commissions, whose membership may include members of the Advisory Council or other persons or both, to advise upon general or special questions, professional and technical subjects, questions concerning administration, problems affecting regions or localities, and related matters.

## METHODS AND POLICIES FOR ADMINISTRATION

SEC. 205. (a) Any physician, dentist, or nurse legally qualified by a State to furnish any services included as personal health service benefits under this title shall be qualified to furnish such services as benefits under this title (except as otherwise provided in subsection (c) of this section or in subsection (f) of section 214), and this provision shall extend to any group of physicians, dentists, or nurses or combinations thereof whose members are similarly qualified.

(b) Every individual entitled to receive general medical or general dental benefit shall be permitted to select, from among those designated in subsection (a) of this section, those from whom he shall receive such benefit, subject to the consent of the practitioner or group of practitioners selected, and every such individual and every group of such individuals shall be permitted to make such selection through a representative of his or their own choosing, and to change such selection.

(c) Services which shall be deemed to be specialist or consultant services, for the purposes of special rates of payment under this title, shall be those so designated by the Surgeon General, and the practitioners from among those included in subsection (a) of this section who shall be qualified as specialists or consultants and entitled to the special rates of compensation provided for specialists or consultants shall be those so designated by the Surgeon General as qualified to furnish such specialist or consultant services and only with respect to the particular class or classes of specialist or consultant services he shall determine for each such specialist or consultant, in accordance with general standards previously prescribed by him after consultation with the Advisory Council. In establishing such standards and in designating such specialists or consultants the Surgeon General shall utilize as far as is consistent with the purposes of this title standards and certifications developed by competent professional agencies and shall take into account the personnel resources and needs of regions and local areas.

(d) The services of a specialist or consultant shall ordinarily be available only upon the advice of the general or family practitioner or of a specialist or consultant attending the individual. The services of specialists and consultants shall also be available when requested by an individual entitled to specialist and consultant services as benefits and approved by a medical administrative officer appointed by the Surgeon General.

(e) The Surgeon General shall publish and otherwise make known in each local area to individuals entitled to benefit under this title the names of medical and dental practitioners and groups of practitioners who have agreed to furnish services as benefits under this title and to make such lists of names readily available to individuals entitled to benefits under this title. Such lists of names shall include general or family practitioners and qualified specialists and consultants, respectively, and with respect to qualified specialists and consultants the class or classes of specialist or consultant services for which each has been qualified.

(f) The methods of administration, including the methods of making payments to practitioners, shall—

(1) insure the prompt and efficient care of individuals entitled to personal health service benefits;

(2) promote personal relationships between physician and patient;

(3) provide professional and financial incentives for the professional advancement of practitioners and encourage high standards in the quality of services furnished as benefits under this title through the adequacy of payments to practitioners, assistance in their use of opportunities for postgraduate study, coordination among the services furnished by general or family practitioners, specialists and consultants, laboratory, and other auxiliary services, coordination among the services furnished by practitioners, hospitals, public-health centers, educational, research, and other institutions, and between preventive and curative services, and otherwise;

(4) aid in the prevention of disease, disability, and premature death; and

(5) insure the provision of adequate service with the greatest economy consistent with high standards of quality.

(g) Payments from the Account to general medical and family practitioners or to general dental practitioners, for services under this part, shall be made—

(1) on the basis of fees for services rendered to individuals entitled to benefits, according to a fee schedule;

(2) on a per capita basis, the amount being according to the number of individuals entitled to benefit who are on the practitioner's list;

(3) on a salary basis, whole time or part time; or

(4) on a combination or modification of these bases, as the Surgeon General may approve;

according in each local area as the majority of the general medical and family practitioners or of the general dental practitioners, respectively, to be paid for such services shall elect: *Provided*, That (1) the Surgeon General may also make payments by another method (from among the methods listed in this subsection) to those general medical and family practitioners or to those general dental practitioners who do not elect the method of such majority, especially when in the judgment of the Surgeon General such alternative method of making payments contributes to carrying out the provisions of subsection (f) of this section; (2) any of the methods of making payments (from among the methods listed in this subsection) may be used, according as the Surgeon General may approve, in making payments to groups of practitioners that contain designated specialists or consultants as well as general or family practitioners; and (3) nothing in this subsection shall prohibit the Surgeon General from negotiating agreements or cooperative working arrangements to utilize inclusive services of hospitals and their staffs and/or attending staffs, or from entering into contracts for such inclusive services, in accordance with the provisions of section 203.

(h) The methods of making payments from the account to designated specialists and consultants for services under this title, furnished as special medical or special dental benefit, may include payments on salary (whole time or part time), per session, fee-for-service, per capita, or other basis, or combinations thereof, as the Surgeon General and the specialists and consultants may agree.

(i) Rates or amounts of payment for particular services or classes of services furnished as benefits under this title may be nationally uniform or may be adapted to take account of relevant regional or local conditions and other factors. Payments shall be adequate, especially in terms of annual income or its equivalent and by reference to annual income customarily received among physicians, dentists, or nurses, having regard for age, specialization, and type of community; and payments shall be commensurate with skill, experience, and responsibility involved in furnishing service.

(j) In order to maintain high standards in the quality of services furnished as medical or dental benefit, the Surgeon General may prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish general medical or general dental benefit, and such limits may be nationally uniform or may be adapted to take account of relevant factors.

(k) In any local area where payment for the services of a general or family practitioner is only on a per capita basis, the Surgeon General shall make per capita payments (subject to limits, prescribed in accordance with subsection (j) of this section) on a pro rata basis among the practitioners and groups of practitioners of the local area on the list established pursuant to subsection (e) of this section with respect to those individuals in the local area who, after due notice, have failed to select a general or family practitioner or who having made one or more successive selections have been refused by the practitioner or practitioners selected.

(l) In each local area the provision of general medical or general dental benefit for all individuals entitled to receive such benefits shall be a collective responsibility of all qualified general medical or family practitioners or of all qualified general dental practitioners, respectively, in the area who have undertaken to furnish such benefit.

(m) Home-nursing benefit shall ordinarily be available only upon the advice of a legally qualified attending physician. Home-nursing benefits shall also be available when requested by an individual entitled to this benefit and approved by a medical officer designated by the Surgeon General.

#### PARTICIPATING HOSPITALS

SEC. 206. (a) The Surgeon General shall publish a list of institutions which he finds to be participating hospitals, and shall from time to time revise such list to include thereon all institutions which he thereafter finds to be participating hospitals and to withdraw therefrom all institutions which he finds cease to meet the requirements of a participating hospital. Inclusion of an institution upon such list shall, unless and until withdrawn by the Surgeon General, be conclusive that such institution is a participating hospital for the purpose of this section.

(b) The Surgeon General is directed to make findings of fact and decisions as to the status of any institution as a participating hospital in accordance with general standards previously prescribed by him after consultation with the Advisory Council. Any institution which is not included by the Surgeon General in the list of participating hospitals, or having been included thereon has been withdrawn therefrom, may file with the Surgeon General a petition to be included in such list, which petition shall set forth such information as the Surgeon General may deem necessary to establish that such institution meets the requirements of a participating hospital. Whenever requested by any institution the petition of which has been denied, the Surgeon General shall give such institution reasonable notice and an opportunity for a fair hearing with respect to the decision denying such petition, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse his findings of fact and such decision.

(c) The Surgeon General shall exercise no supervision or control over a participating hospital (which is not owned and operated, or leased and operated, by the United States), nor shall any requirement for participation by a hospital or any term or condition of any agreement under this part relating to, or on behalf of, any such hospital prescribe its administration, personnel, or operation.

#### APPEAL; JUDICIAL REVIEW; LIMITATIONS UPON THE POWERS OF THE SURGEON GENERAL

SEC. 207. (a) The Surgeon General is hereby authorized to establish necessary and sufficient appeal bodies to hear complaints from individuals entitled to benefits under this title, from practitioners who have entered into agreement for the provision of services as benefits under this title, and from participating hospitals, and, having regard for the findings, conclusions, and recommendations of such appeal bodies, to take such steps as may be appropriate and are not contrary to any other provision of this title to remedy the grounds for complaint, if any; and to establish necessary and sufficient appeal bodies to hear and determine disputes among practitioners and/or participating hospitals, and to take such steps as may be appropriate and are not contrary to any other provision of this title to settle such dispute: *Provided*, That with respect to any complaint or dispute involving matters or question of professional practice or conduct the hearing body shall contain competent and disinterested professional representation: *Provided further*, That with respect to any complaint or dispute involving only matters or questions of professional practice or conduct the hearing body shall consist exclusively of such professional persons.

(b) In the administration of subsection (a), the Surgeon General shall, insofar as they are applicable to this title, have all the powers and duties conferred upon the Board by sections 204, 205, and 206 of the Social Security Act, as amended. Such powers and duties shall be subject to the limitations and rights of judicial review contained in section 205 of such Act. The provisions of subsections (e) and (f) of section 205 of such Act and the provisions of sections 207 and 208 of such Act shall be applicable to this title in the same manner and to the same extent as they are applicable to title II of the Social Security Act, as amended: *Provided*, That nothing in section 205 (i) of such Act shall prevent the Surgeon General from certifying payments to such individual, agency, office, or institution as the Board or the Surgeon General may prescribe: *Provided further*, That nothing in section 207 of such Act shall limit the right of any person or the Surgeon General to transfer or assign moneys payable under this title to a participating hospital or to any agency or institution utilized under this title.

(c) The Board is directed to make findings of fact and decisions as to the rights of any individual applying for benefits under this title. In carrying out this responsibility the Board shall have all of the powers and duties conferred upon it under title II of the Social Security Act, as amended. Such powers and duties shall be subject to the same limitations and rights of judicial review contained in section 205 of such Act. The provisions of subsections (e) and (f) of section 205 of such Act and the provisions of sections 207 and 208 of such Act shall be applicable to this title in the same manner and to the same extent as they are applicable to title II of the Social Security Act, as amended.

#### RELATION WITH WORKMEN'S COMPENSATION BENEFITS

SEC. 208. No individual shall be entitled to any benefits under this title with respect to any injury, disease, or disability on account of which any medical, dental, home nursing, laboratory, or hospitalization service is being received, or

upon application therefor would be received, under a workmen's compensation plan of the United States or of any State. In the case of an individual receiving any personal health service with respect to any such injury, disease, or disability, the Surgeon General shall be subrogated to the rights of such individual, against any person, organization, or agency in connection with such injury, disease, or disability, to the extent of the estimated cost incurred in furnishing such service. Reimbursements and recoveries for any such service shall be paid to the Secretary of the Treasury and he shall credit them to the Account.

PROVISION OF BENEFITS FOR NEEDY AND OTHER NONINSURED PERSONS AND  
REIMBURSEMENTS FOR SERVICES

SEC. 209. (a) Notwithstanding any other provision of this title, any or all benefits provided under this title to individuals entitled to such benefits may be furnished to other individuals for any period for which equitable reimbursements to the Account on behalf of such other individuals have been made or for which reasonable assurance of such reimbursements has been given by public agencies of the United States, the several States, or any of them or of their political subdivisions, such reimbursements to be in accordance with agreements and working arrangements negotiated by the Surgeon General with such public agencies and in accordance with contracts into which the Surgeon General may enter. Services furnished as benefits to such other individuals shall, as far as may be practical in each area, be of the same quality, be furnished by the same methods, and be paid for through the same arrangements, as services furnished to individuals entitled to benefits under this title.

(b) The provisions of subsection (a) of this section shall extend to groups of persons for whom the Congress of the United States makes provision (including needy persons entitled to medical care under part C of title I of this Act) and to moneys appropriated therefor, and to moneys provided for grants to States or for administrative expenses under this Act and other Acts of Congress. The provisions of subsection (a) of this section shall also extend to services furnished with respect to any injury, disease, or disability excluded by section 208 from entitlement to benefit, and reimbursements made in accordance with such provisions of subsection (a) may be in full satisfaction of reimbursements or recoveries otherwise required by section 208.

LIMITATIONS ON BENEFITS

SEC. 210. (a) The Surgeon General may, after consultation with the Advisory Council and with the approval of the Administrator, determine for any calendar year or part thereof that every individual entitled to general medical, general dental, or home-nursing benefit may be required by the physician, dentist, or nurse furnishing such benefit to pay a fee with respect to the first service or with respect to each service in a period of sickness or course of treatment. Such determination shall be made only after good and sufficient evidence indicates that such determination is necessary and desirable to prevent or reduce abuses of entitlement to any such benefit, and shall fix the maximum size of such fee at an amount estimated to be sufficient to prevent or reduce abuses and not such as to interpose a substantial financial restraint against proper and needed receipt of medical, dental, or home-nursing benefit. Such determination may also limit the application of such fees to home calls, to office visits, or to both, and may fix the maximum total amount of such fee payments in a period of sickness or course of treatment, and may also provide for differences in the maximum size of such fees or total amount of such fee payments for urban and rural areas and with regard for differences among States or communities. Each such determination shall be withdrawn as rapidly as the Surgeon General finds practical.

(b) The Surgeon General, having regard for the adequacy of available personnel, may, after consultation with the Advisory Council and with the approval of the Administrator, determine for any calendar year or part thereof that general dental, special dental, or home-nursing benefit shall have such restricted content as the Surgeon General may determine: *Provided*, That on and after July 1, 1947, the restricted content of general dental or special dental benefit shall include at least (1) examination (including X-ray survey) and diagnosis; (2) prophylaxis; (3) extraction of teeth which are considered by the dentist and an attending physician to be or likely to be injurious to the general health of the individual; and (4) treatment of acute diseases of the teeth, their supporting structures, and adjacent parts, including fractures of the teeth or jaws.

With respect to general dental or special dental benefit, such determination may fix an age above which the restriction on content shall apply. With respect to home-nursing benefit, restriction of content may be effected by limitation of the service to part-time care on an hourly or visit basis, by limitation of the types of cases for which such benefit shall be available, by limitation of the maximum amount of service per case, or otherwise, as may be practical and necessary. Any restriction on the content of general dental, special dental, or home-nursing benefit shall be reduced or withdrawn as rapidly as the Surgeon General finds practical.

(c) The maximum number of days in any benefit year for which any individual may be entitled to hospitalization benefit under section 201 or 202 shall be sixty; *Provided, however,* That when the Surgeon General finds that moneys in the Account are adequate, he may increase the maximum with respect to hospitalization benefit provided under section 201 or section 202, or both, to not more than one hundred and twenty days for the following calendar year.

(d) No application by an individual for hospitalization benefits shall be valid under this title (1) with respect to any day of hospitalization if such application is filed more than ninety days after such day; (2) with respect to any day of hospitalization more than thirty days following the diagnosis of tuberculosis or a psychosis; and (3) with respect to any day in a hospital or other institution for mental or nervous disease or tuberculosis.

(e) The Surgeon General, after consultation with the Advisory Council and with the approval of the Federal Security Administrator, having regard for current and prospective amounts in the Account, may limit for any calendar year or part thereof the cost of laboratory benefit which shall be borne by payments from the Account, and such limitation may be with respect to a class of services, supplies, or commodities, with respect to maximum payments per beneficiary in a benefit year, with respect to a specified fraction of the cost, or combinations thereof.

REPORT CONCERNING DENTAL, NURSING, AND OTHER BENEFITS; CARE AND PREVENTION FOR CHRONIC SICKNESS AND MENTAL DISEASES

SEC. 211. (a) The Surgeon General and the Social Security Board jointly shall have the duty of studying and making recommendations as to the most effective methods of providing dental, nursing, and other needed benefits not already provided or not currently furnished under this title, and as to expected costs for such needed benefits and the desirable division of the costs between (1) the financial resources of the Account or other public funds, and (2) payments to be required of beneficiaries receiving such benefits, and shall make reports, with recommendations as to legislation, on such benefits from time to time but not later than two years after the effective date of this title.

(b) The Surgeon General and the Social Security Board jointly shall also have the duty of studying and making recommendations as to needed services and facilities for the care of the chronic sick afflicted with physical ailments and for the care of individuals afflicted with mental or nervous diseases, and as to needed provisions for the prevention of chronic physical diseases and of mental or nervous diseases, and shall make reports, with recommendations as to legislation, from time to time but not later than three years after the effective date of this title.

PERSONAL HEALTH SERVICES ACCOUNT

SEC. 212. (a) There is hereby created on the books of the Treasury of the United States a separate account to be known as the "Personal Health Services Account" (in this title, referred to as the "Account"). There is hereby authorized to be appropriated to the account such sums as may be required to finance the benefits, payments, and reimbursements provided under this title.

(b) From such appropriations, the Secretary of the Treasury shall credit quarterly to the Account amounts equivalent to 3 per centum of the wages (as defined in section 217 (a)) paid after June 30, 1946, with respect to employment (as defined in section 217 (b)) after such date.

(c) From such appropriations, the Secretary of the Treasury shall credit annually to the Account amounts estimated by the Surgeon General, with respect to the preceding fiscal year, to have been expended for the payment or provision

of general dental, special dental, and home-nursing benefits. The Surgeon General shall report to the Congress each year the basis for such estimate.

(d) From such appropriations, the Secretary of the Treasury shall credit annually to the Account amounts estimated jointly by the Surgeon General and the Social Security Board to have been expended for the payment or provision of benefits, other than general dental, special dental, and home-nursing benefits, provided under section 202 with respect to individuals who became entitled thereto by reason of currently insured status (as defined in section 215) or of fully insured status (as defined in title II of the Social Security Act, as amended) acquired through wages paid prior to January 1, 1946, including (1) the total amount estimated with respect to individuals who acquired such status wholly prior to such date, and (2) an equitable share of the amount estimated with respect to individuals who acquired such status partially prior to such date. The Surgeon General and the Social Security Board shall jointly report to the Congress each year the basis for such estimate.

(e) The Secretary of the Treasury shall also credit to the Account reimbursements to the Account made in accordance with the provisions of sections 203 and 209.

(f) The Secretary of the Treasury is directed to pay from time to time from the Account into the Treasury the amount estimated by him and the Surgeon General which will be expended during a three-month period for the administration of this title. Such payments shall be covered into the Treasury as miscellaneous receipts for the reimbursement of expenses incurred in connection with the administration of this title. If it subsequently appears that the estimates for any particular period were too high or too low, appropriate adjustments shall be made by the Secretary of the Treasury in future payments.

(g) The amounts which stand to the credit of the Account shall be available for the payment or provision of benefits and for administrative expenses under this title, and for no other purposes; and the sum of disbursements for the payment or provision of benefits under this title and for the payment of reimbursements to the Treasury for administrative expenses incurred therewith shall not exceed the amounts which stand to the credit of this Account, as specified in this section.

#### GRANTS-IN-AID FOR MEDICAL EDUCATION, RESEARCH, AND PREVENTION OF DISEASE AND DISABILITY

SEC. 213. For the purposes of encouraging and aiding the advancement and dissemination of knowledge and skill in providing benefits under this Act and in preventing illness, disability, and premature death, the Surgeon General is hereby authorized and directed to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education. Such grants-in-aid shall be made with respect to each project (1) for which application has been received from a nonprofit institution or agency, stating the nature of the project and giving the reasons for the need of financial assistance in carrying it out, and (2) for which the Surgeon General finds, with the advice of the Council established under section 204 and after consultation with other Federal departments and agencies concerned with research or professional education, that the project shows promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, dental, nursing, hospital, laboratory, and related benefits provided under this title, or to human knowledge with respect to the cause, prevention, mitigation, or methods of diagnosis and treatment of disease and disability. During the five-year period beginning January 1, 1946, the Surgeon General and the Advisory Council shall give preference and priority to grants-in-aid with respect to projects to aid servicemen (as defined in section 217 (g)) seeking postgraduate education as medical or dental practitioners or training for administration of personal health services, disability benefits, rehabilitation services, and related services. For the purposes of this subsection there shall be available for the calendar year 1946 the sum of \$10,000,000, for the calendar year 1947 the sum of \$15,000,000, and for each calendar year thereafter an amount equal to 2 per centum of the amount expended for benefits under this title in the last preceding fiscal year. Such grants-in-aid, in such amounts and for payment at such times as are approved by the Surgeon General, shall be certified for payment to the Secretary of the Treasury, who shall pay them from the Account to the designated institutions or agencies.

## DEFINITIONS

SEC. 214. As used in this title—

(a) The term "personal health service benefits" includes general medical benefit, special medical benefit, general dental benefit, special dental benefit, home-nursing benefit, laboratory benefit, and hospitalization benefit.

(b) The term "general medical benefit" means services furnished by a legally qualified physician or by a group of such physicians, including all necessary services such as can be furnished by a physician engaged in the general or family practice of medicine, at the office, home, hospital, or elsewhere, including preventive, diagnostic and therapeutic treatment and care, and periodic physical examination.

(c) The term "special medical benefit" means necessary services, requiring special skill or experience, furnished at the office, home, hospital, or elsewhere by a legally qualified physician who is a specialist or consultant with respect to the class of service furnished, by a group of such physicians, or by a group of physicians including such specialists or consultants.

(d) The term "general dental benefit" means services furnished by a legally qualified dentist or by a group of such dentists, including all necessary dental services such as can be furnished by a dentist engaged in the general practice of dentistry (with or without the aid of an assistant or hygienist under his direction) and including preventive, diagnostic and therapeutic treatment, care and advice, and periodic examination.

(e) The term "special dental benefit" means necessary services, requiring special skill or experience, furnished at the office, hospital, or elsewhere by a legally qualified dentist (with or without the aid of an assistant, a hygienist, or an anesthetist under his direction) who is a specialist or consultant with respect to the class of service furnished, by a group of such dentists, or by a group of dentists, including such specialist or consultants.

(f) The term "home-nursing benefit" means nursing care of the sick furnished in the home by (1) a registered professional nurse; or (2) a practical nurse who is legally qualified by a State or, in the absence of State standards or requirements, who is qualified with respect to standards established by the Surgeon General after consultation with the Advisory Council and with competent professional nursing agencies, and who furnishes nursing care under the direction or supervision of the State health agency, the health agency of a political subdivision of a State, or an organization supplying and supervising the services of registered professional nurses.

(g) The term "laboratory benefit" means such necessary laboratory or related services, supplies, or commodities as the Surgeon General may determine, including chemical, bacteriological, pathological, diagnostic and therapeutic X-ray, and related laboratory services, refractions, and other ophthalmic services furnished by a legally qualified practitioner other than a physician, physiotherapy, special appliances prescribed by a physician, and eyeglasses prescribed by a physician or other legally qualified practitioner: *Provided*, That when any such services, supplies, or commodities are provided to a hospitalized patient, or are provided by a physician or dentist incidental to services furnished under subsections (b), (c), (d), and (e) of this section, payment for such services, supplies, or commodities shall be included in payments for hospitalization or for services furnished under such subsection, respectively, as otherwise provided in this title.

(h) The term "hospitalization benefit" means an amount, as determined by the Surgeon General after consultation with the Advisory Council: Not less than \$3 and not more than \$7 for each day of hospitalization, not in excess of thirty days, which an individual has had in a period of hospitalization; and not less than \$1.50 and not more than \$4.50 for each day of hospitalization in excess of thirty in a period of hospitalization; and not less than \$1.50 and not more than \$3.50 for each day of care in an institution for the care of the chronic sick. In lieu of such compensation, the Surgeon General may enter into contracts with participating hospitals for the payment of the reasonable cost of hospital service at rates for each day of hospitalization neither less than the minimum nor more than the maximum applicable rates specified in this subsection, such payment to be full reimbursement for the cost of essential hospital services, including the use of ward or other least expensive facilities compatible with the proper care of the patient: *Provided*, That such payment

may be included in a contract, between the Surgeon General and a participating hospital, for inclusive services of a participating hospital and its staff and/or its attending staff, as provided in sections 203 and 205: *Provided further*, That such payment shall not affect the right of participating hospitals to require payments from patients with respect to the additional cost of more expensive facilities furnished for lack of ward facilities or occupied at the request of the patient, or with respect to services not included within a contract.

(i) The term "period of hospitalization" means a period of one or more consecutive days of hospitalization.

(j) The term "day of hospitalization" means any day for the whole of which an individual has been confined in a participating hospital on the advice of a legally qualified physician for the purpose of receiving necessary hospital service: *Provided*, That, with respect to a day in which an individual is admitted to or discharged from a hospital, such term may, in accordance with regulations to be prescribed by the Surgeon General, include a period of time of less than a whole day.

(k) The term "participating hospital" means an institution providing all necessary and customary hospital services, and found by the Surgeon General to afford professional service, personnel and equipment adequate to promote the health and safety of individuals customarily hospitalized in such institution and to have procedures for the making of such reports and certifications as the Surgeon General may from time to time require, to assure that hospitalization benefit will be provided only to or on behalf of individuals entitled thereto: *Provided*, That with respect to inclusion in the list of participating hospitals the Surgeon General may accredit a hospital for limited varieties of cases and may accredit an institution for the care of the chronic sick, taking into account for the purpose of such limited accrediting, the type and size of community which the institution serves, the availability of other hospital facilities, and such other matters as the Surgeon General may deem relevant.

(l) The term "dependent" means an unmarried child (including a stepchild, adopted, or foster child) of an individual, who is under the age of eighteen, or who is under a disability which has continued for a period of not less than six consecutive calendar months and is living with such individual or receiving regular support from him; a wife of an individual living with such individual or receiving regular support from him; a husband who is under a disability which has continued for a period of not less than six consecutive calendar months, and is living with or receiving regular and substantial support from such individual; and a parent who is living with or receiving regular and substantial support from such individual.

#### ELIGIBILITY

SEC. 215. (a) An individual shall be deemed to be currently insured under this title if he (1) had during his eligibility period been paid wages of not less than \$150, or (2) acquired not less than six quarters of coverage during the first twelve of the last fourteen completed calendar quarters immediately preceding the first day of a benefit year, not counting among such completed quarters any quarter in any part of which the individual was under a disability which lasted six consecutive months or more.

(b) The term "eligibility period" means the first four of the last six completed calendar quarters immediately preceding the first day of a benefit year.

(c) As used in this title, the term "quarter" and the term "calendar quarter" mean a period of three calendar months ending on March 31, June 30, September 30, or December 31; and the term "quarter of coverage" means a calendar quarter in which the individual has been paid not less than \$50 in wages. In any case where an individual has been paid prior to 1946 in a calendar year \$3,000 or more in wages, or after 1945 in a calendar year \$3,600 or more in wages, each quarter of such year following his first quarter of coverage shall be deemed a quarter of coverage. In any case where wages have been paid pursuant to a ruling based on the National Labor Relations Act or a labor relations act of any State, or under a compromise settlement resulting from a dispute within the jurisdiction of any such Act, such wages shall be deemed to have been paid on the employer's normal dates of payment of wages earned in the periods to which such wages apply.

(d) The term "benefit year" means a period of four consecutive calendar quarters, as determined by the Board.

## EFFECTIVE DATE

SEC. 216. The benefits provided under this title shall become effective beginning April 1, 1947.

## COVERAGE PROVISIONS AND DEFINITIONS

SEC. 217. When used in this title—

(a) The term "wages" means all remuneration for employment, including the cash value of all remuneration paid in any medium other than cash, and the sum paid to an individual pursuant to an order based on the National Labor Relations Act, or the labor relations act of any State or under a compromise settlement resulting from a dispute within the jurisdiction of any such Act, which sum if it had been paid for services rendered during the period for which reinstatement has been ordered would have constituted remuneration for employment; except that such term shall not include—

(1) That part of the remuneration which, after remuneration equal to \$3,600 has been paid to an individual during any calendar year after 1945, is paid to such individual during such calendar year;

(2) The amount of any payment made to, or on behalf of, an employee under a plan or system established by an employer which makes provision for his employees generally or for a class or classes of his employees (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment), on account of (A) retirement, or (B) sickness or accident disability, or (C) medical and hospitalization expenses in connection with sickness or accident disability, or (D) death, provided the employee (i) has not the option to receive, instead of provision for such death benefit, any part of such payment, or, if such death benefit is insured, any part of the premiums (or contributions to premiums) paid by his employer, and (ii) has not the right, under the provisions of the plan or system or policy of insurance providing for such death benefit, to assign such benefit, or to receive a cash consideration in lieu of such benefit either upon his withdrawal from the plan or system providing for such benefit or upon termination of such plan or system or policy of insurance or of his employment with such employer;

(3) The payment by an employer (without deductions from the remuneration of the employee) of any social-insurance contributions imposed upon an employee;

(4) The value of services exchanged for other services for which there is no payment other than the exchange.

(b) The term "employment" means any service of whatever nature, performed after June 30, 1946, by an employee for the person employing him, irrespective of the citizenship or residence of either, (A) within the United States, (B) under a contract of service which is entered into within the United States, or (C) in connection with an American vessel or civil aircraft during the performance of which the vessel touches at a port in the United States, if the employee is employed on and in connection with such vessel when outside the United States, except—

(1) Casual labor not in the course of the employer's trade or business;

(2) Service performed on or in connection with a vessel not an American vessel by an employee, if the employee is employed on and in connection with such vessel when outside the United States;

(3) Service performed in the employ of the United States Government, or of an instrumentality of the United States which is wholly owned by the United States: *Provided*, That service performed in the employ of the Tennessee Valley Authority on an hourly basis shall not come within this exception;

(4) Service performed in the employ of a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned by one or more States or political subdivisions;

(5) Service performed by a duly ordained or duly commissioned or licensed minister of any church in the regular exercise of his ministry and service performed by regular members of religious orders in the exercise of duties required by such orders;

(6) Service performed by an individual as an employee or employee representative as defined in section 1532 of the Internal Revenue Code;

(7) Service performed in any calendar quarter in the employ of any organization exempt from income tax under section 101 of the Internal Revenue Code; if—

(A) the remuneration for such service does not exceed \$45; or

(B) such service is in connection with the collection of dues or premiums for a fraternal beneficiary society, order, or association, and is performed away from the home office or is ritualistic service in connection with any such society, order, or association; or

(C) such service is performed by a student who is enrolled and is regularly attending classes at a school, college, or university;

(8) Service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(9) Service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) If the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) If the Secretary of State shall certify to the Board that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof.

(c) For the purposes of this title, the term "employment" and the term "remuneration" includes the services of a self-employed individual.

(d) If the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than thirty-one consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by paragraph (6) of subsection (b).

(e) The term "employee" includes (in addition to any individual who is a servant under the law of master and servant) any individual who performs service, of whatever nature, for a person, unless the service is performed by the individual in pursuit of his own independently established business. The term "employee" also includes an officer of a corporation.

(f) The term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented nor numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State.

(g) The term "serviceman" means a man or woman who has performed active military or naval service in the Army or Navy of the United States, the United States Marine Corps, or the United States Coast Guard, or in any component part of any of the foregoing, after September 7, 1939.

(h) The term "State" includes Alaska, Hawaii, and the District of Columbia.

### TITLE III—GENERAL PROVISIONS

#### SEPARABILITY

SEC. 301. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

[Correspondence with President Truman. For release Thursday, March 21, 1946]

STATEMENT BY JAMES E. MURRAY, CHAIRMAN, SENATE COMMITTEE ON EDUCATION AND LABOR

WASHINGTON, D. C.

Senator James E. Murray, chairman of the Senate Education and Labor Committee, released today a letter received from President Truman endorsing a pro-

posal of William Green, president of the American Federation of Labor, for a clarifying amendment in the national health insurance bill, S. 1606 and H. R. 4730.

In a letter to Senator Murray of March 12, 1946, Mr. Green, on behalf of the American Federation of Labor, pointed out to Senator Murray that the portion of the bill dealing with maternal and child-health services overlapped the insurance system—by providing free health services for mothers and children who would also be covered under the insurance plan. Mr. Green recommended that if the Children's Bureau program is to finance personal health services, as distinguished from community projects, "this phase of its program should be limited to those who are not eligible for insurance benefits. \* \* \*" Mr. Green suggested a clarifying amendment to limit the Children's Bureau program in this fashion.

In a letter to the President of March 14, 1946, Senator Murray, on behalf of himself, Senator Wagner, and Representative Dingell, wrote to President Truman and asked his view on Mr. Green's proposal. He also transmitted a preliminary draft of a clarifying amendment to carry out Mr. Green's suggested change in the bill.

In his reply to Senator Murray, President Truman stated that he is "wholeheartedly in favor of Mr. Green's suggestions," and that "Mr. Green has rendered a distinctive service by making a constructive suggestion for clarification and improvement of the national health bill, S. 1606."

The texts of President Truman's letter to Senator Murray, Senator Murray's letter to President Truman (together with a preliminary draft of the clarifying amendment), and Mr. Green's letter to Senator Murray are as follows:

THE WHITE HOUSE,  
Washington, March 20, 1946.

HON. JAMES E. MURRAY,  
*United States Senate, Washington, D. C.*

DEAR SENATOR MURRAY: Thank you for your letter of March 14 and for calling to my attention the helpful suggestions made by Mr. William Green to improve the national health bill, S. 1606.

The keystone of the national health program, which I submitted to the Congress on behalf of the administration on November 19, 1945, is the contributory insurance principle. While a health program based upon this principle should be as comprehensive as practicable, still it might not include some groups in the population. Accordingly, it is sound to have additional provisions for Federal-State services for persons not covered by the insurance system.

I am, therefore, wholeheartedly in favor of Mr. Green's suggestions to clarify the relation between title I, part B, and title II of S. 1606. As I said in my health message, "Federal aid for community health services—for general public health and for mothers and children—should complement and not duplicate prepaid medical services for individuals. \* \* \*" I fully agree with you that Mr. Green has rendered a distinctive service by making a constructive suggestion for clarification and improvement of the national health bill, S. 1606.

Sincerely yours,

HARRY TRUMAN.

UNITED STATES SENATE,  
COMMITTEE ON EDUCATION AND LABOR,  
March 14, 1946.

HON. HARRY S. TRUMAN,  
*The White House, Washington, D. C.*

DEAR MR. PRESIDENT: In connection with the national health bill (S. 1606), which Senator Wagner, Representative Dingell, and I introduced to implement your health message of November 19, 1945, I have received the attached communication from Mr. William Green, president of the American Federation of Labor.

Mr. Green's letter deals with the same subject that my office has been discussing with Mr. John Snyder and his staff. Mr. Green points out that as the bill is now drafted, title I, part B, dealing with maternal and child health services could duplicate some of the provisions of the insurance system set up by title II. He suggests that a clarifying amendment be drafted to indicate that the Children's Bureau program under title I should be directed toward community services, special research, special demonstrations, training of personnel, and special educational programs to assure high standards of maternal and child care. If the

Children's Bureau program is also to provide personal health services, Mr. Green suggests that this phase of its program should be limited to those who are not eligible for insurance benefits under title II.

I and the other sponsors of the national health bill are entirely in agreement with Mr. Green's suggestion. In fact, I believe that he has rendered a great service in pointing out the need for clarification in the bill.

In view of your deep personal interest in the national health legislation, however, I should appreciate having your views on Mr. Green's suggestion before I communicate with him. A preliminary draft of a clarifying amendment, which I have drawn up in accordance with Mr. Green's proposal, is enclosed.

Respectfully yours,

JAMES E. MURRAY.

(Enclosures: Letter from William Green. Draft amendment.)

PRELIMINARY DRAFT OF AMENDMENTS TO NATIONAL HEALTH BILL, S. 1606

On page 13, after "adequate" and before "maternal" insert the word "community".

On page 14, line 1, after "health services" insert "by providing adequate personal health services for maternity cases and for children not entitled to such services as benefits under title II of this Act,".

On page 16, line 1, after "as" and before "services" insert the word "community".

On page 16, after paragraph (8) insert a new paragraph (9) as follows:

"(9) provide that as personal health services are furnished under the plan they shall be available to all maternity cases and to all children in the State or locality who are not entitled to such services as benefits under title II of this Act and who elect to receive such services under the plan;".

On page 16, change paragraph (9) to paragraph (10).

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AMERICAN FEDERATION OF LABOR,  
*Washington, D. C., March 12, 1946.*

HON. JAMES E. MURRAY,  
*United States Senate, Senate Office Building,  
Washington 25, D. C.*

Dear SENATOR MURRAY: In connection with the national health bill (S. 1606), a measure which receives the wholehearted endorsement of the American Federation of Labor, it has been called to my attention that there is an inconsistency between the various provisions of this measure. Title II of S. 1606 sets up a comprehensive program of health insurance for the families of all workers who are covered by the pay-roll tax. Title I, however, provides mothers and children with free personal health services financed from general revenues. This provision, as it now stands, covers all the mothers and children who would be covered under the insurance plan set forth in title II.

I am sure that the intention of yourself and the other sponsors of S. 1606 was that health insurance be the keystone of our national health program, and that other health services, as stated by the President in his health message of November 19, 1945, "should complement and not duplicate prepaid medical services for individuals \* \* \*."

In order to avoid any misinterpretation on the part of the general public, it might be desirable to have a clarifying amendment indicating that the Children's Bureau program under title I is to be basically directed toward community services, special research, special demonstrations, training of personnel and special educational programs to assure high standards of maternal and child care. If the Children's Bureau program is also to provide personal health services, this phase of its program should be limited to those who are not eligible for insurance benefits under title II.

I should appreciate your views on this matter at your earliest convenience.

Sincerely yours,

W. GREEN,  
*President, American Federation of Labor.*

## FEDERAL AGENCY REPORTS

FEDERAL SECURITY AGENCY,  
 Washington 25, March 14, 1946.

HON. JAMES E. MURRAY,

*Chairman, Committee on Education and Labor,  
 United States Senate, Washington 25, D. C.*

DEAR MR. CHAIRMAN: This letter is in response to your request for a report on S. 1606, a bill "to provide for a national health program."

The bill would remove the present money limitations upon the grants to the States for general public health work, for maternal and child health services, and for services to crippled children; would introduce a statutory formula for these grants, such that the poorer States would receive a larger proportion of their expenditures than the wealthier States; and would specify the conditions with which States desiring grants must comply. It would authorize grants to the States for medical care of needy persons. Finally it would establish a national system for the prepayment of medical costs for the people of the country.

On November 19, 1945, President Truman presented to Congress a program designed to assure to the whole population "the right to adequate medical care and the opportunity to achieve and enjoy good health." I interpret S. 1606 as intended to carry out a large part of the President's national health program.

The Federal Security Agency is in full accord with the objectives of S. 1606. The services authorized would contribute substantially toward improving the health and well-being of the American people. Other measures pending in the Congress would deal with other phases of a complete health program, including provision for grants-in-aid for the construction of needed hospitals and health centers and for income against temporary and permanent disability, both of which were included in the President's recommended national health program.

It is the opinion of the Federal Security Agency that a national health program, such as that advocated by the President and implemented in part by S. 1606, is long overdue.

Over the past several years, this Agency has been carrying on studies on national health needs of the American people. As a plan for meeting those needs, the Public Health Service in its annual report of 1944 proposed a six-point program. This program included:

1. Extension to every citizen of the protection afforded by modern environmental sanitation by safeguarding food and milk supplies, constructing and improving, as necessary, water supplies and sewage disposal facilities and utilizing effective measures for the control of insects, rats, and other disease vectors;

2. Construction of hospitals and health centers in order to achieve an equitable distribution of hospitals and health facilities, to encourage physicians to establish practice in areas where their services are needed, and to aid doctors to practice medicine of high quality;

3. Expansion of public health services so that health departments may be established in every part of the country and public health services made available to everyone, no matter where he may live;

4. Encouragement of more public and private research to discover means of preventing and curing diseases and remedying conditions which sap the national vitality, and to make these findings available quickly to the whole population;

5. Provision of an educational program so that medical personnel may be trained well and in sufficient numbers to meet the needs, and to permit the continual retraining of doctors, nurses, dentists, and other health workers so that they may keep abreast of the latest developments in medical science;

6. Institution of a medical care program to provide medical and hospital service to everyone who needs it, regardless of his ability to pay, and to insure all of the benefits of medical science to the whole population.

The Social Security Board has recommended for several years in its annual reports a compulsory medical care insurance system.

"Neither the course of present developments in this country nor experience in other countries which have tried voluntary health insurance gives any indication that comprehensive and adequate arrangements to insure medical costs can be made in any way except through a compulsory insurance system. In this aspect of health security the United States faces a situation not unlike that in old-age security a decade ago. At that time, many employers had established sound retirement systems for their workers; some persons had banded together to provide for themselves as a group or had made adequate individual provisions through annuities or other forms of commercial insurance. It was clear then, however, as it is clear now for medical care insurance, that those voluntary

arrangements could not be expected to extend to even a majority of the population in need of insurance or to the groups whose needs were greatest.

"Medical-care insurance would enable self-supporting families to pay for and get needed medical services without any important alteration because of the insurance system in present forms or organization of medical practice. Moreover, families dependent on public funds could be covered through payment of contributions on their behalf by the agencies administering assistance. They thus would receive care in the same way in which others receive it; the stigma and, typically, the inadequacy of 'poor-law medicine' could be wiped out" (Ninth Annual Report, p. 30).

## TITLE I OF S. 1606

The proposals of part A of this title, generally, appear most desirable.

Certainly, availability of the basic public health services to every community is a prime requisite in a national health program. The Federal Government should assist the States in reaching this goal through provision of more liberal grants-in-aid than are now available. Federal grants-in-aid to States now amount to not more than 10 percent of the total sum expended for public health work. S. 1606 would remove the present ceiling of \$20,000,000 on Federal grants for public health services, and would obligate the Federal Government to supplement State funds (through a specified grant-in-aid formula) as necessary to provide these services. The occurrence of disease and illness anywhere in the country affects the whole country. Yet, as the President has pointed out, approximately 40,000,000 citizens live in communities which lack full-time public health services, largely because community financial resources are inadequate to provide them. The principle that the resources of the whole Nation should be available toward equalizing the opportunities of all its citizens to obtain public health service was clearly recognized as a national policy with the passage of the Social Security Act in 1935. The wisdom of this policy has been repeatedly demonstrated since that time. The significance of S. 1606 in this regard is that provision is made for effectuating this policy in fact for the country as a whole.

While I approve the proposal to remove the present statutory limitation upon the total amount of Federal funds which should be made available to the States for public health work, and to entitle each State to a predetermined percentage of its expenditures in this field, this approach requires that the definition of "public health work" be scrutinized with care, since the definition would determine which of the expenditures by a State would give it a call upon the Federal Treasury. We have not had opportunity to complete our study of the implications of the definition in the bill, but the two following comments may presently be made:

1. The definition overlaps, in certain respects, services for which funds could be granted under part B and part C of title I, and services which would be provided under title II of the bill. Authority is provided in the bill for the Federal agencies concerned to enter into agreements for the coordination of the several parts of the program, and it may be that duplication could thus be avoided; but I believe the bill should be closely examined from this point of view. I assume that parts A and B of title I are intended to deal primarily with the community aspects of health services, and to leave individual care to be provided mainly under title II. In this connection I wish to invite your attention to the President's statement:

"Of course, Federal aid for community health services—for general public health and for mothers and children—should complement and not duplicate pre-paid medical services for individuals, proposed by the fourth recommendation of this message."

2. I recommend that this part of the definition of "public health work" which excludes the maintenance and operation of hospitals be so modified as to permit funds under this part to be made available for hospitalization of the chronically ill. Title II provides hospitalization for only a limited period, the maximum duration of benefit being 60 to 120 days a year, and care in mental and tuberculosis institutions is specifically excluded. This leaves the problem of chronic illness largely untouched. Provisions for more adequate care of the chronically ill are needed by all States—desperately by some. Many institutions for all or special categories of chronic illness give little more than custodial care. The problem of caring for the chronically ill, moreover, is increasing as the average age of the population advances. Federal assistance in meeting these problems is urgently needed.

Since demonstration and training of personnel are closely related to the development of the whole public health program, it may be wise to remove

the \$5,000,000 ceiling upon expenditures for such activities after the first year and to earmark for demonstrations and training of personnel a specified proportion—perhaps 3 percent—of the total annual Federal and State public health expenditure.

Finally, the bill should be designed specifically to encourage the local participation which is essential to public health programs. It should be a requirement that State plans encourage local administration and financial participation under State standards. However, in order that required local financial participation shall not impede the development of adequate services, especially in communities with insufficient financial resources, the bill should require that the States shall provide for such distribution of funds within the States as to insure meeting in full the needs of all localities, in accordance with standards established by the States. Such a requirement, as a condition for approval of State plans under section 101 (with respect to section 314 (f) (2) of the Public Health Service Act) would be in accord with the principles that underlie Federal grants adjusted to the economic resources of the States.

If specific legislative provision is to be made for maternal and child care and for services to crippled children, the provisions of part B of title I seem appropriate for dealing with this phase of public health services. I assume that they will be discussed fully, and their appropriate relationship to title V of the Social Security Act will be indicated, by the Department of Labor. I have already called attention to the duplication between parts A and B, and to the desirability of a better dovetailing of these provisions.

The proposals of part C of this title, making Federal financial aid available to States to provide medical care for needy persons, are generally sound and desirable. The provision that State and local agencies may arrange to have care furnished to needy persons through the health insurance system established by title II is of particular importance, because of the encouragement this gives to the provision of high quality care for needy persons and to the effective coordination of the several parts of a national health program. Of course, if provision were made for universal coverage under title II there would be no need for the special provisions of part C of title I.

I shall wish to make some further recommendations later with respect to part C, especially concerning the treatment of inmates of public institutions.

All three parts of title I contain provisions for grants varying between 50 and 75 percent of State expenditures, depending on the per capita income of the States. I am strongly in favor of a variable matching provision. The formula contained in the bill is one of several formulas which achieve the general result of varying Federal grants in accordance with the economic and fiscal capacities of the States. I believe it is a sound formula. Whether or not this precise formula is used, however, I think it important that the formula for the three parts of title I be identical, in order to avoid financial incentive to the States to include particular services or groups of persons under one part of the program as against another.

#### TITLE II OF S. 1606

This title would establish a system of prepaid personal health service benefits, including medical, dental, hospital, nursing, and laboratory services. The provisions are generally workable and in accord with the President's recommendations.

Under the provisions of this title a large part of the population—probably something like 85 to 85 percent—would be eligible for prepaid personal health services on the basis of automatic coverage as workers or dependents or as beneficiaries of other parts of the social insurance system. The bill also provides for supplementary coverage of groups not covered automatically, through voluntary arrangements made by public agencies on their behalf. The bill thus goes a long way toward meeting the objective stated by President Truman of "the broadest possible coverage for the insurance system." It falls short of the President's recommendations with respect to three large occupational groups.

The President said: "I believe that all persons who work for a living and their dependents should be covered under such an insurance plan." S. 1606 fails to cover automatically railroad workers, Federal workers, State and local government workers, and their dependents. I recommend that title II be amended to include the first two groups, through deletion of the exclusions in section 217. Questions have been raised as to the compulsory coverage of State and local employees under the present old-age and survivors insurance system, because of doubt as to whether the Federal Government can, under our Constitution, require the States to pay premiums as employers. That question does not

necessarily arise under S. 1606, since the bill contains no provisions as to the method of financing. Nevertheless, I would recommend that coverage of this group be extended through voluntary agreements unless, of course, there were universal coverage.

The proportion of the total population who would be eligible for prepaid personal health services might be further increased through a broadening of the definition of dependents of insured workers to include all persons actually dependent on the worker for support. Dependent nondisabled children over 18 and dependent sisters, brothers, aunts, and relatives-in-law would be among the groups not now covered under S. 1606, who could be brought within such coverage.

I believe, however, that the goal of a national health program should be to assure medical, hospital, and related services to every person who needs them, without regard to his employment, source of income, or ability to pay; and that no individual should be excluded from ready access to needed health and medical care. Complete coverage, moreover, though not the only possible method, would be the simplest and most effective way of assuring that medical service would not be stratified so that certain segments of the population, such as the needy, would receive a lower standard of care. It would also make for simplicity, efficiency, and economy of administration, and would eliminate the procedures necessary to establish eligibility. The greater simplicity would conduce to more ready and fuller utilization of the services by the people, as well as to lesser costs of administration. Finally, if general revenue financing is to carry any considerable part of the cost of the health service benefits, the equity of excluding any groups from the benefits may be questionable. In view of the above considerations, I would recommend that the Congress also give consideration to making the provisions of title II applicable to the entire population. If this be done, the provisions of title I, part C, would become unnecessary.

Regardless of the extent of the coverage which Congress might provide, there would be no inconsistency with existing provisions of law for medical and hospital service to particular groups, such as members of the armed forces, veterans, merchant seamen, and the beneficiaries of Federal and State workmen's compensation laws. Special facilities and services designed to meet the special needs of particular groups would, of course, continue to be required; but all of these groups would become entitled to many services which either they or their dependents do not presently enjoy. It may safely be assumed that they would get their money's worth, or more, for any contributions they might be required to make to a health insurance system.

The basic "methods and policies of administration" set forth in the bill are in accord with the President's recommendations. As the President said, people must remain free to choose their own physicians and hospitals, and doctors must remain free to accept or reject patients and to participate in the system full time, part time, or not at all.

It is generally agreed that the administration of such a program as is contemplated by title II should be decentralized to the maximum extent that is practicable, and that the State and local governments should assume their full share of administrative responsibility. Likewise, the values of regional organization of services should be assured so that patents everywhere can readily cross State and local political boundaries when necessary to obtain professional services in other localities.

The provisions of S. 1606 which require that the Surgeon General give priority and preference to utilizing the facilities and services of State and local governments are in keeping with Federal policy generally. At the same time, it is essential that the availability of benefits and adequacy of services be assured for the entire country by Federal authority. S. 1606 very properly places on the Federal Government the responsibility to see that the services are available and authorizes it to specify minimum standards to insure satisfactory quality of services, whether provided through State or local agencies or directly by the Federal Government.

State and local participation in the administration of the program is in the already established pattern of public health. If this pattern continued under title II of S. 1606, it would have the great merit of bringing preventive and curative services under effective coordination.

It must be recognized that the utilization of State and local agencies in the administration of this title will call for some measure of Federal control over the expenditures within a State or a political subdivision, in order to avoid the possibility of excessive costs either for administration or for the actual

provision of services. For this reason I suggest that the bill be amended to establish or to authorize the Surgeon General to establish appropriate limitations upon the amounts which would be made available to agencies cooperating in the administration of the program.

By providing that the Surgeon General of the Public Health Service shall administer the program, the bill gives assurance that there will be coordination between the preventive, curative, and public-health aspects of health legislation.

Section 204 would establish an advisory council to advise the Surgeon General on "questions of general policy and administration." In my judgment the bill is wise in providing that the council's functions in the program shall be purely advisory.

In his message, the President stated that research in medicine and allied fields is an essential part of a general research program to be administered by a central Federal research agency, and that it is also an essential part of a national health program. He called attention to the need for coordination of the two research programs, and pointed out that legislation dealing with medical research should provide for such coordination. Section 213 of the bill, which provides specified sums for the first 2 years and thereafter a proportion of the amount expended for personal health service benefits for grants-in-aid for medical education and research, is in accord with the President's recommendation.

S. 1606 contains no provisions for the raising of revenue. It seems to me wise to consider the benefits to be provided by such a bill separately from the nature of the premiums or taxes which, once the benefits have been decided upon, may be found necessary to finance them. For this reason I shall confine my remarks to one general observation.

As the President pointed out, the people of the United States have been spending, on the average, nearly as much for medical, hospital, and related services as the estimated cost of the health benefits to be furnished under the bill. I believe it is sound policy that individual contributions, in the form of earmarked taxes, should provide a substantial part of the revenues necessary to finance the program.

We are continuing our study of the bill and hope to have available for your committee in the near future more detailed comment and suggestions with respect to particular provisions of this legislation.

We are advised by the Director of the Bureau of the Budget that, while there is no objection to the presentation of this report to your committee, this advice should not be construed as involving any commitment as to the relation to the program of the President of our alternative proposal to afford universal entitlement under the medical care insurance plan.

Sincerely yours,

WATSON B. MILLER, *Administrator.*

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EXECUTIVE OFFICE OF THE PRESIDENT,

BUREAU OF THE BUDGET,

Washington 25, D. C., March 14, 1946.

Hon. JAMES E. MURRAY,

*United States Senate, Washington 25, D. C.*

MY DEAR SENATOR MURRAY: This is in reply to your request for a report on S. 1606, a bill to provide for a national health program.

The measures proposed in this bill are specifically related to the recommendations contained in the President's health message of November 19, 1945, and should be considered as in full accord with the President's program. Of the five-point program contained in that message, three are provided for under S. 1606:

1. To expand the present Federal-State cooperative health programs dealing with general public health, specific diseases, maternal and child health services, and services for crippled children;
2. To strengthen professional education in medical and related fields and to support medical research;
3. To establish a national system of prepaid medical costs by expansion of the existing compulsory social insurance system.

(Of the remaining points in the President's health message, his recommendation referring to construction of hospitals and related facilities is provided for in S. 191 and in H. R. 5628, and his recommendation for a system of insurance paying cash benefits to cover a part of earnings lost as a result of sickness or disability is included in S. 1050 and H. R. 3293.)

An examination of specific provisions contained in the bill suggests a number of points on which there may be a question as to whether the provisions as written in the bills satisfactorily carry out the objectives sought by the legislation. I have asked my staff to prepare the enclosed memorandum indicating some of the more important points which appear to need further examination. I hope you may find the memorandum helpful during the consideration of the bill.

Very truly yours,

HAROLD D. SMITH, *Director.*

MEMORANDUM ON S. 1606, A BILL TO PROVIDE A NATIONAL HEALTH PROGRAM

TITLE I. PART A—GRANTS TO STATES FOR HEALTH SERVICES

This part of the bill continues three separate programs and three separate systems of grants-in-aid for (1) venereal disease control, (2) tuberculosis control, and (3) general public health services. For venereal disease and tuberculosis control, the present method of allotment is continued whereby the amounts available in the appropriations are, without statutory matching, distributed among the States on the basis of population, size of the problem, and financial need of the States. In the case of aid for general public health services, a new formula is established whereby the amount allotted to the States must be from 50 percent to 75 percent of the total to be expended under an approved State plan. The percentage of Federal participation will vary in accordance with the per capita income in the several States.

We raise three questions for consideration under this part:

1. To what extent will the new formula increase the Federal portion of present expenditures for public health services rather than actually increase the total expenditure for health services? There appears to be no protection in the bill against this contingency.

2. If present State levels of expenditure were maintained and Federal funds added on a 50-75 percent matching basis, Federal appropriations would increase sharply by upward of \$100,000,000 per year. Although ultimate expenditures at this level are clearly indicated in the President's health message, is it wise to attempt expansion at the forced rate of a compulsory matching formula of 50-75 percent? A slower rate might give better insurance of proper planning, training, and availability of qualified personnel so that benefits of the increased expenditure would be actually felt in the improvement of services to the people.

3. Could not a single formula be devised within which a single grant program would encompass general public health services, tuberculosis control, venereal disease control, control of other diseases which are proposed from time to time, as well as the health programs of the Children's Bureau and the proposed new program of grants for medical care for the needy?

We question the desirability of a formula in this field which requires the Federal Government to match State expenditures. We would consider preferable a formula whereby funds made available under an increased specific authorization would be distributed to the States subject to suitable requirements for matching by the States. Under this type of control, the authorized limitation on total grants could be reviewed by Congress from time to time as in the past. If the compulsory Federal matching formula is retained, we believe that for a number of years at least, the percentage required of the Federal Government should be less than the 50-75 percent provided in the bill.

In the section dealing with venereal disease control, authority for operating rapid treatment centers, now being requested in separate legislation, could well be incorporated in this bill.

In view of the hospital construction program in S. 191, authorization for construction of tuberculosis hospitals in section 101 could well be eliminated in the interest of coordinating construction of tuberculosis hospitals with the broader program covering hospitals of all types.

TITLE I. PART B—GRANTS TO STATES FOR MATERNAL AND CHILD HEALTH SERVICES

We would raise the same question re the proposed financing formula as in the case of general public health grants. Also, we would raise the same question re consolidation of this grant program with those for other health purposes.

## TITLE I. PART C—GRANTS TO STATES FOR MEDICAL CARE OF NEEDY PERSONS

In discussing the prepaid medical care program, the President, in his health message, said that increased Federal funds should be made available by the Congress under the public assistance programs to pay part of the premiums and direct State expenditures for providing medical services to needy persons.

This recommendation does not necessarily involve the establishment of a new and separated grant-in-aid program as proposed in the bill. The same purpose could be accomplished as in S. 1050 by removal of limitations with respect to payments to individuals so as to permit the cost of medical care to be included in the Federally matched public assistance grants (including, as in S. 1050, assistance to needy persons outside of the present three categories).

## TITLE II. PREPAID PERSONAL HEALTH SERVICE BENEFITS

This portion of the bill is so broad in its terms as to have much of the nature of a general charter rather than a closely defined working program. The need for a high degree of flexibility in a new program of this type is obvious. However, there are a number of points on which more definiteness appears both feasible and desirable. Among these points, the following are suggested for consideration:

1. *Financing.*—Section 212 (a) authorizes unlimited appropriations to the Personal Health Services Account. Section 212 (b) provides that from such appropriations amounts equal to 3 percent of wages shall be transferred to the account by the Secretary of the Treasury. Section 212 (c) provides for transfer to the account of an unlimited amount to cover cost of dental care and home nursing benefits. Section 212 (d) provides for transfer to the account of an additional amount to cover benefit costs of those who had acquired rights on account of wages paid prior to the date of enactment.

Under the foregoing provisions there is no over-all limit on the cost of the program.

In the absence of such limitation, there is no adequate control against the contingency of run-away costs resulting from excessive services or excessive compensation for services rendered. A commendable objective of the bill is to remove any financial deterrent in the way of an individual's securing full medical service in order to secure the full benefit of prevention and early treatment. But the contingency of excessive demand for services is recognized in the bill by authorization to the Surgeon General to provide for partial payments by the individual if he considers it necessary to prevent abuses and to provide for services of restricted content in the field of dental care, home nursing, and laboratory service. With reference to excessive compensation for services rendered, no definitive formula is provided in the bill. An over-all limitation on funds available would provide the needed maximum within which the discretion of the Surgeon General would be exercised in controlling these situations.

It might be further desirable in connection with such limitation to provide separate limitations for the component parts of the program, such as (1) general medical services, (2) special medical services, (3) general dental services, (4) special dental services, (5) laboratory services, and (6) home nursing services. Such limitations would limit somewhat the flexibility of the program, but would aid in the establishment of compensation for services, and, if needed, in the determination of restricted program content or of partial payment of fees by the individual.

Provision for financing the program of prepaid personal health service benefits is left to separate legislation. Provision for such financing should be made prior to final enactment of the program legislation.

Section 212 (f) of the bill directs the Secretary of the Treasury to pay from time to time from the account into the Treasury the amount estimated by him and the Surgeon General which will be expended for the administration of this title. This provision might remove from Congress and from the regular budget process the determination of requirements for administrative expenses for operation of the prepaid medical care program. This provision is, we believe, open to serious question. Explicit provision could well be made for reimbursement from the account of expenditures for administrative purposes under annual appropriations made by Congress in the regular manner.

2. *Combination of Federal, State, local, or private operation permitted.*—The authority contained in section 203 (c) for cooperative working agreements with any type of public or private agencies permits the following:

(a) Direct Federal payment to individual practitioner or hospital.

(b) Operation through a State or local system. (Priority to this type of operation is given in section 203 (e).)

(c) Operation through such private groups as Blue Cross or other group hospitalization or group health organizations.

This very high degree of flexibility is mentioned more by way of emphasis than criticism and to suggest that the actual pattern which may result from enactment of the bill will be evolved more out of experience than out of the terms of the bill itself.

3. *Coordination with Children's Bureau.*—Section 293 (d) provides for agreements with the Children's Bureau to insure coordination with programs carried on by that bureau under part B of title I of the bill. There is a clearly indicated need of further definition of the limited responsibility of the Children's Bureau under part B of title I in view of the fact that full medical service for all covered individuals, including mothers and children, would be provided for under title II.

GRANTS-IN-AID FOR MEDICAL EDUCATION, RESEARCH, AND PREVENTION OF DISEASE AND DISABILITY

S. 1606 and the President's health message both provide for a general program of subsidizing medical research and education for medical and related professions.

The provision for 2 percent of the amount expended for benefits to be available for this purpose after the calendar year 1947 is questionable in view of the lack of demonstrable relationship between the cost of benefits provided for under the program and the needs for stimulating medical research and education. Either an augmented specific limitation after 1947 or complete removal of the specific limitation would appear preferable.

In view of the authorization for medical research presently contained in Public Law 410, 78th Congress, the desirability of an additional authorization for the same purpose is subject to some question. Assuming the enactment of a pay roll tax to provide for a substantial part of the prepaid medical care program, the authorization, as contained in the bill, would provide for a certain portion of an expanded medical research program to be paid for out of funds derived from these special taxes. At the same time, a program of expansion in medical research is going forward under the authorization contained under Public Law 410, which now includes grants to research agencies as well as direct research by the Public Health Service. It would appear desirable to contain development of the medical research program of the Public Health Service within a single authorization. This would not preclude charging a portion thereof against the special funds derived from pay-roll taxes.

THE SECRETARY OF COMMERCE,  
*Washington 25, March 14, 1946.*

HON. JAMES E. MURRAY,  
*Chairman, Committee on Education and Labor,  
United States Senate, Washington, D. C.*

Dear Mr. CHAIRMAN: This is in reply to your request for a report on S. 1606, a bill to provide for a national health program.

I am very glad to have this opportunity to express approval of the objectives and provisions of this bill. For many years, and particularly after having been a member of the Committee on Economic Security, which as early as 1934 studied the need for and made recommendations regarding a system of health insurance, I have been interested in the problems of health. I have been concerned over the fact that in a Nation with the economic resources of the United States—and in spite of the great improvements brought about in national health during the last decades—there are still large groups of the population who are physically and economically handicapped due to lack or inadequacy of medical services.

It seems out of keeping with the high standard of living in this country that more than one-third of the counties and other local units still have no full-time public health services. This means that 40,000,000 Americans are without the protection of such services; that infant mortality rates in some areas and among some groups of the population are three to five times as high as in more prosperous areas and among more well-to-do groups; that one-third of the popula-

tion receives either practically no medical care at all or completely inadequate care; and that millions more suffer from the economic handicaps caused by poor health and the economic burdens imposed by illness. Like everyone else, I was shocked by the statistics made available from selective-service examinations, which have shown that fully 50 percent of American men in the age groups where physical fitness is presumably at its highest level were unfit for military service. There can be no question that steps must be taken to improve the health of large groups of our population and to assure to all Americans an opportunity to live in healthful surroundings and to achieve and enjoy good health.

The measures authorized by S. 1606 would, I believe, go far toward achieving these goals. The bill would remove the present statutory limitations on the amount of Federal funds which can be made available to the States for general public health services, maternal and child health services, and services for crippled children. Instead, it would require the Federal Government to supplement State funds as may be necessary to provide these services, and establish a grant-in-aid formula under which the Federal Government would pay a larger proportion of expenditures for these services in the poorer States than in the wealthier States. The bill would also authorize Federal grants to the States for medical care of needy persons. Finally, it also would establish a national system of medical-care insurance. This would include medical, dental, hospital, nursing, and laboratory services, which would be available to almost the whole population.

I endorse these provisions fully. In order to encourage the improvement of public health services everywhere in the United States, additional Federal aid to the States is needed. Owing to the limited financial resources of many communities, special provision for Federal financial assistance to the poorer States is necessary in order to equalize the opportunities of our citizens in all communities to have adequate public health services. For the same reason, adequate medical care of needy persons everywhere in the United States can be placed on a secure foundation only if the Federal Government bears a part of the costs of such care, just as it bears a part of the cost of cash assistance to the needy. The desirability of a compulsory national system for the prepayment of medical costs needs little comment in view of the heavy and unforeseeable financial burdens imposed by serious illness on individual families not only in the low-income group but also in the middle-income groups as well.

The bill provides that grants to States under the three grant-in-aid programs proposed in title I shall be varied in accordance with State per capita income figures provided by the Department of Commerce. This Department has prepared such State figures for all years since 1929 through 1941, and believes that they represent a practical and adequate basis upon which to allocate grants among States. Accordingly, we would be able to discharge the responsibilities falling upon this Department if the grant-in-aid sections of the bill were enacted.

Since the bill contains no provision regarding the method of financing the personal health service benefits, I shall not go into this question here. I note that the sponsors of the bill, in introducing it, indicated that the financial arrangements were being left to separate legislation since, under the Constitution, such legislation must originate in the House of Representatives.

In addition to its value from a humanitarian and social point of view, a national health program such as that proposed by S. 1606 would also be of great advantage to business. Every businessman knows that illness and poor health among workers raises costs and lowers production. Progressive American business leaders have for a long time been interested in protecting and raising the health of their workers, not only for humanitarian reasons, but also for purely practical considerations.

Sickness and poor health among workers affect business costs in a variety of ways. Every year, more than 500,000,000 man-days of work are lost because of ordinary illness and accidents among the working population, and over nine-tenths of this loss is due to nonindustrial causes, illness, and accidents not having their source in the work of the individual. While no detailed study has been made of the costs to business of workers' absenteeism due to such illness and accidents, the United States Public Health Service in a report made in 1936 enumerated some of the cost factors and made some tentative estimates. Among the items listed were the cost of interference with production resulting in failure to fill orders on time, loss of bonuses, or payment of forfeits; the cost of time lost by other workers who stop to assist a fellow worker who becomes ill; the cost of time lost by foremen and supervisors in making arrangements

for substitutes; the cost of selecting and training new workers to replace the incapacitated; and the cost of paying the wages of sick employees both before and after the period of their disability when their services may be worth only a part of their normal value. On the basis of these considerations, the United States Public Health Service study estimated that 1 day's absence of a sick worker costs the employer at least  $1\frac{1}{2}$  times the amount of the daily wage. At an average daily wage of \$6, the cost to the employer of absenteeism due to nonindustrial sickness and accidents would thus amount to about \$4,000,000,000 a year.

But this by no means indicates the total cost to business of low health standards. Selective-service examinations have shown that in the age groups where there is the largest concentration of industrial workers, over half the men examined had physical or mental defects making them unfit for military service. The fact that over 50 percent of the working population suffer from some kind of ailment undoubtedly has a serious effect on productivity. Workers who are in poor physical condition are less efficient and less cooperative, have less initiative, and in general present more personnel problems than healthy workers. Labor turn-over among these groups is also likely to be higher than among workers who are physically fit.

Furthermore, it has been found that there is a correlation between the incidence of industrial accidents and the physical condition of the worker. This has been indicated by a study which showed that those who have the most accidents are, on the whole, those who pay the most visits to the medical department for minor illnesses. Such accidents not only reduce production but also increase workmen's compensation premiums. No accurate estimate can be made of the cost to business of these losses due to poor health, but it is probably considerably higher than the cost of absenteeism due to illness and accidents.

There is every indication that a comprehensive health program would contribute substantially toward improving the health of the American working population and lowering the business cost of illness and poor health. About  $1\frac{1}{2}$  million men with physical defects have been rendered fit for military duty as a result of the Army rehabilitation program. In addition, selective-service officials have indicated their belief that at least one-sixth of the defects for which men were rejected could have been remedied quite easily. Authorities agree that early diagnosis and medical treatment could have prevented the development of many of the chronic disabilities for which men were rejected for military service.

Various studies made by Government and business groups have shown the effectiveness of factory health programs in reducing the business costs of illness and low health standards. The United States Public Health Service study referred to above estimated that a competent industrial medical service may be expected to reduce the rate of absenteeism due to nonindustrial illness and accidents by at least two-thirds of a day. This is an appreciable reduction, considering that every worker loses about 9 days per year due to such causes. A recent survey of factory health programs made by the National Association of Manufacturers indicated that such programs reduced absenteeism due to nonindustrial illness and injury by 29.7 percent, accident frequency by 44.9 percent, occupational disease by 62.8 percent, labor turn-over by 27.3 percent, and workmen's compensation premiums by 28.8 percent. In terms of dollars, it was estimated that, at an average daily wage of \$5 and not counting the costs of the program, the reduction in absenteeism, accidents, and industrial disease alone saved a plant employing 500 workers about \$12,000 per year, or more than 30 percent of the cost of these factors in the absence of a health program. To this must be added the savings resulting from the reduction in labor turn-over and workmen's compensation premiums and from the increased efficiency of healthier workers, in order to give a full picture of the profitability to the plant of the program.

The steady increase in the number of factory health programs in the United States, and in the number of features incorporated in these programs, indicates that American business is fully aware of the advantages of measures designed to raise the health standards of the working population. The cost of these programs, however, tends to place small business at a disadvantage in relation to large firms. In a study made by the American College of Surgeons in 1938, it was found that the per capita cost of industrial health plans increased as the number of employees decreased. In establishments having 1,000 or more employees, the cost was \$4.93 per worker, as against \$6.97 in plants employing 500 to 1,000 workers, and \$8.76 in plants employing fewer than 500 workers. This cost differential is an important reason why small firms find it more difficult to provide their employees with adequate medical services. Yet, before the war businesses

having fewer than 500 workers employed at least two-thirds of all workers. It seems clear that only a compulsory national program such as that provided by S. 1606, therefore, will effectively provide proper medical care to all workers regardless of the size of the firm in which they happen to be employed, and only such a program will make available to small business the advantages resulting from high health standards among its workers.

Moreover, the health program set forth in S. 1606 would go further than any factory health program can generally go by itself. Only very few firms can afford programs which provide complete medical care and hospitalization to their employees and to their families, and most firms are forced to limit their medical services to the health of their workers while actually on the job. Furthermore, many health services, such as most public health measures, are outside the scope of factory health programs. A Nation-wide program, therefore, able to deal with all aspects of health and medical care, may be expected to afford even greater advantages to business and to provide a larger stimulus to increased national production than factory health programs have brought in the past.

It hardly needs pointing out that, in addition to its direct benefits to business, the measures provided by S. 1606 would also benefit the economy as a whole. The annual loss of about 500,000,000 man-days of work through illness and injury represents a loss not only for business but also for the Nation. It deprives this country every year of billions of dollars worth of goods and services. Billions more are lost because of the low health standards prevailing among a large proportion of the American working population, which reduce the productivity and efficiency of workers. By raising the level of health and well-being and thus cutting down this unnecessary waste, the programs authorized by S. 1606 would contribute toward achieving the higher levels of production required in this country.

Finally, adoption of the measures proposed in S. 1606 would also have a beneficial effect in the direction of increasing employment opportunities and consumer demand. It would expand the demand for doctors, nurses, laboratory technicians, and other workers trained in the medical and allied fields and in public health work. In addition, by effecting a considerable reduction in the loss of working time, and hence in loss of earnings due to ordinary illness, it would raise the total income received as wages by employees and as earnings by the self-employed; this increase in consumer income would raise consumer demand. Moreover, the availability of medical services under a health insurance program should enable people to devote a higher proportion of their current incomes to consumption than in the past. The fear of sudden and large medical and hospital expenses is an important reason at the present time why families and individuals should save. If families are insured against medical costs, and know that they cannot be suddenly confronted by large medical bills, they can afford to spend more of their current income to satisfy current wants. Such a shift toward increased consumption would have a beneficial effect in reducing long-run deflationary tendencies in the economy. The whole economy would profit from such an improved combination of collective thrift and higher standard of current living. To the extent that the proposed national health program would thus lead to an increase in job opportunities and in consumer demand, it would help to promote a high level of employment and business activity.

Due to the urgency of this matter we have not as yet been able to secure clearance from the Bureau of the Budget of this report.

Sincerely yours,

H. A. WALLACE, *Secretary of Commerce.*

The CHAIRMAN. We meet today to initiate public hearings on one of the most important and constructive legislative proposals to come before the Congress.

#### LEGISLATIVE BACKGROUND

In past years the Committee on Education and Labor has had occasion to consider many important measures dealing with various aspects of the Nation's health. Seven years ago, in April of 1939, this committee had referred to it the first comprehensive bill for a national health program, S. 1620, introduced on February 28, 1939, by the distinguished Senator from New York, Mr. Robert F. Wagner, who is with us here today.

Through a subcommittee, of which I had the honor to be chairman, we held extensive hearings, heard many witnesses, and received many statements on health conditions, needs, and proposals. Early in August of 1939 I made a preliminary report for the committee in which I summarized the results of the hearings on S. 1620. It was already late in the congressional session and there were some unresolved problems concerning the bill. Consequently the committee could only record its intention to report out an amended bill at the next session of the Congress.

We were convinced at the end of 1939 that there were large unmet health needs in this country, that the Federal Government had an obligation to help meet those needs, and that this could and would be done.

Our intention to proceed with national health legislation early in 1940 was, however, frustrated by a catastrophic event. The war in Europe was gathering momentum and its threats to our national security were becoming clearer and clearer. As the clouds of war rolled up and finally engulfed us, comprehensive national health legislation had to be laid aside, to await the end of the war.

We did consider a limited program in 1940. The National Hospital Act of that year, S. 3230, introduced by Senators Wagner and George, providing Federal grants for the construction of some needed hospitals and making limited grants toward their maintenance, was considered. After hearings on the bill, I reported it favorably from this committee and it was passed by the Senate. Unfortunately, it failed to receive active attention in the House of Representatives.

Between 1941 and 1945 we have had many health measures before us dealing with special problems. Other bills containing health programs to be developed as parts of social security and related programs were also pending before other committees of the Senate.

During the war years, our Special Subcommittee on Wartime Health and Education did a magnificent job, studying and reporting on special problems and needs precipitated by the war. The Nation owes a real debt of gratitude to Senator Pepper, chairman of that subcommittee, and to the other members, Senators Thomas, Tunnell, La Follette, and Wherry, for the comprehensive, thorough, and penetrating work they have done. More recently Senator Pepper and other members of the Committee on Education and Labor have also carried forward the work on health problems through our legislative subcommittee on public health.

The hearings held by the subcommittees, and the reports prepared by Senator Pepper and his able committee, will long continue to be invaluable sources of information and helpful guides for constructive health plans. The public health laws of the United States were completely recodified in 1944, making somewhat more ample provisions for various public health programs.

Last year this committee had before it a bill proposing the first step toward a comprehensive national health program, including Federal grants to survey hospitals and public health centers, to plan the construction of additional facilities and to assist in such construction. That bill, S. 191, introduced on January 10, 1945, by Senators Hill and Burton, was considered in public hearings and extensively revised, reported favorably by this committee on October 30, 1945, and passed

by the Senate on December 11, 1945. It is now being considered by the Committee on Interstate and Foreign Commerce in the House.

Thus it is clear that extensive studies and deliberations have been devoted to national health legislation over a period of 7 years. Many important bills have been considered and some have been or are in the process of being enacted. While this is true, it is also true that most of the main health problems, the basic problems that clamored for attention and action in 1939, are still unsolved. The principal unmet health needs of the last years before the war are still unmet and the war has made some of them more serious and acute.

The bill which is now before us transcends all of the earlier bills in importance. It represents a logical culmination of the vast amount of work already done in planning for the Nation's health. It offers a constructive program for assuring to all of the population the medical care that we all look forward to having in the future.

On November 19 President Truman submitted to the Congress his recommendation for a comprehensive and modern health program for the Nation, consisting of five major parts, each of which contributes to all of the others.

The five parts are (1) Federal grants for construction of hospitals and related facilities; (2) expansion of public-health, maternity, and child-health services; (3) Federal grants for medical education and research; (4) establishment of a national social-insurance system for the prepayment of medical costs; and (5) expansion of our present social-insurance systems to furnish protection against loss of wages from sickness and disability.

On the same day, the national health bill, S. 1606, was introduced in the Senate by Senator Wagner and myself, and in the House of Representatives by Representative John D. Dingell, of Michigan. This bill provides for three of the five points of the President's program, namely, expansion of public health, maternity, and child-health services; more adequate funds for medical education and research, and a system of prepaid medical costs. Federal aid for the construction of hospitals and related facilities, the first of the President's five points, had already been provided for in the Hospital Survey and Construction Act which passed the Senate in December of 1945, and is now before the House. Insurance benefits to compensate for loss of wages during periods of sickness and disability, the President's fifth point, is provided for in the general social-security bill now pending before the Finance Committee of the Senate and the Ways and Means Committee of the House.

#### PLANS FOR HEARINGS

Intense public interest in the national health bill that we are considering today is evidenced by the hundreds of letters and telegrams that have been coming to this committee from organizations and individuals who asked for an opportunity to testify to this legislation. If all who have already requested an opportunity to present oral testimony were to be heard, the committee's hearings would have to extend for many months.

Thus far hearings have been scheduled only for the month of April. The witnesses who will appear during the course of these hearings are representatives of national organizations, both for and against

the bill, and spokesmen of the Federal agencies most directly concerned with the health program.

The schedule of the first week's hearings has already been made public. Next week we shall hear from various national organizations, religious groups, women's organizations, business and professional groups, consumers, and organized labor. Then we shall start to receive testimony from the medical and health professions, doctors, dentists, hospitals, nurses, public health officers, and voluntary insurance organizations. During the final part of the presently scheduled hearings, we shall hear from farm and veteran organizations.

Those who have requested time for oral testimony and who have not been scheduled have been asked to submit written statements which can be printed in the record of the hearings. Arrangements have already been made with the Legislative Reference Service of the Library of Congress to have a research analyst prepare a weekly summary of all testimony and written statements. These summaries will be available to the public and will also facilitate committee consideration of the views and recommendations presented to us.

I have appointed a subcommittee to weigh the requests of all who may still think that they should have an opportunity to present oral testimony. If the subcommittee so recommends, I am sure that the committee will extend the hearings in order to provide time for additional witnesses. This subcommittee is composed of the Senator from Florida, Mr. Pepper; the Senator from Arkansas, Mr. Fulbright; the Senator from New Jersey, Mr. Smith; the Senator from Oregon, Mr. Morse; and myself.

During recent years there has been extensive, and sometimes intensive, controversy over the question of whether we should have compulsory health insurance. These hearings will provide a new occasion—perhaps the best opportunity yet afforded—for all the issues in this controversy to be thoroughly examined. These hearings offer a challenge to all who participate, a challenge that can be successfully met only by a sincere determination on the part of everyone to try to understand the other man's point of view and to examine the problems in the light of facts rather than slogans or prejudices.

#### POST EDITORIAL

I would like at this time to call attention to an editorial which appeared in the Post this morning, which discusses this situation in the country, where instead of discussing these problems intelligently and dealing with facts, people sometimes go outside the facts and charge that some of these progressive measures that are being advocated in the Senate are communistic or socialistic. I would recommend that everyone read that editorial in the Post this morning.

I am confident that—

Senator TAFT. I think it is very socialistic, so I disagree entirely with the editorial. I think that you might have that to start with; if you are going to make a partisan statement, I am going to make one.

The CHAIRMAN. I did not make a partisan statement.

Senator TAFT. But if you are going to give a rebuke to people who consider it socialistic, I consider it socialism. It is to my mind the most socialistic measure that this Congress has ever had before it, seriously.

The CHAIRMAN. I do not understand where you get the notion that I was giving any rebuke, I merely was calling—

Senator TAFT. You were commending the Post for rebuking those who called it socialistic and a socialistic measure.

The CHAIRMAN. I was merely calling upon the people to consider these matters without going outside the facts and resorting to abuse like you sometimes do when we have measures like the full employment bill on the floor. You charged that to have been taken out of the Constitution of the Soviet Republic.

Senator TAFT. It was, and Congress fortunately took out all of that part and passed a very good bill by means of the efforts of the minority of this committee, and not your efforts.

The CHAIRMAN. I want to tell you that they passed a good bill because we stood by our guns and you voted for it, too, and then afterwards tried to charge it with being a communistic movement, which was absolutely false and you have not been given any great credit in the country for your actions in that matter.

Senator TAFT. On the floor of the Senate we adopted every principal amendment that the minority of this committee tried to put in, which you refused to accept, and which the Senate adopted. And after the Senate adopted all of our amendments I voted for the bill because it then was a sound bill.

The CHAIRMAN. I want to say that nothing of the kind occurred. You changed the name of the bill from "full employment" to "maximum employment," and I cannot understand the difference in meaning from "maximum employment" to "full employment."

Senator TAFT. That is a minor feature.

The CHAIRMAN. You were attempting to confuse the minds of the people on a bill that was very worthy and very valuable to this country.

Senator TAFT. We obtained everything that we wanted.

The CHAIRMAN. I do not propose to let you bluff me on anything. Now, you think that you are going to get away with it, but you are not going to get away with it with me. You are not going to make a grandstand play.

Senator TAFT. Not at all. You started it. I never would have said a single word about it.

The CHAIRMAN. You had so much gall and so much nerve that you would not let me complete my statement. I would have been glad to give you an opportunity to express yourself as far as you wished, but you are very impolite, you are very sarcastic, and I do not think that you are having any success with it.

Senator TAFT. Mr. Chairman, I think that you are the one that is being impolite.

The CHAIRMAN. I am the chairman of this committee, and I want you now to subside and let me go ahead with this hearing.

Senator TAFT. You are so polite, Mr. Chairman, that I accede to your ruling.

The CHAIRMAN. I want you to shut down right now, or I will call the officers here and have you removed from the room, if you are going to make a roughhouse out of it.

Senator TAFT. Mr. Chairman, I want—

The CHAIRMAN. You think that you are pretty smart, a good bluffer, and a bulldozer, but you cannot get away with it.

Senator TAFT. I think if that is the spirit in which you are going to conduct these hearings—

The CHAIRMAN. You are expressing the spirit.

Senator TAFT. You started it. You started your statement with an attack upon the opponents of the bill, and I have a perfect right to reply to it, and I have done so courteously.

The CHAIRMAN. You have no right to interrupt me in my statement here. You have no right to interrupt me. You are very impertinent and very unfair, and I do not think that you are creating a good impression on the people here that are listening to these proceedings.

Senator TAFT. Well, Mr. Chairman, you showed your intention to conduct this solely as a propaganda machine. This hearing is just a propaganda machine, and that is all right with me. That is your right; you are the chairman of the committee, and I am perfectly agreeable to it.

The CHAIRMAN. That is one of the things that the editor is reprimanding here this morning in this editorial. Everything that has been attempted to be done for the welfare of the American people has men like you coming along charging it with being communistic. Nothing, as this editorial says, has done so much to raise the Communists' prestige in this country as the habit fallen into by a few of attributing to the Communists everything that is progressive. Communists do not deserve such kudos; "progressivism" is thoroughly American and thoroughly a democratic characteristic. But you want to make out that every effort on the part of the people of this country to make some improvement is communistic.

Senator TAFT. Mr. Chairman, I did not call it communistic, I called it socialistic.

The CHAIRMAN. You charged the full employment bill—

Senator TAFT. That it came right out of the Soviet Constitution, that is all that I said. I read it on the floor.

The CHAIRMAN. Which was absolutely false and you know it.

Senator TAFT. Not at all.

The CHAIRMAN. And you are going to make a political play—

Senator TAFT. The words came right out of the Soviet Constitution. However, that is a minor question.

The CHAIRMAN. I just want to say that you are reflecting your general habit and conduct here this morning, that you do every time a progressive measure is up for consideration in the United States Senate.

Senator TAFT. Mr. Chairman, your politeness is so great that I think that I should state that I intend to present to this committee a comprehensive plan for health and Federal activity in the health field, which I consider is not socialistic.

The CHAIRMAN. Wait until I get through with my statement, and then you can present anything that you please.

Senator TAFT. I did not want to interrupt you, but it seemed to be a conversation, so I will wait until you get through.

The CHAIRMAN. I am confident that when these hearings are concluded, there will be less conflict and more agreement on what the Federal Government should do, so that the full benefits of modern medicine can be brought within the reach of all of our people.

Among the unsung heroes and heroines of World War II are the members of the medical profession. On the battle front are doctors, dentists, nurses, corpsmen, who wrought miracles of medical care. On the home front, those who remained to serve the civilian population performed patiently and pre severingly under a work load of unprecedented proportions.

Now that the war is over, another task of heroic proportions confronts the medical professions, to bring the full gamut of preventative, diagnostic, and therapeutic health services within reach of the fifteen or more million men and women who served in the armed forces, the civilians who backed them up on the home front, and the families of both.

It is my hope that the work of this committee will result in a national health program that will open for the public a new chapter in man's age-old quest for health and vigor and will give the professions and the hospitals a new and larger opportunity to serve the public in their beneficent work.

We have here this morning with us two other authors of the bill, the chief author being Hon. Robert Wagner, United States Senator from New York, and I wish to call on Senator Wagner at this point.

Senator TAFT. I would like to make a statement; and I have to leave for the mark-up on the housing program bill.

The CHAIRMAN. No; you will not make a statement now.

Senator TAFT. I stand on my right to make a statement in this committee; and now either that, or I will take the whole matter on the floor and describe the spirit in which you have conducted this hearing—in which you are proposing to conduct this hearing—and all I wish to make is this statement—

The CHAIRMAN. You can have an opportunity to make your statement at the proper time. This meeting was scheduled, and the next witness is Robert Wagner, and he will make his statement, and Mr. Dingell, of the House, will make his statement, and then you can make your statement, and I am going to regulate this hearing in that form.

Senator TAFT. I am a member of the committee, and I demand the right to make a statement. I have to attend the hearings on the mark-up on the Wyatt housing bill, which is being considered in the Banking and Currency Committee, and all I wish to say, and it is very simple, is that—

The CHAIRMAN. This hearing will be going on for a month or 6 weeks, and you will have plenty of time to make your statement.

Senator TAFT. You have used this as a method of propoganda, of your statement, and I propose to make a statement.

The CHAIRMAN. That is a falsehood, that is slander, and that is in line with your general conduct. I resent it.

Senator TAFT. You can resent it all you like, and I don't resent anything that you say.

The CHAIRMAN. I resent your further interruptions, and I will not consent to them.

Senator TAFT. Mr. Chairman, I propose—

The CHAIRMAN. I will have to demand that you—

Senator TAFT. I intend—

The CHAIRMAN. I will have to demand that you subside. I am not going to permit you to run this committee.

Senator TAFT. Mr. Chairman, I want—

The CHAIRMAN. As long as I am chairman of this committee, you are not going to come in here and start this kind of thing.

Senator TAFT (to the reporter). I hope that you get all of this, because I want to take it to the floor.

The CHAIRMAN. You can take it anywhere you want.

Senator TAFT. All I intend to do is to—

The CHAIRMAN. You can take it to the National Republican Committee or any place you want to.

Senator TAFT. I intend to present to this committee a bill providing—

The CHAIRMAN. Now, you can make that statement at the proper time. You are not going to make that statement now.

Senator TAFT. Mr. Chairman, I have a right to make a statement to this committee, and I have never heard of a chairman of a committee refusing to recognize a member when he asked to make a statement.

The CHAIRMAN. You are hearing one now.

Senator TAFT. I am hearing one now.

The CHAIRMAN. Because you have been impertinent and insulting.

Senator TAFT. I have neither been impertinent or anything as compared to the chairman.

The CHAIRMAN. You interrupted me in my statement without my consent, and you did not ask me the privilege; you just interrupted.

Senator TAFT. Mr. Chairman, I now desire to state a very simple statement that I intend to offer to the Senate, and to this committee, a comprehensive bill providing for Federal aid—

The CHAIRMAN. You will make that statement at some other time, but not at this time, and you are not going to get away with this bulldozing that you are attempting here, to come in and disrupt this meeting, and you are not going to get any credit for it, either, with the American people.

Senator TAFT. For Federal aid to States as to the operation by States of comprehensive—

The CHAIRMAN. You are not going to come in here like this.

Senator TAFT. Of comprehensive State medical aid—

The CHAIRMAN. You are interrupting the chairman of this committee.

Senator TAFT. To be conducted by the States—

The CHAIRMAN. You are not going to get away with it, and I am not going to let you do it.

Senator TAFT. I move that when you have recovered—

The CHAIRMAN (to the reporter). You may stop taking this.

• (Discussion off the record.)

The CHAIRMAN. You have disrupted the committee meeting, and you have attempted to make something other than a dignified meeting by your conduct. You are so self-opinionated, and you think that you are so important that you can come into this meeting and disrupt it.

Senator TAFT. Mr. Chairman, I have not made the slightest attempt to disrupt anything. I asked to make a statement.

The CHAIRMAN. You did not ask to make a statement.

Senator TAFT. I just did.

The CHAIRMAN. You just did. You asked to make a statement, and then you made it anyway.

Senator SMITH. I feel that the Senator should be allowed to make his statement. I think that that is only fair.

The CHAIRMAN. I am not going to disrupt the procedure that I have adopted. There are two or three opening statements that are to go into this record.

Senator SMITH. I think that he should make his statement.

The CHAIRMAN. I told him several times that he would be given an opportunity to make a statement. If he wants to come in here and act like a Senator and a statesman, he will have an opportunity to make his statement at the proper time.

Senator TAFT. That is exactly what I have done, and I make the request now to make the statement.

The CHAIRMAN. I will make an answer to that. You will be given an opportunity at the proper time to make your statement.

Senator TAFT. Mr. Chairman, I am not going to attend any more meetings of your committee. We are through, and I think that everyone will know that the report of this committee under your chairmanship will be a partisan report which can command no support or no respect.

(At this point Senator Taft left the room.)

The CHAIRMAN. Senator Wagner will now make his statement.

Senator WAGNER. May I make my statement without interruption?

The CHAIRMAN. You may.

#### STATEMENT OF HON. ROBERT F. WAGNER, A UNITED STATES SENATOR FROM THE STATE OF NEW YORK

Senator WAGNER. Mr. Chairman and members of the committee, I am very glad to appear before the committee today in support of the national health bill which I have introduced with Senator Murray and Representative Dingell. The bill is designed to establish a national health program along the lines set forth by the President in his message on this subject.

In my opinion, this bill is one of the most important bills ever considered by this committee. It is an important bill, because without good health the individual, his family, and the Nation cannot prosper. Good health is a matter of vital interest to every man, woman, and child in the Nation.

#### A NATIONAL HEALTH BILL IS ESSENTIAL

The national health bill is an essential part of a broad program to improve our domestic security.

There is no doubt of the need for improving the health of our Nation. And there is no doubt that the American people are in favor of improving their health through health insurance.

Every year thousands of mothers and children are dying needlessly from preventable causes. Every year thousands of men and women in the prime of life are dying needlessly from tuberculosis, pneumonia, influenza, and other preventable diseases. I know something about pneumonia. Every year we lose more persons from preventable and premature deaths than we lost on the battlefields during all of World War II.

We cannot allow these preventable deaths to occur year after year. Every year of delay in establishing a national health program means the loss of thousands of lives. Every year of delay means needless suffering to thousands of people who do not now obtain adequate medical care. In the past we have taken some small piecemeal steps to try to deal with the problem. Now what we must do is tackle the job with everything we have.

The most important way now to accomplish that purpose is by the enactment of a national health insurance plan supplemented by other improvements in existing health legislation.

§. 1606, the national health bill, contains three titles:

Title I provides for grants to the States for health services. You have stated it already, Mr. Chairman, if you do not mind my repeating it. This title has three parts:

Part A—Grants to States for public health services.

Part B—Grants to States for maternal and child health services.

Part C—Grants to States for medical care of needy persons.

All three parts of title I provide grants-in-aid to the States for health services for which the Federal Government already provides limited funds. In general, the purpose of this title is to amend and broaden existing legislation by eliminating existing restrictions so that present State and local programs can operate more effectively.

Title II provides for national health insurance protection.

Title III contains general provisions.

I have had prepared for convenient reference a one-page summary of the bill which I have appended to my statement. In addition, I have included a one-page summary of the various benefits available under the health insurance title; a summary of why voluntary health insurance plans cannot do the job and summaries of what the bill would mean to (1) the medical profession, (2) hospitals, (3) veterans, (4) farmers, (5) businessmen, and for (6) maternal and child care.

#### HEALTH INSURANCE IS NOT SOCIALIZED MEDICINE

Some organized medical groups have criticized a national health insurance program on the ground that it involves "regimentation of doctors and patients," "lowered standards," "political medicine," and "socialized medicine," and so on. There is absolutely no foundation to these charges. May I emphasize that there is absolutely no foundation to these charges. Health insurance is not socialized medicine; it is not State medicine. These terms have been used by opponents of the bill to confuse the issue, which you have so emphasized.

Health insurance is simply a method of assuring a person ready access to the medical care that he or she needs by eliminating the financial barrier between the patient and doctor or hospital. Under the bill patients are guaranteed free choice of doctors, doctors are guaranteed the right to accept or reject patients, and hospitals are guaranteed freedom to manage their affairs. Specific provision is included in the bill for hearings and appeals on any issues which may arise between doctors, hospitals, and covered persons. Specific provision is made for the judicial review of any disputed issues arising under the plan. It is clear, therefore, that the bill does not involve regimentation of doctors, hospitals, or patients. Neither do I believe that the doctors of this country will lower the standards of

medical care simply because they are guaranteed payment for their services.

Those of us who have sponsored social legislation have faced similar unfounded objections against many proposals for social betterment. But we have lived to see these new programs eventually accepted as part of our basic system of American freedom and democracy even by the very groups who first opposed them. I remember when old-age assistance and free public employment offices were opposed as being socialistic. Similar arguments were advanced against income-tax legislation.

Over 35 years ago in the New York Legislature I fought for workmen's accident compensation, and most of the highly emotional arguments which are being made against health insurance now were made against workmen's compensation then. Employers' organizations, insurance companies, doctors—all are now in favor of the fundamental principle embodied in workmen's compensation laws. All these laws now include medical benefits, which is health insurance for industrial accidents and disease. The time has come for us to extend the principle of health insurance to cover nonindustrial accidents and diseases as well.

The fears and doubts expressed about workmen's compensation, old-age insurance, public employment offices, and other measures for social security have proved to be without foundation. I am convinced that the American Medical Association itself will be able to say about a national health insurance program after it is in operation, that many of its present apprehensions and misgivings were groundless.

#### FREEDOM OF CHOICE SAFEGUARDED

Under the bill each person is guaranteed freedom to choose his own family doctor from among all physicians or groups of physicians in the community who have voluntarily agreed to go into the system. Each doctor or group of doctors is free to go in or stay out of the system. Doctors who participate are free to accept or reject patients who may wish to select them as their family doctor. Patients and doctors may change the arrangements after they have been made if they become dissatisfied.

I want to quote the exact language from page 45 of the bill, lines 2 to 18, to prove this to you and to show you that many of the charges that are made against the bill are false. Here is what the bill actually provides:

SEC. 205. (a) Any physician, dentist, or nurse legally qualified by a State to furnish any services included as personal health service benefits under this title shall be qualified to furnish such services as benefits under this title \* \* \* and this provision shall extend to any group of physicians, dentists, or nurses or combinations thereof whose members are similarly qualified.

(b) Every individual entitled to receive general medical or general dental benefit shall be permitted to select, from among those designated in subsection (a) of this section, those from whom he shall receive such benefit, subject to the consent of the practitioner or group of practitioners selected, and every such individual and every group of such individuals shall be permitted to make such selection through a representative of his or their own choosing, and to change such selection.

Every effort also has been made in the bill to protect the professional position of dentists, nurses, and nursing organizations. Hospitals are

guaranteed protection in section 206 (b) against interference in the management of their own affairs. The basic policy has been to provide medical and related services through arrangements that are worked out so that they will be satisfactory to the public and to those who furnish the services. Mutual agreements reached through negotiations and contracts, are specified in section 203 (c) of the bill as the method to be used, and that is the democratic way of doing things.

The Surgeon General is authorized to negotiate cooperative working arrangements with Federal, State, or local governmental agencies and with private groups or individuals to provide the benefits by utilizing their services and facilities on payment of fair compensation. This will assure local administration and full utilization of all existing facilities and personnel.

The bill provides that the health benefits may be furnished to non-covered persons such as needy persons receiving public assistance, if appropriate arrangements are made to pay on their behalf the cost of services furnished to them.

#### VOLUNTARY PLANS AIDED

All qualified hospitals, all qualified medical groups or organizations, will be able to participate in the program as organizations furnishing services to the insured persons who choose them; they will receive fair payments for the services they furnish under the bill; and they will have enlarged opportunities to be service agencies for particular groups or for their communities. This applies to service organizations created by trade unions, consumer groups, employers, non-profit community groups, churches, fraternal associations, groups of doctors or individual doctors, medical societies, or many other kinds of sponsors, or groups of sponsors. The bill not only provides for utilizing existing service organizations but it also encourages the creation of new ones.

Now, I think that this is important. The Blue Cross or similar hospital-insurance plans will be able to continue to act as representative of the participating hospitals and the community groups that own or manage the hospitals. They will have large opportunities to be important public organizations that facilitate the administration of vital parts of the insurance system.

Medical service groups—private clinics, salaried staffs of hospitals, group-service plans such as the Kaiser or similar plans—furnishing service under the system would be as free as they are today to select their own staffs and their own methods of paying physicians and others on their staffs, irrespective of the method of payment which prevailed among the individually practicing physicians or dentists of the local area.

#### FINANCING HEALTH INSURANCE

How would the cost of the health insurance benefits in title II of this bill be financed? I think that you emphasized that, Mr. Chairman, but I think that it can stand repetition.

There is already pending before the Congress legislation to finance the cost of health insurance. On May 24, 1945, I introduced with Senator Murray and Representative Dingell a comprehensive social security bill (S. 1050 and H. R. 3293) providing for social insurance

contributions for all social insurance programs. This bill was drafted on the assumption that 3 percent of pay rolls (up to \$3,600 per year) would be allocated for health insurance, of which one-half would be paid by employers and the other half by employees. In other words, 1½ percent of pay rolls would be contributed by employers and 1½ percent by employees. The bill also provides that the additional cost above 3 percent due to the gradual introduction of dental and home nursing services would be financed out of general revenues.

I have been asked many times why the premiums for health insurance were not included in the national health bill, S. 1606, and I should like to clarify the situation for the record.

Under the Constitution, all revenue bills must originate in the House of Representatives. This means that the House must consider and pass revenue legislation before the Senate. In order that the health insurance legislation can be considered and passed by the Senate without waiting first for House action, it was necessary to consider the benefit and revenue provisions separately.

This separation of legislation between the revenue and benefit aspects is in keeping with previous practice. In both 1935 and 1937 legislation relating to railroad retirement was considered and enacted in this way. I was one of the authors of that bill, too.

Another reason for separating the benefit and revenue provisions is that under present arrangements in Congress different committees are concerned with these two matters. In the Senate, for instance, the Committee on Education and Labor handles all health legislation such as the hospital survey and construction bill, and the Public Health Service Act. The many technical problems involved in revenue legislation are handled by the Senate Committee on Finance. Similarly, in the House of Representatives, health matters are handled by the House Committee on Interstate and Foreign Commerce, but revenue matters are handled by the House Committee on Ways and Means. The financial details relating to the raising of the revenue for the plan raises many special problems which have a bearing on existing income taxes and pay-roll contributions and should be considered in relation to these laws.

In terms of priority, it is essential that the benefits should be given consideration first. If the Congress thinks that health insurance benefits should be provided, then the method of financing can be worked out in terms of the scope and character of the medical care provided.

Now as to my summary, during the course of the hearings before your committee you will hear from experts who will testify on the technical aspects of the bill. I hope that the committee will incorporate in the bill any constructive suggestion that will come out of the hearings so that we can have a comprehensive health insurance plan that will meet the needs of the American people.

(The summary is as follows:)

#### SUMMARY OF WAGNER-MURRAY-DINGELL NATIONAL HEALTH BILL S. 1606; H. R. 4730

The bill provides for a national health program, including—

##### *I. Community-wide health services*

Federal grants-in-aid to States for (1) expanded public health services, (2) expanded maternal and child health services, and (3) medical care of needy persons. Federal Government will pay between 50 and 75 percent of what a

State spends for such programs, with poorest States getting the largest percentage of Federal aid. Administration of these programs will be coordinated with—

## II. A Nation-wide system of prepaid personal health service benefits

1. *What will benefits include?*—All needed preventive, diagnostic, and curative services by a general practitioner, specialists' and laboratory services, special medicines and appliances, and hospital care up to 60 days, or 120 days if funds permit; dental and nursing services are provided but may be limited at the outset of the plan if personnel is unavailable.

2. *Who will be eligible for the benefits?*—All employees in industry and commerce (except railroad workers), agricultural and domestic workers, employees of nonprofit institutions, farmers, small businessmen, and other self-employed persons, and recipients of old-age or survivor's benefits will be covered. So will wives of employees and self-employed persons, their children under 18 (or over 18 if disabled), disabled husbands, and dependent parents. Other persons may qualify if contributions are paid on their behalf by a public agency.

3. *Will there be free choice of doctor, dentist, nurse, or hospital?*—Yes. Every eligible person will be allowed to choose his doctor, group clinic, dentist, nurse, or hospital from among those participating in the plan. Every licensed physician, dentist, or nurse, and every qualified hospital is guaranteed the right to participate. No practitioner or institution will be required to participate.

4. *How will the plan be financed?*—Through a special "Health services account" in the United States Treasury. To this account will be credited an amount equal to 3 percent of earnings up to \$3,600 a year in covered employment, and other sums to cover specified items of service and care for special groups such as needy persons and others on whose behalf premiums are paid by public agencies.

5. *How will the physician be paid?*—According to the method (fee-for-service, salary or per capita basis, or combinations) chosen by a majority of physicians in an area. Individual physicians or organized groups may be paid by a method other than that chosen by the majority, under mutual agreements between them and the insurance administrators.

6. *How will the plan be administered?*—Through the United States Public Health Service, with decentralized administration. Special provision is made to utilize State and local agencies. A National Advisory Council, with professional and public representatives, will advise the Surgeon General who must include their recommendations in his report to Congress. Local advisory councils are also to be set up.

7. *Provision is made for assuring high-quality care, and for medical research, and training of doctors and other health workers, with priority being given to projects for training of men and women returning from the armed forces.*

### PERSONAL HEALTH SERVICE BENEFITS AVAILABLE UNDER THE NATIONAL HEALTH ACT

The National Health Act (S. 1606; H. R. 4780) provides for comprehensive medical care for workers and their dependents and for other insured persons.

Care would be provided by the physicians, dentists and hospitals chosen by the patients from among all in the area who participate in the plan.

The following services would be provided:

*Medical care.*—All needed services that can be furnished by the family physician or general practitioner at the office, home, or hospital.

*Specialist care.*—Services from a specialist or consultant, when recommended by the family physician or general practitioner or by another specialist who is attending the patient.

*Surgical care.*—Major and minor surgery available immediately. No limit on number of surgical cases per year.

*Maternity care.*—Available immediately.

*Preventive care.*—All types of preventive services, including health examinations.

*Hospital care.*—Up to 60 days per person in each year (or 120 days when funds permit). Up to \$7 per day, for basic accommodations, for the first 30 days; up to \$4.50 per day thereafter. The insured person may use more expensive room accommodations and pay the hospital the extra cost. Provided in a general or special hospital.

*Dental care.*—At least: examinations, cleansings and (if the physician also advises) extractions. More complete dental services, especially for children, will be provided insofar as dentists and other personnel are available.

*Nursing care.*—Necessary nursing services will be provided for hospitalized cases. Also, when requested by the physician, for cases at home, up to the limits of available nursing personnel.

*Eye care.*—Eye examinations and glasses provided, when prescribed by the physician or optometrist.

*X-ray, etc.*—X-rays for diagnosis and treatment, electrocardiograms, basal metabolism tests, and all other diagnostic tests provided, when requested by the physician.

*Laboratory services.*—These services provided, when requested by the physician. They include blood tests, urine analyses, tissue examinations, etc.

*Physiotherapy.*—These services provided, when requested by the physician.

*Medicines.*—Expensive drugs and medicines will be provided when prescribed by the physician.

\* \* \* \* \*

*No illnesses excluded.*—None. Hospital care, however, will not be provided for more than 30 days following the diagnosis of tuberculosis or a psychosis. Also, since special institutional arrangements are needed for tuberculosis and for mental or nervous diseases, and, in large measure there already are arrangements for such cases in tax-supported hospitals, care in such special hospitals is excluded.

#### WHY VOLUNTARY HEALTH-INSURANCE PLANS CAN'T DO THE JOB

The National Health Act (S. 1606, H. R. 4730) provides among other things for comprehensive prepaid personal health services for gainfully employed workers and their dependents. Physician's care in the office, home and hospital, and hospital care would be provided by physicians and hospitals of the patient's choice. X-ray and laboratory services, and related services, certain medicines and appliances, and (possibly limited) dental and home-nursing care would also be provided.

Some of the services provided under this bill are now available to some people through voluntary prepayment plans. The questions are raised, "Why can't voluntary plans do the whole job? Why have a compulsory insurance system?"

Why voluntary plans can't do the job. The reasons are found in the experiences of the voluntary plans themselves.

1. *Complete coverage unattainable.*—No type of voluntary plan, here or abroad, has succeeded in including all of the population in a region or has even approximated this goal. As a rule, those who are most in need of protection are not covered. Experience the world over has shown that only through social insurance can complete coverage, and certainly coverage of those most in need of protection, be assured.

2. *Membership restricted.*—Most or all existing voluntary plans have restrictions; some will not enroll persons above or below a specified age, or persons not enrolled in groups, or persons above a specified income. Some are limited to particular occupational or other groups.

3. *Services limited.*—Service provided in voluntary plans is usually limited, and such plans are tending to narrow the scope of services offered instead of broadening it. With only a few exceptions, the only plans with substantial membership are those providing only hospital care or care while the patient is in the hospital. In most of the plans with any considerable membership, care is not available until the patient is already seriously ill and needs hospital, surgical, or obstetrical care. Most plans will not give care for pre-existing conditions or chronic illness and many exclude care for various specified conditions.

4. *Patients charged extra.*—Many plans that give more extensive care limit the total money value of care that will be provided in a year; or they require the patient to pay regular fees for the first one or two calls in each illness, thereby discouraging the patient from seeking care early in an illness.

5. *Costs are high.*—Because voluntary plans tend to attract those who expect to need medical or hospital care, the premium costs are necessarily higher than with comprehensive coverage. Enrollment costs, and the constant turn-over in membership, contribute to increase the overhead costs of voluntary plans.

6. *Contributions not related to ability to pay.*—Usually in voluntary plans contributions are not related to income; under the National Health Act payments would be related to ability to pay.

7. *Consumer not represented in management.*—Voluntary plans owned by groups of physicians or sponsored by medical societies exclude the consumer from planning and management.

The passage of this bill will not interfere with the continuance of existing voluntary organizations or agencies that provide medical or hospital services. On the contrary, the health insurance system would provide new opportunities for them to provide more service. An insured person may choose such an organized group, rather than an individual physician, if he prefers, and be entitled to receive all the insurance benefits which the organized group is equipped to provide.

#### WHAT THE NATIONAL HEALTH ACT WOULD MEAN TO THE MEDICAL PROFESSION

The National Health Act (S. 1606 and H. R. 4730) provides for a system of prepaid personal health service for gainfully employed workers and their families. Medical benefits provided through the bill include all needed service—preventive, diagnostic, and curative—furnished by a general practitioner of the individual's choice (from among all doctors in the area participating in the program), specialist and consultant services, laboratory and related services, and necessary hospital care up to 60 days a year for each member of the family, or 120 days if funds permit. Dental and home-nursing services are also provided, although these may be limited in scope at the outset of the program if there is insufficient personnel. All licensed physicians are guaranteed the right to participate in the plan if they wish to do so.

Aside from the benefits which the worker and his family would derive from this program, the plan would be of great benefit to the medical profession—

1. *Best possible care for his patient.*—The physician would be able to use for his patient the full resources of medicine. All too often this is not possible at present, because the patient cannot afford the necessary expense. The physician would have the advantage of consultant, specialist, laboratory, and diagnostic services for his patient, hospital care, and expensive medicines and appliances. In other words, health insurance would make it increasingly possible for the physician to practice medicine in the way he thinks it should be practiced.

2. *Improved relationships between patient and physician, with wider freedom of choice.*—Under health insurance, the physician does not charge the patient; the strain of financial relationship between the physician and his patient is removed. By eliminating the financial relationship between physician and patient, there is wider freedom of choice; the fee no longer stands between the patient and the doctor. Under the bill, freedom of choice on the part of the patient and the physician is guaranteed; the patient is free to choose his own physician and the physician has the right to accept or reject a patient who chooses him.

3. *Assurance of prompt payment of doctor's bills.*—Physicians would be professionally independent, as they now are—practicing as they now do. In addition, they would be sure of being paid for all services rendered to insured persons. The present burden of providing care, free of charge, for the poor would be eliminated in the case of all who are insured.

4. *More adequate incomes.*—Under this plan, most physicians would receive more adequate and more stable incomes. With the removal of the economic barrier between patient and doctor, there would be maximum utilization of the time of all available medical personnel. Under these conditions, a situation such as that in 1941, when more than one-fourth of the country's physicians had incomes below \$1,200, is not likely to recur.

5. *Increased opportunity to practice in the community of his choice.*—By making money available to pay for medical care, regardless of any particular patient's income, physicians who wish to practice in low-income or rural areas may do so without the customary financial worry.

6. *Opportunities for increasing his skill and knowledge.*—The bill provides for professional and financial incentives for the professional advancement of physicians. Funds would be provided for "refresher" and postgraduate work.

7. *Advancement of the science of medicine.*—Through the bill, funds would be provided for medical research and physicians would be informed of new and improved medical techniques.

## WHAT THE NATIONAL HEALTH ACT WOULD MEAN TO HOSPITALS

The National Health Act of 1945 (S. 1606 and H. R. 4730) includes a plan for a national prepaid personal health service for gainfully employed workers and their families. In addition to general practitioner, specialist, and laboratory and related services (and dental and home-nursing services), the bill provides for necessary hospital care up to 60 days a year for each family member; if funds permit, hospitalization may be extended up to 120 days. All hospitals may participate in the program if they meet general standards set up by the Surgeon General after consultation with an advisory council.

Under the bill, each hospital may choose how it is paid. It can be paid directly from the insurance fund. Or else it can submit its bill to the patient and the patient will receive a reimbursement from the fund.

The bill provides that the Surgeon General shall exercise no supervision or control over a participating hospital and that requirements for participation shall not prescribe the administration, personnel, or operation of any non-Federal hospital.

For the participating hospitals, the provisions of the bill would mean—

1. *Relief from the strain of meeting operating costs and balancing budgets.*—Even in the period of wartime prosperity, with its increased demand for hospital care accompanied by increased ability to pay on the part of the public, the strain of keeping “out of the red” persisted for many hospitals. Assurance of payment for the hospital care of many patients who are unable to pay, would mean greater assurance of balancing the hospital budget. A contingency fund, such as that which would be established under a health insurance system, would assure stability of income to hospitals during the ups and downs of the business cycle. Since higher occupancy rates would result from the insurance program, hospital income would be increased.

2. *Relief from the burden of providing free or part-free care to patients.*—Hospitals would be guaranteed payment for essential care for insured patients, regardless of the patients' ability to pay. If public welfare agencies bring “needy persons” into the program, free or part-free care would no longer be a burden to be borne by the hospital.

3. *Encouragement in the construction, expansion, and improvement of hospital facilities.*—In many communities, capital funds can be found to construct needed hospitals if future financial means are in sight to support the institution and its personnel. By providing payment for necessary hospital care, the bill would enable hospitals to meet their operating costs and, as a result, give them the needed financial encouragement to improve and expand their facilities. Through the Hospital Survey and Construction Act (S. 191), already passed by the Senate and now before the House, grants are to be made available for the construction of needed hospitals.

4. *The assurance of competent hospital personnel.*—With prompt and adequate payments to hospitals, they will be able to afford the competent, high-calibered personnel necessary for their efficient operation and the provision of high-quality care.

Moreover, hospitals will have increased opportunities to further improve and extend the training of interns and student nurses. This, in turn, will result in higher standards of service within the hospital.

## WHAT THE NATIONAL HEALTH ACT WOULD MEAN TO VETERANS

Passage of the National Health Act (Senate bill 1606; House bill 4730) would put into effect most of the national health program called for by President Truman. It includes a plan of prepaid personal health insurance, as a part of the social security system. Gainfully employed workers and their families could get needed medical and hospital care, from the doctor or hospital of their choice, and have the bills for such services paid from the insurance funds.

The National Health Act leaves open the question as to how the costs of the health insurance benefits are to be divided among workers, employers, and the Government, all of whom already spend money for medical care. The total costs of the insurance benefits are estimated at about 3 percent of earnings, up to \$3,600 a year, at the beginning; they might be as much as 4 percent later. Congress will, no doubt, want to hear from the public how these costs should be met.

For the veteran, such a plan would mean—

*I. Full medical and hospital services for himself*

The GI laws go only part of the way.

They entitle the veteran to complete medical care for service-connected injuries or disabilities.

They are far from adequate when it comes to non-service-connected illnesses, injuries, and disabilities. For these the veteran can get service—if he goes to one of the Veterans' Facilities (sometimes a distance of 100 miles or more); if there is a bed available; if he cannot afford to pay for care elsewhere.

S. 1606 would fill in the gaps. It provides: services of the family doctor; specialist's services, laboratory services, special medicines, and appliances; hospital care up to 60 days (120 days if funds permit); dental services; and home-nursing services.

(Note: The last two may be limited at the outset because of the shortage of dentists and nurses.)

*II. Free choice as to where, when, for what, and from whom he will get needed services*

Where? At the veterans' facility, if he prefers it and can get there or—

In his home town—at home, at the doctor's office, at a local outpatient clinic, or in a local or nearby hospital.

When? He can call a doctor when he thinks he needs one. For what? For whatever ails him, no matter whether the illness is service-connected or not.

From whom? From a doctor (general practitioner) of his own choice, and specialists if he needs them.

*III. Full medical and hospital care for his family*

All services listed above as available to the veteran, under S. 1606, are also available to each member of his family—his wife and children, and if they are dependent on him, to his parents as well.

*IV. Preference in the educational and training program proposed in S. 1606.*

Because there is a shortage of trained personnel in medical and allied fields, S. 1606 calls for grants-in-aid to educational institutions for postgraduate work in medicine or dentistry, and for training personnel for jobs in administration of personal health services, disability benefits, rehabilitation service, and related fields.

The bill specifies that in such programs preference and priority shall be given to projects to aid servicemen get these types of special training.

WHAT THE NATIONAL HEALTH ACT WOULD MEAN TO FARMERS

The National Health Act (S. 1606, H. R. 4730) would provide:

Prepaid personal health benefits for all members of the family, including doctors' services; hospitalization, up to \$7 per day; laboratory and clinical fees; special appliances (such as eyeglasses); dental care; and home-nursing care.

Adequate community-wide public-health services.

Health services for the needy.

Special health services for maternal and child care.

Funds for expanded medical research and education.

*Health at least as good as that of city people*

There was a time—before the development of modern health services in the cities—when the country was the healthiest place to live. But the glowing pictures of healthy rural life no longer jibe with cold facts.

Deaths of mothers in childbirth: One-third higher in rural areas than in large cities.

Deaths of babies in their first year: One-fourth higher.

Preventable deaths from diseases such as typhoid and diphtheria: Regularly higher in rural districts.

Rejection rates for World War II: 53 out of every 100 farm boys rejected, as against 43 out of 100 in general.

Under the National Health Act, farm areas could catch up and keep up with modern progress in health and medical science.

*Medical care at the time it is needed*

Too many farm families must wait with that trip to the doctor until after the crops have been sold and there's enough cash to pay the doctor. Dread of debt keeps countless farm families from seeking early medical care.

Under the National Health Act, nothing would stand in the way of timely and complete care at the time sickness strikes.

*Family doctors within reach—even specialists*

The faithful country doctor is a familiar part of farm life. But there are far too few of them.

One doctor for every widely scattered 1,700 persons in rural counties.

One doctor for every 650 persons in the big cities.

The cities offer physicians more adequate incomes, more elaborate facilities. Under the National Health Act, good incomes for farm doctors and specialists would be provided through the insurance fund. Better hospitals would also be provided. Doctors would thus be attracted back to rural areas.

*Hospitals and public centers for farm families.*

Two out of every five counties lack satisfactory hospitals. Even more are without public-health services. There are fewer clinics, and equipment is poorer.

Legislation providing for Federal aid for hospital construction is now before Congress. But passage of this legislation will assist in construction only, not in maintenance of hospitals. Scores of farm areas will be unable to build new hospitals unless the National Health Act—which would assure sufficient income to meet maintenance expenses—is also enacted.

## WHAT THE NATIONAL HEALTH ACT WOULD MEAN TO BUSINESSMEN

Passage of the National Health Act (S. 1606, H. R. 4730) would put into effect most of the national health program recommended by President Truman. It provides for prepaid personal health insurance, as a part of the social-security system. Persons in business for themselves, as well as other workers, and their families, could get medical, hospital, and other services from the doctor or other practitioner or from the hospital of their choice, and have the bills paid from insurance funds.

The National Health Act leaves open the question as to how the costs of health-insurance benefits are divided among workers, employers, and the Government, all of whom already spend money for medical care. The total costs of the insurance benefits are estimated at about 3 percent of earnings, up to \$3,600 a year, at the beginning; they might be as much as 4 percent later. Congress will, no doubt, want to hear from the public how these costs should be met.

For businessmen, such a plan would mean—

*I. Health protection for businessmen and their families*

The health services provided to insured persons include: All needed care from a family doctor; specialist's services; laboratory services, special medicines, and appliances; hospital care up to 60 days in a year (120 days if funds permit); dental and home-nursing services (somewhat limited at outset because of possible shortage of dentists and nurses).

*II. Lower business costs*

A national health-insurance program will give all business firms the advantages of a health program for their workers. Contributions employers make to the health insurance fund will be offset by reduction in their business costs. Factory health programs have lowered costs of production appreciably but the cost of these programs, if operated by individual firms, places small business at a serious disadvantage.

(a) *Decreased labor turn-over and absenteeism.*—Absenteeism is highest among workers in poor health. One day's illness costs the employer an estimated one and one-half times the amount of the sick worker's daily wage. Approximately 500,000,000 man-days are lost each year due to illness. Factory health programs have lowered absenteeism and labor turn-over.

(b) *Higher productivity.*—Workers with poor health are less productive than workers in good health. Health insurance means prompter and more adequate care and therefore better health. Also, workers who do not worry about medical care for their families are better workmen.

(c) *Decreased workmen's compensation premiums.*—Experience indicates that healthy workers have fewer industrial accidents and less industrial disease. Industrial accidents in factories with health programs have been reduced, on the average, by more than 40 percent. Workmen's compensation premiums, over a period of time, would become lower as the rate of industrial accidents declined.

### *III. Increased prosperity for the community and for business*

Better health and less time lost due to illness will increase productivity and family incomes. Families may spend more of their incomes for current needs when their medical bills are paid by the insurance funds and they need not keep reserves against illness. Small businessmen in particular will gain from such increased consumer demand; all businessmen will gain from the increased economic stability and prosperity of the community.

## WHAT THE NATIONAL HEALTH ACT WOULD MEAN FOR MATERNAL AND CHILD CARE

Passage of the National Health Act (S. 1606, H. R. 4730) would put into effect most of the national health program called for by President Truman. It includes a plan of prepaid personal health insurance, as a part of the social-security system; it also strengthens the community-wide public health and maternal and child health programs.

The health of mothers and children would be protected and improved, under the bill, through—

### *I. Adequate medical care and personal health services*

The health services provided to insured persons include: All needed care from a family doctor; specialist's services, including services of obstetricians and pediatricians; hospital care up to 60 days (120 days if funds permit); laboratory services, special medicines, and appliances (such as eyeglasses); dental and home-nursing services—which, however, may be limited at the outset because of the shortage of dentists and nurses.

Children whose fathers or mothers work in gainful employment and women whose husbands are in gainful employment (except railroad and Government employment) will be insured and entitled to these health services.

Other children and mothers may become insured and entitled to these health services if premiums are paid on their behalf by a public agency, such as a State public assistance agency or a State agency administering a maternal and child-health program.

### *II. Special maternity and child-health services*

Federal financial aid is made available to the States for community-wide maternal and child-health programs, including: Well-baby clinics and demonstration projects; health education; services to locate crippled or physically handicapped children; special health services not provided under the health insurance system—such as long-continued hospital or institutional care and training; provision of needed medical care for mothers and children who are not insured, as workers or dependents of workers—either by paying insurance premiums on their behalf, or otherwise; training of personnel for State and local maternal and child-health work.

The amount of Federal financial aid would depend on the relative wealth of the State, with more Federal aid given to the poorer States, which now generally have the highest rates of maternal and infant deaths and of poor health among children.

### *III. Other measures to improve the health of the community*

Federal financial aid is made available to the States for adequate community-wide public health services, including sanitation, control of communicable diseases, preventive health services—all of which would benefit mothers and children as well as the rest of the community.

Federal financial aid is made available to the States for medical care for needy persons—State public assistance agencies could provide medical care for needy mothers and children who are not insured, as workers or dependents of workers—either by paying insurance premiums on their behalf, or otherwise.

Research on the causes, prevention and treatment of disease would be encouraged and aided through grants from the health insurance fund,

The CHAIRMAN. Congressman Dingell, do you have a statement that you would like to make?

Mr. DINGELL. Yes, Mr. Chairman, I would like to make my statement.

The CHAIRMAN. You may proceed.

**STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN**

Mr. DINGELL. Mr. Chairman, I consider it a high honor to be associated with Senators Wagner and Murray in the sponsorship of such an important piece of legislation as the national health bill.

I think it is customary for a witness to qualify himself before testifying on a bill. For many years I have been vitally interested in health legislation. As a member of the House Ways and Means Committee I helped to frame the public health and maternal and child-health provisions in the original Social Security Act of 1935 and the amendments of 1939 which extended these provisions. I have followed closely the problems of medical benefits, occupational accidents and diseases under Federal and State workmen's accident compensation laws, both as a legislator and as a lifetime member of the International Typographical Union.

**OPPOSITION OF AMERICAN MEDICAL ASSOCIATION**

I want to confine my remarks today to the health-insurance provision—title II of the bill—pending before this committee because that is the part I presume you are going to hear most about during these hearings. That is the part against which the American Medical Association and its satellite organization—the National Physicians Committee—has been shooting at right along; laying down a deadly barrage of baseless propaganda for the sole purpose of creating fear and confusion among the American people. The object of this campaign is to perpetuate a system which is as selfish as it is deficient if it is not altogether outmoded. The American Medical Association—

Senator SMITH. I just want to register an objection to an attack upon the opponents of the bill as being wrongly motivated at this point. I am not objecting to the bill at the moment, but I do not like to start off with damning your enemies. I want to hear a constructive presentation of what is here and not what others may think about it.

Mr. DINGELL. May I be permitted to ask the question whether I, as a Member of the House, must come here and have a Senator purge my statement? That is my opinion, whether I am right or wrong.

The CHAIRMAN. The Senator has concluded his objection.

Senator SMITH. I did not intend to hurt the witness' feelings.

Mr. DINGELL. Mr. Chairman, I submit that my opinions as contained in my statement are not subject to censorship by Senator Smith, whether he agrees with my views or not. As a Member of the House of Representatives, I will not be subjected to the purging of my expressions. The statement will appear in the committee hearings unexpurgated or not at all. I am not insistent that the Senator agree with me. These statements, however, are my views.

Am I privileged to go ahead and make my statement?

The CHAIRMAN. You may proceed.

Mr. DINGELL. The American Medical Association and the National Physicians Committee have attacked the health insurance provisions of the bill as "socialized medicine," "state medicine," and "political medicine." In my opinion, those who peddle such nonsense are either woefully ignorant or inexcusably rigid in their stand-pat attitude. I say this because anyone who studies the bill carefully, section by section, and line by line, will find that these charges are not true. For instance, section 205 (a) and (b) specifically provides for free choice of doctor by the patient and free choice by the doctor as to whether he wishes to enter into the system full time, part time, for 10 patients, 1 patient or not at all. Is this state medicine? Of course not.

Moreover, section 205 (g) of the bill specifically gives each doctor the right to choose the method by which he wishes to be paid for the services he renders. Is this political medicine? Of course not.

Section 205 (i) guarantees that payments to the doctors shall be adequate and shall vary with skill, experience, and responsibility involved in furnishing service. Is not this fair and proper? Of course it is.

These various sections as well as others in the bill are concrete answers to the many false charges that have been hurled against the bill.

I want to warn members of the committee that the health-insurance features of this bill have been the subject of more willful misrepresentation and misinformation than any other piece of legislation I have ever seen presented in all my 13 years in Congress.

The National Physicians Committee, formed specifically to preserve the A. M. A.'s tax-exempt status under the income-tax laws, is spending hundreds of thousands of dollars to circulate false statements to try to defeat the health-insurance provisions of the bill. It is collecting money under the false pretext that contributions to it "should be deductible" from income taxes by individuals who contribute. As a member of the House Ways and Means Committee responsible for drafting our tax laws, I believe that the National Physicians Committee's statement to this effect is deliberately misleading and any such deduction is a violation of existing law which should be investigated by the Treasury Department.

The A. M. A. and the National Physicians Committee have the right to oppose this bill or any bill, to make its views known, and to spend as much money as they want to try to defeat this bill. But it should be clear that the American Medical Association in the field of medical economics does not come into the court of public opinion with clean hands. The American Medical Association's attempt to kill voluntary health insurance plans was finally stopped by the United States Supreme Court only after the A. M. A. was convicted of engaging in illegal activities in restraint of trade under the Sherman anti-trust law.

The false information which the A. M. A. circulated against the British health-insurance system has been repudiated by the secretary

of the British Medical Association, who said that the A. M. A. pamphlet on Health Insurance in England—

contains only a succession of distorted and confused facts and a partisan selection of opinions. \* \* \* Almost every page of the pamphlet provides matter for criticism on the score of inaccuracy or unfair presentation.

I predict that members of this committee, like Members in the House, will be bombarded with similar misrepresentation. My experience is that I cannot keep abreast of the volume of propaganda against the bill.

#### PUBLIC OPINION POLLS

As to public opinion polls, numerous public polls taken during the past 8 years have shown that the American people are in favor of health insurance. I would like to include in the record a summary of the most important polls taken on this subject.

The CHAIRMAN. That may be done.

(The polls referred to are as follows:)

#### THE WASHINGTON POST POLL

The Washington Post in January 1946 conducted a survey of Washington residents to determine their reactions to the President's health insurance proposals made in a message to Congress November 1945. There follows a summary of the questions, replies, and findings of the poll.

The President has suggested that a small amount be paid from a worker's wages into an insurance fund that would help pay doctor, dentist, and hospital bills for the worker and his family. Do you approve or disapprove of the plan?

	<i>Percent</i>
Approve .....	70
Disapprove.....	21
Don't know.....	9
Reasons for disapproval:	
"Too much deducted from salaries now".....	30
"Will lead to socialized medicine".....	17
"Want to select own doctor".....	17
"Too much coddling".....	15
"Other miscellaneous reasons".....	8
No reason given.....	13

Fifty percent of Washington residents now participate in some private health hospitalization, or accident insurance program.

Seventy-nine percent of those now participating favor adoption of the compulsory Government plan.

Eighty-four percent of those now without insurance support the President's plan.

An inquiry as to the amount of family doctor and hospital bills in 1945 revealed: Cost of family medical care:

	<i>Percent</i>
Less than \$100.....	59
Between \$101 and \$500.....	35
More than \$500.....	6

(Source: The Washington Post, January 28, 1946, page 1, column 4.)

#### UNIVERSITY OF DENVER POLL

The National Opinion Research Center, University of Denver, in August 1944, undertook a survey of public opinion for the Physicians' Committee on Research, Inc., to determine the opinion of the American people regarding certain limited aspects of medical care, especially the question of United States Government responsibility in the matter.

Over 2,500 civilian adults in all sections of the United States, proportionately representative of men, women, old, young, rich, poor, whites Negroes, city dwellers, townspeople, farmers, and other groups were questioned. Below are summarized the findings of the poll.

Do you think it would be a good idea or a bad idea if the social-security law also provided paying for the doctor and hospital care that people might need in the future?

	<i>Percent</i>
Good idea.....	68
Bad idea.....	19
Don't know.....	13
<b>Total.....</b>	<b>100</b>

If this meant that 2½ percent of people's pay checks would be taken out instead of the present 1 percent, would you think this a good idea or a bad idea? (Asked of those who answered that social-security insurance was a good idea.)

	<i>Percent</i>
Good idea.....	58
Bad idea.....	10
Don't know.....	13
<b>Total.....</b>	<b>81</b>

Would you rather have the social-security law handle the insurance that would pay for people's doctor and hospital care, or would you rather have it handled through some private insurance plan? (Asked of those who answered that social-security insurance was a good idea.)

	<i>Percent</i>
Social Security.....	48
Private insurance.....	13
Don't know.....	20
<b>Total.....</b>	<b>81</b>

If you could get some insurance for which you paid a certain amount each month to cover all the doctor care you might need in the future, would you rather do that, or would you rather pay the doctor what he charges you each time?

	<i>Percent</i>
In advance.....	55
Each time.....	38
Don't know.....	7
<b>Total.....</b>	<b>100</b>

Would you be willing to pay \$3 a month if you were assured complete doctor and hospital care for you and your family any time in the future you might need it?

	<i>Percent</i>
Yes.....	67
No.....	25
Don't know.....	8
<b>Total.....</b>	<b>100</b>

Have you ever put off going to a doctor because of the cost?

	<i>Percent</i>
Yes.....	31
No.....	68
Don't know.....	1
<b>Total.....</b>	<b>100</b>

Have you ever had to borrow money in order to pay doctor or hospital bills?

	<i>Percent</i>
Yes.....	23
No.....	77
<b>Total.....</b>	<b>100</b>

What do you think is the main reason people put off seeing a doctor?

	Percent
Fear .....	27
Objection to way doctors charge .....	3
Expense .....	34
Doctors at fault .....	4
Inconvenience .....	9
Patient's indifference .....	27
Doctors are uncooperative .....	1
Doctors are overworked .....	1
Don't like what doctors order .....	2
Miscellaneous .....	2
Don't know .....	7
<b>Total</b> .....	<b>117</b>

<sup>1</sup> Multiple answers permitted.

Do you think anything should be done to make it easier for people to get medical care when they need it?

	Percent
Yes .....	82
No .....	10
Don't know .....	8
<b>Total</b> .....	<b>100</b>

What do you think should be done? (Asked of the 82 percent who answered yes to the preceding question.)

Whom they want to do something:	Percent
Federal Government .....	14
State government .....	5
Local government .....	7
Charity .....	3
Private insurance .....	6
Doctors .....	5

What they want done:	Percent
Specific suggestions regarding doctors without anyone responsible for execution of plans .....	4
Specific suggestions regarding hospitals without anyone responsible for execution of plans .....	4
Specific suggestions regarding clinics without anyone responsible for execution of plans .....	15
Specific suggestions not classifiable under Federal, State, or local government or under suggestions regarding what doctors, hospitals, or clinics should do .....	8
Group insurance .....	4
Don't know .....	16
<b>Total</b> .....	<b>190</b>

<sup>1</sup> Multiple answers permitted.

Do you have any insurance to cover any hospital bills you might have?

	Percent
Yes .....	34
No .....	66
<b>Total</b> .....	<b>100</b>

No .....

Do you and your family have regular a doctor you usually go to when you're sick?

	Percent
Yes .....	79
No .....	21
<b>Total</b> .....	<b>100</b>

Why do you see the same doctor every time? (Asked of those who answered yes to preceding question.)

	Percent
Personal likes.....	15
Efficiency of doctor.....	47
Familiarity with family.....	13
Habit.....	10
Convenience.....	7
Company or insurance doctor.....	1
Miscellaneous.....	1
<b>Total.....</b>	<b>194</b>

<sup>1</sup> Multiple answers permitted.

Have you or has anyone in your family had to see a doctor at any time in the past year?

	Percent
Yes.....	74
No.....	26
<b>Total.....</b>	<b>100</b>

During the past year, about how many dollars would you say you and your family spent for doctor and hospital bills—not counting the dentist? (Asked of those who answered yes to preceding question.)

	Percent
\$0 to \$9.99.....	7
\$10 to \$24.99.....	13
\$25 to 49.99.....	11
\$50 to \$74.99.....	10
\$75 to \$99.99.....	3
\$100 to \$ 99.99.....	12
\$200 to \$299.99.....	6
\$300 to \$499.99.....	5
\$500 and over.....	5
Amount not specified.....	1
Don't know.....	1
<b>Total.....</b>	<b>74</b>

Do you have a social security number?

	Percent
Yes.....	53
No.....	47
<b>Total.....</b>	<b>100</b>

Proponents of the Wagner-Murray-Dingell bills: Before a person could be considered a proponent of the provisions of the Wagner-Murray-Dingell bills, it would probably be generally agreed that that person would have to withhold any opposition to social-security coverage in principle, support social-security coverage in view of a 2½-percent pay-check deduction, and prefer social-security coverage to any private plan. When a person falls down in any of these three respects, he cannot fairly be counted with the bill's advocates.

Utilizing this criterion of a proponent, National Opinion Research Center statisticians by machine analysis determined that 41 percent of all respondents answered the general question on social-security coverage with "good idea" or "don't know"—that is, didn't answer with "bad idea"; answered the question about the amount of deduction with "good idea"; and said they preferred social-security coverage to private insurance plans.

Because 20 percent of all persons are doubtful where they should stand on these bills, this 41 percent increases to 51 percent when only those with opinions are considered.

(Source: Denver University National Opinion Research Center. What Do the American People Think About Federal Health Insurance? October 1944.)

## AMERICAN INSTITUTE OF PUBLIC OPINION POLL, AUGUST 13, 1943

At present the social security program provides benefits for old age, death, and unemployment. Would you favor changing the program to include payment of benefits for sickness, disability, doctor, and hospital bills?

	<i>Percent</i>
Yes.....	59
No.....	29
Undecided.....	12

(If "Yes") Would you be willing to pay (or have your husband pay) 6 percent of your salary or wages in order to make this possible?

	<i>Percent</i>
Yes.....	41
No.....	11
Undecided.....	4

Source: Public Opinion Quarterly, fall, 1943, p. 488.

## NATIONAL OPINION RESEARCH CENTER POLL, JUNE 1943

Question. Do you think there shou'd be a social security plan to take care of working people while they are sick?

Answer:	<i>Percent</i>
Yes.....	85
Qualified answer.....	2
No.....	10
No opinion.....	3
Total.....	100

Source: Appendix to the Congressional Record, vol. 89, pt. II, p. A3358.

## FORTUNE POLL, JULY 1942

Question. Do you think the Federal Government should [or] should not collect enough taxes after the war for medical care for everyone who needs it?

Answer:	<i>Percent</i>
Should.....	74.3
Should not.....	21.0
Don't know.....	4.7
Total.....	100.0

Source: Fortune, July 1942, p. 14.

## NEW YORK STATE COMMISSION ON MEDICAL CARE POLL, 1945

(1) Do you think everybody who lives in New York State should have insurance which pays doctor and hospital bills?

Results:

	Up-State	Metropoli- tan New York	New York State
	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>
1. Yes.....	84.2	87.0	86.0
2. No.....	9.0	7.0	7.7
3. Don't know.....	6.8	6.0	6.3
4. Refused.....	.0	.0	.0
Total.....	100.0	100.0	100.0

(2) Which one of these two ways to pay doctor and hospital expenses do you think is better?

(a) To pay doctor and hospital expenses as they come up; or

(b) To make regular payments for insurance that will pay doctor and hospital expenses as they come up.

Results:

	Up-State	Metropolitan New York	New York State
	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>
1. (a).....	23.8	22.4	22.9
2. (b).....	69.5	70.8	70.3
3. Don't know.....	6.6	6.6	6.6
4. No information.....	.1	.2	.2
Total.....	100.0	100.0	100.0

3. Which one of these two methods for doctor and hospital insurance would you choose?

(a) A plan under which the amount of your insurance payments would depend on the amount of your family's income—everybody would have to contribute to it—and it would be handled by the Government; or

(b) A plan under which the amount of your insurance payments would be the same as for everybody—anyone could join or stay out—and it would be handled by a nongovernmental group.

Results:

	Up-State	Metropolitan New York	New York State
	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>
1. (a).....	38.9	59.5	51.9
2. (b).....	44.7	30.2	35.6
3. Don't know.....	16.1	10.3	12.4
4. No information.....	.3	0	.1
Total.....	100.0	100.0	100.0

If (a) is chosen in question (3) 100 percent:

(4) Which Government do you think should handle it: The New York State government or the Federal Government?

Results:

	Up-State	Metropolitan New York	New York State
	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>
1. New York.....	45.1	25.2	32.6
2. Federal.....	31.2	58.5	48.4
3. Don't know.....	22.8	16.0	18.5
4. Neither one.....	.2	.3	.2
5. Either.....	.2	.0	.1
6. No information.....	.5	.0	.2
Total.....	100.0	100.0	100.0

If (b) is chosen in question (3) 100 percent:

(5) Which of the following would handle it?

Insurance companies.

Unions.

Doctor groups.

Others.

Employers.

Results:

	Up-State	Metropolitan New York	New York State
	Percent	Percent	Percent
1. Insurance companies.....	68.4	55.0	59.9
2. Doctors' group.....	10.7	16.9	14.6
3. Employers.....	6.0	7.9	7.2
4. Unions.....	1.0	4.0	2.9
5. Others.....	1.8	2.0	2.0
6. Don't know.....	10.2	11.6	11.1
7. None specified.....	1.9	2.6	2.3
	100	100	100
1. Specified others.....	1.6	2	1.9
8. None specified.....	.1	0	.1

#### NATIONAL PHYSICIANS COMMITTEE POLL—THREE PUBLICS' APPRAISE PREPAYMENT MEDICAL CARE

(Statement by Claude Robinson, Ph. D., president, Opinion Research Corp., at the Sixth Annual Conference of the Professions—Industry, National Physicians Committee for the Extension of Medical Service, New York, November 26, 1945)

The series of opinion research studies for the National Physicians Committee have aimed at a thoroughgoing examination of the public's feeling and thinking on certain economic phases of medical care. The present controversy over a Government-administered health-insurance program is one which eventually will be settled by the people themselves. The doctors will of course bring their influence to bear one way or another, but public demand will be the deciding factor.

Does the public really want any change in the present method of paying for medical care?

If so, what kind of a change?

How does it feel about Government sponsorship and compulsory health insurance as proposed by the Wagner-Murray-Dingell bills?

What is the reaction of people who have had first-hand experience with employer-sponsored insurance plans covering hospitalization and other sickness expenses? Do they like these plans? What do they think of a Government plan?

What do the doctors think about all this? Are they going to cooperate with or fight against prepayment plans—how about private plans? How about the proposed Government plan?

To get these much-needed answers we sent our Nation-wide staff of interviewers out to talk to the people of the country—also to visit employees of companies known to have group-insurance plans, and to probe into the thinking of doctors. The series of slides here will give you the high spots in the thinking of the three publics on this subject.

First of all, the evidence is irrefutable that the public strongly desires some easier way of paying for medical care.

This was found to be true on the survey made late in 1943 which I reported to you last year, and is abundantly evident in the findings of this year's survey. The public is overwhelmingly optimistic that something could be done to ease the financial strain of medical expenses: 77 percent say, "Yes, something could be done to make it easier for people to pay for doctor and hospital care." Furthermore, this optimism is gaining—8 percent more people today than in 1943 say that something might be done to ease this burden.

In spite of the fact that the desire to make a good impression would tend to make people answer this next question negatively we find that more than half are willing to admit that they have at some time experienced hardship in meeting medical bills and 40 percent of the people say they are familiar with cases where others have foregone treatment because of financial stringencies.

Last year we reported a strong sentiment for prepayment as a means of easing the financial burden of medical care. The surveys indicate that the market for

prepaid medical care is broad. We find an overwhelming majority of the people (64 percent) saying they personally prefer to pay in advance. And before any specific plans are discussed with them, more people volunteer the idea of prepayment than suggest any other method of easing the cost of medical care. Note that in second position on the list is the suggestion of a national health-insurance program (13 percent). Following this are: Control of doctors' prices, 7 percent; the idea that welfare or charity agencies should provide for the indigent (4 percent); installment payments (3 percent); teaching people to save (3 percent); joining a plan at the place of employment (2 percent); organizing an association (2 percent); and other miscellaneous ideas (3 percent).

Although there is widespread agreement on the need for an easier method of paying for medical care and general agreement on prepayment as a desirable system, the issue of Government versus private sponsorship is still an undecided question in the public mind.

Public opinion is not yet crystallized, but it is our considered judgment that present sentiment favors insurance-company plans over either Government sponsorship or doctor-organization plans. In arriving at this conclusion we are in much the same position as a roentgenologist in his interpretation of the areas of shade and light on a series of X-ray plates. As we move from one view of the public mind to another on this issue opinions group and regroup themselves to present a somewhat clouded composite picture.

When asked to choose between Government sponsorship and the abstraction of non-Government sponsorship, people's preferences split more or less equally. Here we see the division of choice before any specific plans have been discussed (41 and 36 percent) and after brief descriptions of Government-sponsored and privately sponsored plans have been presented for appraisal (45 and 43 percent).

It should be emphasized that the main issue posed to the public in the descriptions of all the plans discussed here today was one of sponsorships. We deliberately minimized other differences so there would be as few variables as possible which could confuse people's thinking and, incidentally, our statistics.

You may be interested in seeing the brief description of group-insurance-type plans from the booklet which the respondent was handed to read. When there was any doubt in the interviewer's mind of the respondent's ability to read or absorb the material he read the description aloud. This, by the way, is not my reason for reading it to you gentlemen now.

We find wide recognition of the group-insurance type of plan and a high degree of favor for it.

Seventy-one percent of the general public has heard of group-insurance plans, and 65 percent approve of them unreservedly, while another 19 percent say they are "a fair idea." Only 7 percent label them a poor idea.

Here is the brief description respondents were given of the Federal Government plan: As I said before, we found it essential to limit the issue to an appraisal of sponsorship in order to avoid the statistical hazards of uncontrolled variables. Obviously the various plans vary considerably in comprehensiveness of service, types of persons covered, cost, freedom of selection of doctors, and in many other details. Some may argue, therefore that restriction of the issue to the question of sponsorship is an oversimplification. The fact remains that several of the most important differences in the plans revolve around sponsorship. In preliminary testing many respondents became confused by the additional details which were necessary to give well-rounded descriptions of the plans. It was decided to investigate only the primary difference of sponsorship and to minimize other variables.

We find that only 39 percent of the people have heard or read of the Federal Government plan as compared with the 71 percent who have heard or read of group-insurance plans; 49 percent of the people say such a plan would be a good idea, 18 percent say it is a fair idea, and 20 percent brand it a poor idea.

And here is our description of a doctor-organization plan.

Comparatively few people have heard of this type plan; 71 percent admit that they haven't.

In spite of the fact that not many have heard of doctor-organization plans, 38 percent think they would be a good idea, and 24 percent commend them as at least fair.

So to recapitulate, when we bring the votes on the three plans together, we find that the group-insurance plan receives the highest approval with a total of 84 percent, adding the good and fair idea votes together. The Federal Government plan is second in approvals, with a total of 67 percent labeling it a good or fair idea, while doctor-organization plans are lowest in commendation,

although 62 percent grade them as a good or fair idea. In passing, it is interesting to observe that more people voice approval of each plan than were originally familiar with it; 71 percent had earlier knowledge of the insurance-company plan, but 84 percent approve of it; 33 percent knew of the Government plan, but 67 percent approve it; and while only 29 percent knew of the doctor plan, 62 percent approve of it. This further demonstrates that public attention is focused on the desired end of having some sort of prepayment plan instead of on the specific means for reaching that end.

In view of the public's unsettled state of mind about whether Government or non-Government sponsorship will give them a better plan, and considering the strength of the people's desire to find a solution to the financial problems of medical care through prepayment, it seems likely that whichever sponsorship first makes its prepayment plan both widely known and widely available—that sponsorship can count on public acceptance.

This is demonstrated when, after considering descriptions of the three types of plans, people are asked which type they would personally prefer to have. The best known of the plans, the group-insurance plan, is given the edge on the other two; 39 percent of the people prefer it as compared with 34 percent who prefer the Government plan and 12 percent who prefer the doctor plan.

The indefiniteness of the state of public opinion on the issue of sponsorship is again demonstrated by the lack of conviction people have about their choice of plan: "How do you feel about your preference—do you feel sure about it or would you want more facts before deciding definitely?"

But note that those inclined to the better known insurance plan feel more sure of their choice than do the others; that is, 56 percent are convinced of this choice, as against 41 and 37 percent for the other two plans.

Obviously, evidence is not needed to convince the National Physicians Committee that a large-scale program of public education is required in these circumstances. The intense campaign in which the National Physicians Committee is energetically engaged to impress both the medical profession and the public with their several stakes in keeping Government out of medicine has so far been as effective as the campaign of the proponents of Government medicine. While it is evident that much remains to be done in the way of public education, it is encouraging to find that the arguments against Government medicine are getting through to the public equally well as arguments for it.

We find that 16 percent of the people say they have heard or read something recently in favor of having a Government plan and 15 percent say they have heard or read something recently against having such a plan.

In an effort to learn what arguments are most effective and most dangerous on each side of the fence, we showed people lists of arguments compiled from published material expressing differing viewpoints and from volunteered reasons secured on earlier surveys. With each list we asked them to indicate which ones they considered to be the strongest arguments.

On this list of arguments favoring privately sponsored prepayment plans the arguments most frequently considered the strongest are that people would not be compelled to pay into these plans but would be free to join or not as they wished (24 percent); and that doctors and insurance companies would do better work in the open competition of non-Government plans (22 percent). Each of the next two arguments on making biggest efforts to please and on efficiency is chosen by 19 percent of the people, while 17 percent see strong free-enterprise implications and 12 percent choose the personal relationship factor as strongest.

We find that the argument against a Government plan which carries the greatest weight is that Government medicine would involve too much red tape and political influence. This 42 percent is the highest value placed on any of the arguments. The possibility that freedom in choosing their doctors might be curtailed under a Government plan is indicated by 23 percent as a strong argument against such a plan, and 22 percent feel it likely that doctors would take less personal interest in their patients. The destruction of doctors' ambition and incentives, the threat of socialism, and the lowered quality of medical care are mentioned by fewer people.

But many people see one aspect of a Government plan as a strong argument in its favor: 38 percent think that a Government plan would assure more people medical care than ever had it before. Along much the same line, 23 percent choose the argument that it would assure people in small communities and rural areas of getting care.

This finding suggests, then, that designers of privately sponsored prepayment plans will do well to make adequate provision for inclusion of all groups of the

population in their plans. The other two strong arguments are that it would force people to protect themselves against medical expenses (chosen by 25 percent) and that it would provide medical care at lower cost (23 percent). And although, as was shown earlier, people favor private plans because membership is purely voluntary, they reveal that strong resistance to compulsory membership in a Government plan could not necessarily be counted on. In fact, the argument voted strongest against the private plans is that, many people would not join these plans unless forced to (selected by 30 percent of the people). Private plans will do well not only to seek the approval and full cooperation of most of the doctors but to widely publicize any success they have in this respect, for nearly a fifth (19 percent) of the people now think that many doctors would not cooperate in private plans and consider this the strongest argument against such plans. Another 19 percent select the higher-cost argument as strongest. Other arguments reflecting possible shortcomings of the private plans are the variability of types, the incomplete coverage, and the lack of cooperation of some employers.

Answers to this next question reveal that the vote for social medicine is much greater when the issue is put on the basis of what is good for everybody than when it is put on an issue of what is good for me, as an individual.

You will remember that when people were asked to choose among the three plans for themselves, only 34 percent preferred the Federal Government plan. Yet in answer to this question: "Do you think the Federal Government plan would be a good thing or a bad thing for the Nation as a whole?" 55 percent say it would be a good thing and another 8 percent see at least some possibility of good in it.

Additional evidence of the value of getting information across to the public is afforded by comparing the reactions of the better-informed people with those of other people. People who are acquainted enough with some kind of prepayment plan to know how one goes about joining such a plan are, for the purpose of this survey, considered as the "informed" group.

Note that 78 percent of this informed group prefer paying in advance to paying just when sick, while only 51 percent of the rest of the public make this choice.

You will recall that more people had heard of insurance company prepayment plans than had heard of either a Federal Government or doctor organization sponsored plans and that correspondingly the insurance company plan received the highest preferential vote. When we segregate the informed and uninformed groups we likewise find that a larger proportion of the informed group name the insurance company plans as preferred—46 to 32 percent. The other less-informed group even gives a higher vote to the Government plan.

Note, too, how many more of the informed group feel sure of their choice, 47 percent as against 34 percent of the other people.

Besides trying to reach as many people as possible, the private plans would undoubtedly gain more and stronger adherents by planning eventually to extend benefits to a coverage as comprehensive as is actually feasible.

If a Government plan is offered which includes comprehensive medical care coverage while the alternative plans available under private sponsorship offer only limited benefits, there is reason to expect increased favor for the Government plan.

When asked "If you had no insurance at all, which of these kinds of insurance would you consider it most important to have?" nearly half the people in the country say that life insurance comes first.

Hospitalization insurance and sickness benefits tie for second place with 26 percent of mentions.

Surgical benefits and insurance for general doctor bills are mentioned as most important by only 13 and 14 percent, respectively.

It is noteworthy that as many as 16 percent insist that it is important to have all these types of insurance.

(Here again we find that among people who are acquainted with private plans more prefer private sponsorship than prefer Government sponsorship.)

We learn that in the companies having such plans, on the average, more than a fifth of the employees are unaware of the existence of their company plan.

When asked: "Does the company you work for have any plan other than insurance against accidents that helps the employees meet the cost of doctor or hospital care?" Seventy percent know their company had such a plan, but 22 percent do not know of its existence.

Of those who know of their company's plan, 9 out of every 10 express approval by saying it would be a good idea for more companies to adopt the same plan.

Companies who adopt such plans earn dividends in prestige and employee good will.

Seventy-two percent say "yes"; that the fact their company has such a plan makes it a better company to work for.

Twenty percent say this doesn't have anything to do with how good a company it is to work for.

Eight percent are undecided.

The feeling of security and protection their membership in the plan affords them is the aspect which they value most, and this undoubtedly is what accounts for the high approval accorded these plans by the employees, for only 35 percent have actually received benefits through their membership, and only 9 percent have dependents who have benefited specifically.

You will recall that 46 percent of the informed group of the general public favored the insurance company type plan, while 33 percent preferred the Government plan.

The proportions are practically the same among employees of companies having prepayment plans. The private employer as sponsor is preferred by 47 percent, the Government as sponsor by 32 percent; 9 percent give qualified answers; and 12 percent are undecided.

There is, then, among both the better-informed segment of the general public and the employees of firms having plans, a vote of about 3 to 2 in favor of company plans in preference to the Government plan.

When the employees were asked: "What about the plan is not so good—or in what ways would you say it could be improved?" the most frequently voiced criticism of their own company's plan is that it does not provide total coverage. Note that 7 percent voice a complaint because their plan does not cover the whole family, while only 2 percent think their plan is too expensive; 35 percent say it is satisfactory as is, and 29 percent offer no comment one way or the other.

Now I might ask what do you doctors think of these issues? Only 52 percent of the general public believe they know how you feel about the Government plan; 38 percent think you would be against it and 14 percent think you would be for it. But to a large group, 39 percent, your feelings have not been made known. We have taken a national poll of physicians' opinions in order to find out what could be expected from the profession itself.

Eighty-six percent of the doctors say they are familiar with the Wagner-Murray-Dingell bill. Only 14 percent say they are not familiar with it or at least are not aware enough of its details to claim familiarity.

When asked: "From the standpoint of the general public, do you think passage of this bill or some similar bill would be a good thing or a bad thing?" three out of four doctors say it would be a bad thing, but 23 percent (13 and 10) see at least some good which might accrue to the public.

From the standpoint of the doctors themselves, 76 percent think it would be a bad thing and 21 percent see at least some good in the bill as far as their colleagues are concerned.

These are the reasons the doctors think passage of the bill would be a bad thing from the standpoint of the public and the medical profession:

It would give too much power to politicians.

It would destroy ambition and competition.

It would sacrifice the personal relationship between doctor and patient.

It would mean regimentation or socialization of the profession.

Not Government's field—should keep out—incapable.

It would increase the people's tax burden.

It would limit the patient's choice of doctors.

It would lower the standards of medical care.

It would slow up medical research.

It would mean lower fees to doctors.

Those who say outright the bill would be a good thing gives these reasons:

It would make medical care available to all, regardless of financial status.

Doctors would be more certain of being paid.

Medicine is a public utility; all should benefit.

It would encourage early diagnosis and preventive medicine.

It would provide better equipment and would raise standards.

It would make it easier for people to pay their medical bills.

Doctors would get regular vacations.

The survey of the general public has revealed that the economic phases of medical care are admitted sources of dissatisfaction and worry to sizable groups

of the people. You will recall that: 40 percent of the people say they know of someone who has at some time gone without a doctor's care because he couldn't afford it; 53 percent are willing to admit that they or members of their families have at some time had an experience where paying doctor or hospital bills was a handicap.

Yet this very force which might cause the public to accept Government medical insurance, unless private plans are made more widely available soon, has impressed only a minority of the doctors.

A large proportion of the doctors are still unaware of the public's feeling of need for an easier payment method.

Nearly three doctors out of every eight (37 percent) say that no one in their communities goes without medical care because he can't afford it.

Nearly one doctor in four (23 percent) believes that 5 percent or less of the people in his community fail to get adequate care for this reason.

One doctor in eight (12 percent) says he doesn't know what the situation is—or that he is unable to estimate it.

Only a fourth of the doctors (25 percent) think there are more than 5 percent in their communities who don't get adequate care for financial reasons. (Three percent of the doctors give unclassified answers.)

The majority of doctors agree with the public that there is a need for an easier payment method, but a startling minority do not recognize the need or seem to realize the threat to individual enterprise that it may foster. Almost two-thirds of the doctors (65 percent) say there is need for something to be done, but almost a third (30 percent) flatly state that there is no need for anything to be done about making it easier for people to meet medical-care expenses.

However, many doctors can probably be counted on to back the promotion of voluntary, privately sponsored prepayment plans.

Sizable majorities favor the idea of expanding doctor- and insurance-company-sponsored plans.

Three-fourths of the doctors (76 percent) know of one of more prepayment plans set up by medical societies or groups of individual physicians in various parts of the country, and three doctors out of five (62 percent) who know of such prepayment plans think it would be a good thing if there were more plans of this type.

Nearly 23 percent of the doctors say they are now participating in a medical-society- or doctor-group-sponsored prepayment plan.

More doctors (82 percent) know of companies having prepayment insurance plans for their employees than know of doctor-sponsored plans (76 percent), and favorable reaction among doctors to expansion of the company type of plan runs higher than for expansion of doctor-sponsored plans.

Seventy-seven percent of the doctors who know of companies with plans for their employees think it would be a good thing if practically all business firms in the country had them.

Nearly three-fourths of the doctors (72 percent) say they have had patients whose hospital or doctor bills were paid all or in part through their membership in a prepayment plan.

Since the doctors' favor for the doctor-sponsored and employer insurance plans runs high, it is reasonable to assume that their experience with them has been satisfactory.

As reported above, more doctors are familiar with employer-sponsored insurance plans than are acquainted with physician-group-sponsored plans—and more of them approve expansion of the employer-insurance type plans.

But when doctors are asked which of the three types of prepayment plans they would prefer to see developed in the future, they express most confidence in the professionally sponsored plan.

Fifty-two percent say they would prefer to see more medical-society and physician-group prepayment plans developed.

Thirty-seven percent say they would prefer to see more employer-insurance-company plans developed.

Only 7 percent maintain a preference for a Federal Government plan.

Nine percent say they wouldn't want any prepayment plans developed further, even when the trend in this direction is pointed out to them.

In spite of the fact that physicians, themselves, prefer doctor-sponsored plans ahead of the employer-insurance-company type, their strong adherence to private sponsorship over Government will probably assure their sanction of insurance-company plans, especially when they are advised of the public's preference.

Our opinion surveys of the public, of employees of companies having prepayment plans, and of doctors all over the country have revealed that—

- (1) The people feel there is a need for an easier payment method;
- (2) They favor prepayment plans as a means of answering that need;
- (3) They are undecided at this point whether private or government sponsorship would be better; but
- (4) They are most familiar with private employer sponsored insurance type plans; and
- (5) They tend to favor that type plan over others with which they are less familiar. In particular, employees of companies having prepayment plans favor those plans over Government sponsorship.
- (6) The people feel it is most important to provide themselves first with life insurance and, next, with hospitalization and sickness benefit insurance. Surgical benefits and insurance for other doctor bills are considered of secondary importance.
- (7) The doctors are strongly opposed to the proposals in the Wagner-Murray-Dingell bill, but they are today generally in accord with the idea of prepayment plans sponsored by private organizations.

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[From the January issue, 1946, of the American Magazine]

POLL OF EXPERTS CONDUCTED BY ARTHUR KORNEHAUSER, PH. D., BUREAU OF APPLIED SOCIAL RESEARCH, COLUMBIA UNIVERSITY

#### SHOULD WE HAVE COMPULSORY HEALTH INSURANCE?

American medicine is on the move. Medical discoveries and techniques have raced forward during the war as well as in the period before the war. But only a portion of the public receives the full benefit of the new knowledge. Millions of Americans still don't receive adequate medical care.

How can we bring the best of modern medical service to the great masses of our people? At present it is beyond the pocketbook of a large part of the population. And every American family of even moderate income knows the distress that comes in trying to meet the bills that follow a prolonged and unanticipated illness. There is a growing skepticism that the old methods for handling these problems are good enough.

Even before the war, all sorts of new plans and methods of medical care were springing up. Now the pace has quickened. Bills for vast Governmental programs have been strongly urged upon Congress. State and local medical societies, industries, labor and consumer groups, hospitals and private clinics are all becoming increasingly alert to the pressure for change.

But what change? Should we simply improve our existing arrangements for providing medical service? Should we make it possible for most Americans to join private, voluntary medical *insurance* plans? Or should we go further and put health insurance on a compulsory, nation-wide basis? Should medical care be changed from private to Government supervision in the same way that education was changed from private schools to a *public* school system a century ago?

These are the issues The American Magazine Poll of Experts put to the authorities this month. The experts are men and women who have been studying these problems for years. More than half of them are physicians, some in private practice, others in public health work, in hospitals, universities, industries, and group health systems.

First we sought to find if there is any need for a change. We asked the experts how satisfactory our medical services are at present. Their answers make it clear that, taken as a whole, the country is not too well off medically. Large parts of the population fail to receive medical care that is satisfactory in either amount or quality.

How many people are getting inadequate medical service? The majority of experts placed the figure at 40 percent at least. Some went as high as 80 percent. Some groups, of course, are worse off than others. People in large cities fare better than those in small towns and rural areas. Those with higher incomes get better medical care than those who are poorer. It is pointed out, however, that relief clients receive better care than do poor people generally. In fact, those on relief rolls in big cities are said by most experts to receive better care than working people in the lower middle income range.

In the case of this vast lower middle income group, 4 of every 5 experts say the care received is either "definitely unsatisfactory" or "somewhat unsatisfactory" both in cities and rural areas.

All the experts advocate steps to improve matters. Every reply but one favored some form of health insurance. What they recommend is a plan in which the people would pay a regular amount each month as prepayments of insurance. This would cover all or part of their future medical expenses. The one dissenting expert wanted to go even further and have the Government pay the bills.

These answers indicate how far thinking has moved in recent years away from reliance on the simple old doctor bill and pay-it-if-you-can philosophy.

How far should this insurance go in meeting our medical bills? A number of existing popular health plans cover only hospital expenses. But 5 out of 6 of the experts want the payments to cover both doctor and hospital costs. Even the other one-sixth go beyond hospital service alone. They would include doctors' services of especially high cost, such as surgical costs.

But the agreement of the experts ends when they face the question of the form the health insurance should take. That is, should it be private and voluntary, or public and compulsory? The issue is this: Should the Government set up a health-insurance system which would include all persons, require payments from them, and provide the medical service they require if they want it? Or should it be left to individuals voluntarily to join private health plans as they see it?

In either case it is assumed the Government will continue to take care of the needy, veterans, etc. And it is assumed that even under a compulsory system people who want to and can afford it may still go to doctors outside the system, just as they are free to send their children to private schools instead of using the public schools for which they pay taxes.

With these assumptions, our experts split 3 to 2 on the compulsory versus voluntary argument. That is, 60 percent favored a compulsory system as against 40 percent for voluntary plans. The experts who are physicians divided almost exactly 50-50. The social and economic authorities (those without M. D.'s), on the other hand, favored compulsory insurance 75 to 25 percent.

Here are some of the arguments both sides offered for their stands:

#### FOR A COMPULSORY SYSTEM

It will provide medical care to all at a price they can afford. Voluntary plans fail to reach millions of people of limited means, the very people most in need of improved services.

It is a natural extension of the social-security system to cover the risks of illness.

It is economical and financially sound, since it spreads the costs so widely that it won't be overloaded with people of very low incomes or by those who are poor health risks. Voluntary plans, it is argued, attract too many of the poor risks.

Likewise under a national governmental system costs are spread among the States. It is charged that many States and rural districts simply cannot afford an adequate health plan if it is left up to them.

The quality of service will be more uniformly maintained, since minimum standards will be established and supervised on a nation-wide basis.

The plan will provide an efficient system which combines the care of insured persons with broad tax-supported services and programs for preventing disease. Some experts declare that sound voluntary plans should be dovetailed into the same national program.

#### AGAINST A COMPULSORY SYSTEM

Voluntary methods will do the job. They will provide higher quality service and will encourage medical progress.

A Government health insurance system is one more step toward domination of our national life by the Federal Government. It will "regiment" doctors and patients. It is undemocratic and an "un-American" interference with the rights of individuals.

Government administration will be incompetent, inefficient, bureaucratic. It will be run "politically."

It will stand in the way of sound developments suited to the needs of different localities and interfere with States' rights.

The plan will limit the initiative of doctors, destroy the intimate personal doctor-patient relationship, and in general stifle medical progress and lower the standards of medical care.

It will prevent needed experiments with voluntary plans and with State and local systems aimed at finding the best way to provide high-quality service.

Despite the disagreements about what the Government should do, however, there is conspicuous agreement on certain other ideas about how the plans should be run.

For example, 9 out of 10 experts state flatly that any medical plan should let patients decide for themselves what physician they will go to. These replies answer a common criticism that a Government plan would require you to take whatever doctor is assigned you.

Also, they agree overwhelmingly that health systems should provide actual medical service rather than pay cash to the patient.

Most important, the experts are unanimous (save for one lone "doubter") in favor of group practice among doctors regardless of the specific program adopted. The idea is that modern developments in medicine, specialization, expensive equipment, etc., make it advisable for doctors to cooperate as teams to furnish high-grade, up-to-date service to you, and to do it economically. Many experts believe there is no longer any excuse for several doctors in the same locality carrying on individually and in competition instead of pooling their services.

The experts in this poll include:

A. J. Altmeyer, chairman, Social Security Board, Washington, D. C.; Joseph P. Anderson, executive secretary, American Association of Social Workers, New York, N. Y.; Barbara N. Armstrong, University of California, Berkeley, Calif.; Reginald M. Atwater, executive secretary, American Public Health Assn., New York, N. Y.

A. C. Bachmeyer, director of clinics, University of Chicago, Chicago, Ill.; George Baehr, consulting physician, New York, N. Y.; E. Wight Bakke, Yale University, New Haven, Conn.; Samuel Bradbury, Pennsylvania Hospital, Philadelphia, Pa.; Esther L. Brown, Russell Sage Foundation, New York, N. Y.; J. Douglas Brown, Princeton University, Princeton, N. J.; Robin C. Buerki, Philadelphia, Pa.; Allan M. Butler, Harvard University and Massachusetts General Hospital, Boston, Mass.

Dean A. Clark, medical director, Health Insurance Plan of Greater New York, New York, N. Y.; Nelson H. Cruikshank, American Federation of Labor, Washington, D. C.; J. A. Curran, president, Long Island College of Medicine, Brooklyn, N. Y.; Graham L. Davis, W. K. Kellogg Foundation, Battle Creek, Mich.; Michael M. Davis, chairman, Committee on Research in Medical Economics, New York, N. Y.; N. S. Davis, III, private medical practice and Northwestern Medical School, Chicago, Ill.; Martha M. Eliot, Washington, D. C.; Haven Emerson, Columbia University (and member of New York City Board of Health), New York, N. Y.

I. S. Falk, Social Security Board, Washington, D. C.; Morris Fishbein, editor, the Journal of the American Medical Association, Chicago, Ill.; Homer Folks, New York, N. Y.; William T. Foster, president, Pollack Foundation, Newton, Mass.; S. R. Garfield, medical director, Permanente Foundation Hospital, Oakland, Calif.; Franz Goldmann, Yale University, New Haven, Conn.; Ira Hiscock, Yale University, New Haven, Conn.

Victor Johnson, Chicago, Ill.; T. Duckett Jones, Boston, Mass.; Waldemar Kaempffert, New York Times, New York, N. Y.; Jay C. Ketchum, executive vice president, Michigan Medical Service, Detroit, Mich.; Margaret C. Klem, Social Security Board, Washington, D. C.; Clifford Kuh, Permanente Foundation Hospital, Oakland, Calif.; Roger I. Lee, private medical practice, Boston, Mass.; H. Clifford Loos, Ross-Loos Medical Group, Los Angeles, Calif.

Basil C. MacLean, medical director of Hospital, University of Rochester, Rochester, N. Y.; Frederick D. Mott, chief medical officer, Farm Security Administration, Washington, D. C.; James E. Murray, United States Senator from Montana; H. S. Mustard, New York, N. Y.; M. D. Ogden, medical director, Trinity Hospital, Little Rock, Ark.; Marianna Packard (and Margaret Stein), Northern California Union Health Committee, San Francisco, Calif.; George St. J. Perrott, United States Public Health Service, Washington, D. C.; Louis H. Pink, president, Associated Hospital Service, New York, N. Y.; Kenneth Pohlman, health service specialist, United States Department of Agriculture, Washington, D. C.; Ellen C. Potter, Trenton, N. J.

Louis S. Reed, United States Public Health Service, Washington, D. C.; Kingsley Roberts, Director, Medication Administration Service, New York, N. Y.;

E. I. Robinson, president, National Medical Association, Los Angeles, Calif.; C. Ruus Rorem, director, Hospital Service Plan Commission, Chicago, Ill.; Richard H. Shyrock, University of Pennsylvania, Philadelphia, Pa.; Henry E. Sigerist, Johns Hopkins University, Baltimore, Md.; W. G. Smillie, Cornell Medical College, New York, N. Y.; Bernhard J. Stern, Columbia University, New York, N. Y.; Harvey B. Stone, private medical practice, Baltimore, Md.; E. A. Van Steenwyck, executive director, Associated Hospital Service of Philadelphia, Philadelphia, Pa.; Gertrude Sturges, consultant to American Public Welfare Association, Wakefield, R. I.

Robert F. Wagner, United States Senator from New York; Ray Lyman Wilbur, chancellor, Stanford University, Calif.; John J. Wittmer, medical and personnel director, Consolidated Edison Co., New York, N. Y.; Abel Wolman, Johns Hopkins University, Baltimore, Md.

Mr. DINGELL. A recent poll taken by Governor Dewey's State commission on medical care showed that 86 percent of the people said "yes" to the question:

Do you think everybody who lives in New York State should have insurance which pays doctor and hospital bills?

Fifty-two percent voted for a Government plan as distinguished from a voluntary one.

A poll taken in April 1943 by the National Opinion Research Center showed that 85 percent approved the principle of health insurance.

I also want to quote from a recent statement by the president of Opinion Research Corp. summarizing two public opinion polls which this organization took for the National Physicians Committee.

Here is what these polls showed:

First of all, the evidence is irrefutable that the public strongly desires some easier way of paying for medical care. \* \* \* The public is overwhelmingly optimistic that something could be done to ease the financial strain of medical expenses: seventy-seven percent say, "Yes; something could be done to make it easier for people to pay for doctor and hospital care." Furthermore, this optimism is gaining—eight percent more people today than in 1943 say that something might be done to ease this burden. \* \* \* We find that more than half are willing to admit that they have at some time experienced hardship in meeting medical bills and 40 percent of the people say they are familiar with cases where others have foregone treatment because of financial stringencies.

Last year we reported a strong sentiment for prepayment as a means of easing the financial burden of medical care. The surveys indicate that the market for prepaid medical care is broad. We find an overwhelming majority of the people (64 percent) saying they personally prefer to pay in advance.

#### INADEQUACIES OF VOLUNTARY HEALTH INSURANCE

What is the answer that the American Medical Association has given to the tremendous demand for health insurance that has been steadily growing for over 15 years?

Up until very recently the American Medical Association opposed even voluntary health insurance. Just 6 weeks ago Dr. Fishbein published an article in his propaganda journal in which he praised and defended—

the delaying tactics that have been a feature of the policies adopted by the house of delegates (of the American Medical Association) since 1932.

Mr. Chairman, I consider that statement a callous and inhuman admission. Each year while thousands of persons are suffering and dying from preventable diseases the American Medical Association rejoices in its "delaying tactics."

But finally last year the American Medical Association had to come out flat-footed for voluntary insurance. It finally had to be for some-

thing constructive. One of the types of voluntary insurance it now endorses is the insurance sold by private companies. The administrative costs for this kind of insurance now average about 45 percent of the premiums. I repeat, the administrative costs for this kind of insurance now average about 45 percent of the premiums paid by the insured. Just think of it. Forty-five cents out of every dollar of premiums collected never come back to the beneficiary or his family in health benefits. That is not the extreme example, some individual companies have administrative costs of 60, 70, or 80 percent of premiums collected. This is the tribute which an employee must now pay if he wishes to enjoy the doubtful privilege of voluntarily buying private health insurance.

Irrespective of whether the individual purchases his protection from a private insurance company or through a plan controlled by a State or county medical society, he rarely gets complete medical care. Existing contracts have all the usual ifs, ands, and buts in them. The contracts tell you when, where, and how you must get sick in order to be eligible for the contract benefit. If you get sick when you only need a doctor at home or at his office, such medical care isn't covered by the contract. You have to be sick enough to go to the hospital. There are innumerable exclusions, limitations, deductions, exemptions, of the kind you find in the small print in many health-insurance policies.

Let me illustrate from the voluntary plan we have in my own State of Michigan.

Under the Michigan medical-service plan which is run by the Michigan Medical Society, an employee, his wife, and children pay a flat premium of \$2.25 a month or \$27 a year. A flat premium is unrelated to any ability to pay. For a person earning \$100 a month this is equivalent to 2¼ percent of his wages. For the same protection a \$300-per-month man pays only three-fourths of 1 percent of his wages.

For this payment the family can receive medical care but—only while in a hospital. The plan, therefore, violates a cardinal principle of any good medical-care plan, namely to prevent sickness. Only after you are sick enough to go to a hospital does the voluntary plan afford a person protection. Since more than one-half of all expenditures for medical care are made for nonhospitalized illnesses, this means that on the average, families must still pay 100 percent more out of their own pockets for comprehensive medical care.

The Michigan plan has the additional limitation that the individual physician may make unlimited additional charges—and does—to individuals with incomes over \$2,000 and to families with incomes over \$2,500 a year.

In other words, as an example of what a voluntary plan can do, the Michigan plan offers very little security, if any at all, to the sick person. He does not get complete protection. He never knows ahead of time what complete protection will cost him. He must still pay a large part of his medical-care costs when he gets sick. He must still worry about his medical bills. The private plans are, as a rule, but a cheap imitation of the real thing here and now proposed.

And I want to add parenthetically here, Mr. Chairman, that I would like to put into the record two brief articles which appeared in the Detroit Times, about the Blue Cross running \$800,000 in the red

for 1 year, and another one by the same writer, Ward Schultz, indicating that the rate increase on 1,300,000 Blue Cross subscribers will be increased 35.8 percent, because the Blue Cross system in Michigan cannot stand the strain. It is \$800,000 behind, has \$300,000 surplus, and a number of hospitals have thrown up the plan, and unless the subscribers to the plan submit to this unheralded and unauthorized assessment, the plan will blow up and there will probably be no protection for the people who paid into the plan for health protection.

I want this to be made a part of my remarks, Mr. Chairman.

(The two articles referred to are as follows:)

[From the Detroit Times, Thursday, March 21, 1946]

#### BLUE CROSS RUNS \$800,000 IN RED

(By Ward Schultz)

In the red more than \$800,000 in 1945, the Michigan Hospital Service, operators of the Blue Cross insurance plan, today faced the prospect of either sharply increasing rates to its 1,272,000 subscribers or drastically reducing the coverage of its contracts.

Adding to the seriousness of the problem, some Detroit hospitals are threatening to withdraw from the plan because they claim the current payments do not cover costs.

An effort is understood to have been made at a recent meeting of Blue Cross executives and representatives of the hospitals to agree on a solution.

#### \$800,000 IN RED

That a sharp advance in rates to policyholders would be necessary is indicated by the fact that total earned income amounted to only \$9,095,863 last year, whereas total incurred expenses was \$9,896,088, leaving the Blue Cross plan \$800,224 in the red for the year.

As a result, the excess of assets over liabilities dropped to only \$325,961.

The Michigan Hospital Service statement of operations revealed that in 1945 approximately 15 percent of the organization's income went for operating expenses, which totaled \$1,327,408.

#### \$900,000 FOR SALARIES

Of that amount, \$904,121 was for salaries.

Some of the more important items of expense listed by the group included rentals, \$68,570; supplies, \$30,156; postage, \$51,722; telephone and telegraph, \$26,637, and travel, \$56,429.

In addition, Blue Cross listed approximately \$41,000 as its expenditure for public relations.

No details of the proposed rate changes are available, but a new schedule is understood to have been submitted to the State insurance commissioner for his approval.

[From the Detroit Times, Thursday, March 21, 1946]

#### BLUE CROSS RATE ORDERED RAISED

(By Ward Schultz)

A 35.8-percent rate increase for 1,300,000 subscribers to the Michigan Hospital Service and 144 member hospitals was ordered today by David A. Forbes, State insurance commissioner.

The order was issued, Forbes said, after it was shown that the service, operators of the Blue Cross plan, had suffered a loss of \$800,000 for the year ending January 1.

Vastly increased hospital costs, which rose much faster than contemplated, was the reason cited for the deficit.

## RESERVES VANISHING

On January 1, 1945, the hospital service had a surplus of \$1,100,000, Forbes said, and on January 1 of this year that amount had diminished to \$300,000. Forbes explained that it was his "duty to see that premiums received are adequate to cover costs."

So serious had the situation become that some Detroit hospitals had withdrawn from the plan.

Here are rate of increases for various types of subscribers: For a single person, using ward service, from 80 cents to \$1.12 a month; single person, semi-private room, \$1 to \$1.40; family service (married persons), ward service, \$2 to \$2.60; family service, semiprivate room service, \$2.40 to \$3.10.

Forbes added that the method of payment to hospitals by the service also will be altered but the new plan still is under consideration. At present, the service pays the hospital a flat \$5 a day for ward patients and \$6.50 for semiprivate-room patients.

## NEW RATES AT ONCE

Where this amount was inadequate to cover costs as determined by hospital audits, Blue Cross made an additional payment of \$2 a day. If the amount still was insufficient, the hospital service paid 50 percent of the balance.

The new rates will be placed into effect in the immediate future, it was indicated.

The CHAIRMAN. They may be included.

## THE PLAN IS NOT RADICAL

MR. DINGELL. Is compulsory health insurance such a radical idea, as the A. M. A. and the N. P. C. say it is?

If these charges are true, how is it that such eminent businessmen as Gerard Swope of General Electric Co., David Sarnoff of RCA, and a number of other businessmen, bankers, publishers, and individual doctors and dentists have endorsed compulsory health insurance as—

a thoroughly American plan, consistent with our tradition of using Government to aid the people in doing things for themselves.

The principle of compulsory health insurance is no longer a partisan issue. President Truman has endorsed the idea clearly and unequivocally in his special message to the Congress on a national health program.

I should also like to quote another endorsement of compulsory health insurance:

\* \* \* How many fair-minded employers would now give up industrial accident insurance? The number would be infinitesimal, and so it would be with health insurance once it were firmly established. \* \* \*

\* \* \* The issue has always been—shall it be compulsory as is workmen's compensation insurance and unemployment insurance, or shall it be entirely voluntary? \* \* \* The voluntary approach has obviously not struck at the heart of our problem. \* \* \*

In urging \* \* \* a prepaid health-insurance program, I have advocated that participation in the plan be made compulsory. The compulsion applies, however, only to the contributions that are made by the employer and the employee. It does not compel any one to receive any medical care. It does not compel any doctor to treat any patient. It merely compels those who are entitled to medical care to make contributions to the fund for that purpose. It is in no sense different from workmen's compensation insurance, which requires employers to provide medical care for those in their employ who are injured at their work. The worker is not compelled to accept the service, but it is available to him if he desires it.

The man who said that was Gov. Earl Warren of California—a Republican. I congratulate Governor Warren on his outstanding political insight. He knows that the American people want health insurance. He knows that the bugaboo of compulsory health insurance burst in California and that it will not scare anybody; that voluntary insurance can't solve the problem. He knows that it is good sense to advocate compulsory health insurance.

#### THE PLAN DOES NOT REGIMENT DOCTORS

One charge made by the American Medical Association against the bill is that the Advisory Council is merely "advisory" to the Surgeon General. In other words, the American Medical Association implies that if you put a majority of doctors in control of the Council and make the Council's actions binding on the Surgeon General—why, then they would be in favor of a national health-insurance plan. I want to be frank about this. As one sponsor of this bill I would fight with all the energy in me to prevent passage of a health-insurance bill that put control of the fund under the American Medical Association or any other private organization, however reputable it may be.

The charge that the Advisory Council in the bill is just a puppet Council is ridiculous. Let me show you. Here is what the bill provides:

The Surgeon General is directed to establish a National Advisory Policy Council with which he is required to consult on all important questions of policy and administration. Section 204 (a) provides that members of this Advisory Council would be appointed from panels of names submitted by professional and other organizations concerned with medical services, education, hospitals, etcetra. The Advisory Council must also include representatives of the public.

Section 203 (1) provides that the Surgeon General is required to make a full report to the Congress each year on the administration of the program. Such report must include a record of the consultations with the Advisory Council, recommendations of the Council, and any comments thereon. Such a report assures that all relevant facts, opinions, recommendations, and actions of the Surgeon General and the Advisory Council will be public information and that the Congress has full information upon which to revise or amend the law.

To assure that the Advisory Council will and can meet on its own motion, section 204 (b) provides that the Council shall meet not less frequently than twice a year and whenever at least four members request a meeting. The bill also provides that the Council itself and each of its members shall be provided by the Surgeon General with secretarial, clerical, or other assistants. Finally, the Council itself may establish special advisory, technical, regional, or local committees or commissions, whose membership may include members of the Advisory Council or other persons or both, to advise upon general or special questions, professional and technical subjects, questions concerning administration, problems affecting regions or localities, and related matters.

Throughout the bill, there are special provisions requiring the Surgeon General to consult with the National Advisory Council on particular matters. Thus, section 205 (c) requires that in determining what are specialist or consultant services—for the purpose of higher rates of remuneration to persons rendering such services—the Surgeon General must establish general standards only after consultation with the Advisory Council. Similarly, in connection with including any hospital on the list of participating hospitals, section 206 (b) requires that the Surgeon General makes his finding of facts and decisions on the status of any hospital in accordance with general standards established only after consultation with the Advisory Council. In placing any limitations on benefits under section 210 the Surgeon General must also first consult the Advisory Council.

These provisions assure that there will not be any dictatorship or regimentation under the bill as the National Physicians Committee falsely claims.

I do not wish to take up more of the committee's time enumerating the specific provisions of the bill which protect the doctor, the dentist, the nurse, the hospital, the individual patient and his family, and the Surgeon General. But if this committee can strengthen any of these provisions it will perform a great service. Passage of this bill will be a great step forward in improving the health and adding to the happiness of the American people.

The CHAIRMAN. Thank you, Mr. Dingell.

Senator WAGNER. May I congratulate Congressman Dingell on his very persuasive statement. I wish the people would read it. They would be persuaded.

The CHAIRMAN. The Senator from Florida, Mr. Pepper, wishes to make a statement.

You may proceed.

#### STATEMENT OF HON. CLAUDE PEPPER, A UNITED STATES SENATOR FROM THE STATE OF FLORIDA

Senator PEPPER. Mr. Chairman, I deeply appreciate your invitation to present to the full Committee on Education and Labor the findings of the Health Subcommittee, of which I have the honor to be chairman. These hearings will, I am sure, be a high point along the road to better health for all, along which the American people have been struggling for many years. They are a tribute to your firm leadership, which has been discouraged by neither opposition nor delay. Year after year you have joined forces with that great veteran fighter, Senator Robert Wagner, on his first national health bill. Year after year you have carried to the people your message of better health for all, and you have received sustenance from them. Year after year you have given unsparingly of your time to present to the people the message that better health could be achieved through a national health program. This work has made it possible for us to meet here today to begin hearings on one of the most important measures before the Congress, S. 1606, the Wagner-Murray-Dingell national health bill.

I think we will all agree we are now at a critical point in this fight. President Truman sent his health message requesting Federal legislation for a national health program to the Congress last November.

The people want such a program, as I will show in some detail later in my statement. Farsighted medical and social security experts have shown us the means of achieving it. It is now up to the Congress to adopt it without delay. The situation is urgent and brooks no procrastination.

#### WORK OF SUBCOMMITTEE ON WARTIME HEALTH AND EDUCATION

In July 1943, the Senate took cognizance of the Nation's vast and urgent health needs by passing Senate Joint Resolution 74, which I had the honor to introduce, empowering the formation of a special health subcommittee of the Committee on Education and Labor. The distinguished Senator from Utah, Senator Elbert D. Thomas, then chairman of the committee, appointed me chairman of the subcommittee, which was composed of an able group of Senators, many of whom are present here today. For the last 2½ years we, with the brilliant assistance of a devoted and able staff, have studied the state of the Nation's health. Hearings in the field and in Washington have been held, and reports which have won the attention of the Nation have been issued, on many facets of this great subject. Health conditions in the war industry and extracantonment areas, selective-service data on rejections for physical and mental disabilities, medical research needs, hospital and health center requirements, the health needs of veterans, dental and mental health care, and other subjects too numerous to mention, have been brought objectively to the attention of the Congress and of the people.

Finally, the subcommittee is about to issue a report entitled "Health Insurance," which represents some of our most important research. It summarizes the variety of voluntary health plans devised to meet the problems of medical care and the costs thereof to sections of the American people.

I wish to summarize this report as briefly as possible for the committee, since its contents are so central to the matter under discussion.

It first reviews the major facts originally presented in our interim health report which I submit for the record of the hearings.

Here I would like to offer the full exhibit, Mr. Chairman.

The CHAIRMAN. It may be introduced.

(Exhibit I referred to is as follows:)

#### EXHIBIT 1

#### WARTIME HEALTH AND EDUCATION

Interim report from the Subcommittee on Wartime Health and Education to the Committee on Education and Labor, United States Senate, pursuant to Senate Resolution 74, a resolution authorizing an investigation of the educational and physical fitness of the civilian population as related to national defense

(January 1945)

We have the honor to submit herewith the third interim report of the Subcommittee on Wartime Health and Education.

#### THE 4½ MILLION IV-F'S

The Nation has been deeply impressed by the fact that approximately 4½ million young men in the prime of life have been found unfit for military service because of physical and mental defects. In addition, more than a million men

have been discharged from service because of defects other than those sustained in battle. One and one-half million men now in uniform were rendered fit for service only through medical and dental care given after they were inducted.

In all, it is estimated that at least 40 percent of the 22 million men of military age—between 8 and 9 million men—are unfit for military duty. This is more than twice the number of men we now have overseas engaged in the great offensives that will bring total victory.

The 4½ million men in class IV-F are those who remained unfit for military service after all doubtful cases have been reexamined in terms of the latest revision of Army and Navy physical and mental standards, after induction of those acceptable for rehabilitation in the Army and Navy, and after reclassification of all who by self-rehabilitation or other circumstances had become eligible for military duty. It should be emphasized that these 4½ million men are all rejectable under the lowest possible physical and mental standards, as defined by a special commission of physicians appointed by the President.

Interpretation of the selective service rejection data as an index of national health was challenged at the subcommittee's hearings by representatives of the American Medical Association. They pointed out that the standards of physical fitness demanded for military service are considerably higher than those required for normal civilian activity.

While it is true that many people are afflicted with defects that do not prevent participation in ordinary activities, such defects often reduce initiative and working capacity, and, if neglected, may eventually result in serious illness or disability. Certain minor defects of this kind may not appreciably affect mortality and morbidity rates, or life expectancy tables, and they may offer little of interest to physicians engrossed with more spectacular ills. But the patient with a toothache, or with impaired hearing, is well aware of the distress and limitations imposed upon him by his infirmity. In the aggregate, minor defects constitute a serious drain on our manpower.

Regardless of how the selective service data are interpreted, the widespread existence of illness and defects among our population has been demonstrated by numerous extensive surveys conducted under both governmental and private auspices. The findings of some of these surveys, which also have shown that many of these diseases and defects are preventable or remediable with proper medical care, will be cited later in this report.

#### MEANING OF THE FIGURES

It would be wrong to conclude from the selective service rejection figures that we are a nation of weaklings. Our enemies labored under that delusion, and they are learning their error the hard way. On the other hand, it is evident that we have no reason to be smug or complacent about the state of our people's health. We must ask, "What do these figures mean?" and then, "What must we do about it?"

It is clear that the figures do not reflect discredit on the men themselves. The great majority of them are the victims, not the villains, of the situation. Nor do the figures mean that the rejectees are unfit for participation in the war effort; in most cases they are serving honorably in war production or in some other necessary civilian activity.

The large number of rejections does mean that the manpower problems of the Army and Navy have been much more serious than they would have been had the Nation's health been better. The unavailability of the rejected men means that it was necessary to call into military service hundreds of thousands of other men better fitted for essential civilian tasks and more deeply committed to responsibilities in the society we fight to preserve—men with families, trained mechanics, skilled technicians, and teachers in scientific and technical schools.

If this situation was preventable—and we are profoundly convinced that it was—this Nation has an immediate duty to seek an immediate remedy.

#### REHABILITATION OF REJECTEES

According to officials of the Selective Service System, at least one-sixth of the defects for which men were rejected could be remedied with relative ease, as far as medical science is concerned, to fit them for general military service.

Early in the war, test rehabilitation programs were undertaken by the Selective

Service System, but they yielded meager results and were abandoned. In sharp contrast to the results of the Selective Service efforts are those of the Army rehabilitation program. Here remarkable success has been achieved. Approximately 1½ million men with major defects have been inducted and rendered fit for duty, including 1,000,000 men with major dental defects, more than 250,000 with impaired vision, 100,000 with syphilis, and more than 7,000 with hernia. The success of this program demonstrates what can be done by vigorous and coordinated effort.

The magnitude of the Army's total dental program is apparent from the following figures: During 1942 and 1943, more than 14½ million cases<sup>1</sup> were treated, 31,000,000 fillings were provided, 6,000,000 teeth were replaced, and nearly 1½ million bridges and dentures were supplied. This work required 53,000,000 sittings by patients, and the production of three and one-half times the normal quantity of dental supplies and equipment produced in the United States in any one year.

We are told that registrants will continue to be called into service even after VE-day. Since the only physically fit men available will be the newly registered 18-year-olds, men with dependents, and those in essential occupations, wisdom and fairness demand that as many as possible of the registrants now in the IV-F classification be made fit for service. The subcommittee therefore recommends that the Army continue and, if feasible, expand its rehabilitation program.

Another opportunity for better rehabilitation service is presented by the Barden-La Follette Act (Public Law 113, 78th Cong.). This act recently made Federal funds available to State rehabilitation agencies for medical correction of defects hindering employment. Some IV-F's have already been referred by selective-service boards to State vocational rehabilitation agencies and have had their defects corrected. The immediate possibilities of this mechanism are somewhat limited because initiative is in the hands of the individual States, many of which have not yet developed the medical phase of their rehabilitation programs. Nevertheless, if the opportunities offered by the Barden-La Follette Act program were more widely known and utilized, more substantial progress could be made in the rehabilitation of rejected men.

#### HEALTH OF THE REST OF THE POPULATION

According to the National Health Survey, conducted by the United States Public Health Service in 1935, more than 23,000,000 people in the country had a chronic disease or a physical impairment. In the working-age group (15-64), more than 3,000,000 people had impairments such as deafness, blindness, or orthopedic handicaps, and more than a million were estimated to have hernia.

A Farm Security Administration study of 11,495 individuals in 2,480 farm families residing in 21 typical rural counties in 17 States in 1940 showed that 96 percent of those examined had significant physical defects. The average number of defects per person was 3½. Only 1 person out of each 100 examined was found to be "in prime physical condition."

Among nearly 150,000 young people examined by physicians for the National Youth Administration in 1941, 85 percent needed dental care, 20 percent needed eye refractions, 19 percent needed tonsillectomies, and 12 percent needed special diets. Approximately 1 youth in every 7 was in urgent need of some kind of medical or dental treatment. About one-third of the young people had health defects which limited their employability. Only 10 out of each 100 examined had no defects for which the examiner made a recommendation.

High defect rates are not limited to low-income groups such as those studied by the Farm Security Administration and the National Youth Administration. The Life Extension Institute, in examinations of 300,000 insurance policyholders selected indiscriminately with regard to sex, age, and occupation, found that 59 percent were so physically impaired as to need the services of a physician at the time of examination.

Industrial casualties take a heavy toll. From Pearl Harbor to January 1, 1944, 37,600 American workers were killed on the job—7,500 more than the military dead for the same period. More than 200,000 workers were permanently disabled and 4½ million were temporarily disabled,

<sup>1</sup> The word "cases" as used here does not refer to individuals; an individual may have been recorded more than once as a "case" for separate treatments at the same or different Army posts.

## EFFECT OF ILLNESS ON WAR PRODUCTION

The profound influence of illness and disability on war production is illustrated by figures on work absences due to sickness and accidents. In 1943, the average male industrial worker lost 11.4 days and the average female industrial worker 13.3 days of work due to sickness and injury. By far the greater proportion of this loss—80 percent in the case of men and 90 percent in the case of women—was believed to be due to common ailments. Application of these figures to the number of employed male and female workers in the United States today indicates a loss of more than 600,000,000 man-days annually. This is about 47 times the amount of time lost through strikes and lock-outs of all kinds during 1943.

Intensive investigation and the testimony of many expert witnesses has convinced the subcommittee that a great deal of illness and disability could be avoided if the benefits of modern medical and public health science were made readily available in all sections of the country and to all persons regardless of economic status. In recent years, and especially since the outbreak of war, there has been a great awakening of public interest in all matters pertaining to health. More than 10,000,000 men and women in the armed forces are now receiving the benefits of complete medical and hospital care. The advantages of such care will not be forgotten after the war. Considerable increase in the demand for medical care may therefore be expected in the postwar period, and we should plan immediately to meet this increased demand.

On the basis of the information it has gathered to date, the subcommittee is not prepared to formulate a complete national health program or to make detailed recommendations concerning all the health problems that remain unsolved. In this interim report, however, we shall make preliminary observations regarding certain basic subjects which require further study; we shall also make specific recommendations regarding provision of facilities and services which we believe to be prerequisites to better national health and physical fitness.

## NEED FOR IMPROVED PREVENTIVE SERVICES AND FACILITIES

During the period 1900–1940, the death rate in the United States fell from 17.2 per 1,000 population to 10.8 per 1,000, a reduction of nearly 60 percent. Improvement has been most notable with respect to diseases which respond favorably to better sanitation and immunization procedures. The death rate from typhoid and paratyphoid fevers, for example, was reduced by 97 percent, from diarrhea and enteritis by 92 percent, and from diphtheria by 97 percent.

A major share of the credit for this remarkable progress belongs to the public health agencies of Federal, State, and local governments. The development of the preventive services furnished by these agencies, however, has been very uneven in different sections of the country. As recently as 1935, only 615 of the 3,070 counties in the United States had full-time local public-health agencies. By 1942, under the stimulus of Federal grants made available by the Social Security Act, the number of counties served by such agencies had approximately tripled. Today, however, about 40 percent of the counties of the United States still lack full-time local public-health service. Many of the existing health departments are inadequately financed and staffed. Minimum preventive services under the administration of full-time local public health departments staffed with qualified personnel should be provided in every community. To accomplish this, additional Federal financial aid would probably be necessary. If new and consolidated areas of local health administration were established, however, as suggested by the American Public Health Association, the total funds needed probably would not exceed greatly the present total of health department expenditures.

Complete geographic coverage by full-time local health departments would not be sufficient in itself, however, to enable us to take full advantage of the possibilities for further advances in the control of venereal infections, tuberculosis, malaria, and other preventable diseases. Funds are needed for expansion of health-department activities in these fields and many others, such as food and milk sanitation, industrial hygiene, maternal and child health, and health education.

## WATER SUPPLIES, SEWERAGE, AND RURAL SANITATION

The progress made in the control of filth- and water-borne diseases should not blind us to the fact that many communities lack adequate sanitary installations and that rural sanitation in many parts of the country is at a deplorably low level. According to the United States Public Health Service, nearly 5,000 communities need new water systems and approximately 6,500 need water extensions or improvements. New sewerage systems are needed in about 7,700 communities with a combined population of nearly 9,000,000. More than 10,000,000 additional people live in communities where sewer extensions are needed. There are more than 2,800 incorporated communities, with a total population exceeding 25,000,000, that do not have any form of sewage treatment. Approximately 5,250,000 rural homes need new or improved water supplies, and 5,000,000 need sanitary privies. More than 846,000 rural homes do not have so much as an outdoor privy.

The importance of milk as a vehicle for transmission of disease is universally recognized. Although pasteurization can and does prevent the transmission of milk-borne disease, most of the milk used in smaller communities is still consumed raw. Pasteurization plants should be constructed in more than 400 small communities with an aggregate population of about 1,666,000.

In many instances, community facilities such as those mentioned above could be financed on a self-liquidating basis by local governments with the aid of technical assistance and long-term, low-interest loans from State and Federal Governments. In other cases, grants-in-aid would be needed to supplement local resources. Such loans and grants would pay high returns in better health for all the people and in civic improvement throughout the Nation. Moreover, the required projects would give substantial stimulus to industry and would help provide full employment after the war.

## IMPORTANCE OF CHILD HEALTH

Most of the witnesses who testified before the subcommittee emphasized the necessity of correcting physical defects early in the life of the child. The importance of this is illustrated clearly by a study conducted by the United States Public Health Service in Hagerstown, Md. The health of the school children in Hagerstown has been observed over a period of years, and careful records of the findings have been kept. Recently, the selective service medical records of the Hagerstown registrants were compared with the school health records obtained by examination of the same individuals during their childhood. The comparison showed that many of the defects for which registrants were rejected had been discovered as much as 15 years earlier while the registrants were students in high school and grade school, and that in the years intervening between the school health examination and the selective-service examination many of the defects remained uncorrected and unimproved. Seventy percent of those rated poor in nutritional status were rejected 15 years later.

The Hagerstown story is a familiar one to many physicians who freely give their time and energy in annual examination of school children. Every physician who conducts such examinations knows the discouraging experience of seeing his recommendations for the correction of physical defects go unheeded. In many children the same defects are noted year after year, and nothing is done about them. Obviously, more effective methods of following up the doctors' recommendations are needed. A prerequisite to the achievement of better results is the removal of financial barriers to fulfillment of such recommendations. The opportunities for supervision and promotion of children's health in the school are so great that no effort should be spared to develop methods by which present neglect can be overcome. The Nation's and the Government's rightful concern in this matter is demonstrated by the unfitness of millions of young men in a time of national crisis, and the subcommittee plans to investigate the subject further.

## MENTAL HYGIENE

The high rejection and discharge rates for so-called neuropsychiatric causes have focused Nation-wide attention on the prevalence of mental disorders and maladjustments. This subject will be dealt with in a separate report on the health needs of veterans. We wish to emphasize here only the following points:

There is no cause for special alarm at this time about the number of neuropsychiatric discharges. A high rate of rejection and discharge for neuropsychiatric causes could have been predicted. It has long been known that a large

proportion of the illness encountered in general medical practice is essentially neuropsychiatric in origin and that half of the patients in hospitals at any one time are there because of serious mental disorders. Indeed, one may safely predict that in any group of 15-year-olds 1 out of 22 will some day be a patient in a mental institution. It is not surprising, therefore, that the Army and Navy have had to reject and discharge large numbers of men as unfit to cope with the unusual stresses and strains of military life.

The neuropsychiatric causes for rejection and discharge include various degrees of nervousness, emotional instability, personality disorders, and inadequacies. The great majority of men with these difficulties can adjust themselves satisfactorily to civilian life in the home, on the job, and in the community. As indicated by a recent study of the New York Committee on Mental Hygiene, however, many of the men will need professional psychiatric services to help them make the adjustment. At present, psychiatric clinics are altogether inadequate to meet the needs of the returning men, and considerable expansion of such clinical services should be undertaken, primarily as a preventive measure to guard against the aggravation of disorders which are now relatively minor. The acute shortage of trained psychiatric personnel makes it imperative that such expansion be accomplished within the framework of general community medical services rather than as a separate program for care of veterans. There are only 3,000 qualified psychiatrists in the country—too few to permit separate mental hygiene services for different segments of the population. Medical schools could help by arranging their curricula so that the general medical practitioner, who must see most of the patients with psychoneuroses, would have a better knowledge of psychiatric problems and techniques.

From a longer range point of view, the establishment of child-guidance clinics in all communities is urgently needed to prevent early social maladjustments. Such a step would pay tremendous dividends in decreased crime, delinquency, and costs of institutionalizing the mentally ill.

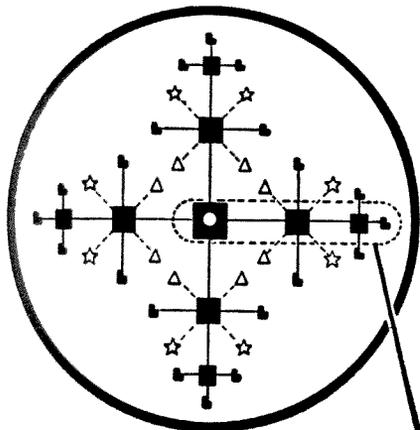
Finally, attention must be drawn to a factor which is beyond the control of medical science. Many expert witnesses emphasize that full employment and adequate social security are indispensable to a truly effective health program. This is especially so in regard to mental health. There is nothing so detrimental to a person's morale and self-confidence as idleness and the feeling that he has no useful place in the scheme of things. It may be too much to say that idleness causes mental or physical disease, but it provides fertile ground for development of fears, anxieties, and a sense of insecurity. These factors are known to have a profound effect on man's resistance to disease.

#### MENTAL EDUCATION

Certainly, from the point of view of future needs, there should be no reduction in the present output of trained medical personnel. According to the American Medical Association, curtailment of this output is threatened. Because of the urgent need of the armed forces for young men, the Selective Service System has deemed it impractical to continue occupational deferment of premedical and pre dental students. For the same reason, the Army Specialized Training Program for premedical and pre dental students has been drastically curtailed. By 1946 medical schools will have to depend upon civilian enrollments for 93 percent of their incoming students. The American Medical Association estimates that enrollment of medical students may fall as much as 50 percent beginning with the class entering in 1945. If this proves to be the case, there will be only 2,500 medical graduates in 1948, about half the usual number, and about 1,000 less than the number of physicians who die annually. The chairman of the executive council of the American Association of Medical Colleges states that not all schools got a full quota of students in 1944, and he predicts that many schools will have marked decreases in their 1945 entering classes. All expert opinion, however, is not so pessimistic. The former chairman of the executive council of the Association of American Medical Colleges has informed the subcommittee that medical-school administrators are not alarmed about the situation. Further study of the facts is apparently necessary.

If there is actually a threatened shortage, it would seem that there must be in the United States the few thousand persons of the age, caliber, and training needed to raise annual premedical and medical school enrollments to the number required for the duration of the war emergency. It is true that an increased effort would have to be made to find students. Many war veterans and young men rejected for military service because of physical defects do not know of the great

# COORDINATED HOSPITAL SERVICE PLAN

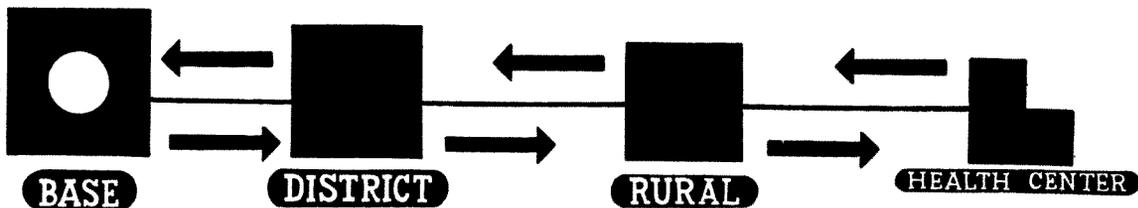


HOSPITAL  
SERVICE  
AREA

- HOSPITAL
- HEALTH CENTER
- ☆ INSTITUTION (CHRONIC DISEASE)
- △ NURSING HOME (CHRONIC DISEASE)

## Teaching Research Consultation

CANCER CLINIC  
PSYCHIATRIC SERVICE  
HEART CLINIC  
MAJOR SURGERY  
INTERNAL MEDICINE  
OBSTETRICS  
PEDIATRICS  
ORTHOPEDIC SURGERY  
COMMUNICABLE DISEASES  
TUBERCULOSIS  
VENEREAL DISEASE  
OTHER  
TEACHING  
NURSES  
INTERNS  
RESIDENTS  
POST GRADUATES  
LABORATORY  
X-RAY  
PATHOLOGY  
BACTERIOLOGY  
CHEMICAL  
PHYSIOTHERAPY  
DENTISTRY  
EYE EAR, NOSE, THROAT  
DIETETICS



**BASE**

**DISTRICT**

**RURAL**

**HEALTH CENTER**

MAJOR SURGERY  
OBSTETRICS  
INTERNAL MEDICINE  
COMMUNICABLE DISEASES  
TUBERCULOSIS  
VENEREAL DISEASE  
OTHER  
PEDIATRICS  
EYE, EAR, NOSE, THROAT  
DENTISTRY  
PHYSIOTHERAPY  
LABORATORY  
X-RAY  
PATHOLOGY  
BACTERIOLOGY  
CHEMICAL  
TEACHING  
NURSES  
INTERNS  
DIETETICS

INTERNAL MEDICINE  
OBSTETRICS  
EYE, EAR, NOSE, THROAT  
DENTISTRY  
MINOR SURGERY  
LABORATORY  
X-RAY  
BACTERIOLOGY

OBSTETRICS  
EMERGENCY MEDICAL  
AND SURGERY  
LABORATORY  
X-RAY  
BACTERIOLOGY  
DENTISTRY  
PRIVATE OFFICE OR  
OFFICES FOR PRIVATE  
PHYSICIANS  
ADMINISTRATIVE PUBLIC  
HEALTH OFFICES  
HEALTH OFFICER  
SANITARIAN  
PUBLIC HEALTH NURSES  
PUBLIC HEALTH CLINICS  
MATERNAL AND CHILD  
HEALTH  
TUBERCULOSIS  
VENEREAL DISEASE  
PUBLIC HEALTH  
EDUCATION

PLAN PROVIDES FOR CONSTANT EXCHANGE BETWEEN  
PERSONNEL OF INFORMATION TRAINING AND CON-  
SULTATION SERVICE, AND PERSONNEL, AND FOR  
REFERRAL OF PATIENTS, WHEN INDICATED



need for doctors or of the opportunities present in the study of medicine. Moreover, certain barriers and prejudices which limit enrollments could be removed. The financial barriers which face many prospective students could be overcome by more adequate scholarships or by loan funds. Some qualified students cannot gain admission to medical schools because of tacit racial or religious discrimination. Lastly, there is a great untapped source of future doctors among the women of the Nation. We are unable to discover any compelling reason for the failure of this country to utilize its womanpower to prevent what is claimed to be a serious future shortage of physicians. Other nations have done so; we have simply never tried.

#### TRAINING FOR DEMOBILIZED PHYSICIANS

The quality of medical education in this country for the past two decades has been very high. The medical schools have rendered outstanding service in the war by increasing the annual output of physicians 30 percent despite serious depletion of faculties and unpredictable Army and Navy policies. But the accelerated undergraduate courses, and the shortened internships and residencies, will make it necessary to provide further supervised training for many recent graduates unless the future quality of medical and dental practice is to be jeopardized. Most of the young graduates are well aware of this. A majority of the replies to a questionnaire recently addressed to medical officers of the Army and Navy indicated a desire for refresher and advanced courses in medicine after the war. Neither the need nor the demand for postwar advanced medical training can be met with the graduate teaching facilities and staffs now available in medical schools. Expansion of such facilities through increased provision of teaching hospitals and medical centers, as part of the program hereinafter described and recommended, will therefore be required.

Many thousands of physician veterans will receive post-graduate training at Government expense under the terms of the G. I. Bill of Rights. Additional financial assistance will be necessary for many of those eligible if they are to avail themselves of training opportunities offered. For example, it is unlikely that a doctor with a wife and two children could maintain himself very long on \$75 a month.

#### DISTRIBUTION OF MEDICAL FACILITIES

The quality of American medicine at its best is very high. Unfortunately, American medicine at its best reaches only a relatively small part of the population. One of the greatest benefits of modern, scientific medicine is the early detection of conditions which, if neglected, may become seriously incapacitating or even fatal. Vast improvement is needed in the application of known diagnostic procedures. Only a negligible proportion of people get a periodic physical check-up. Fifty-five percent of all cases of tuberculosis admitted to sanatoria are in advanced stage of the disease at the time of first admission. In mass chest X-ray studies of presumably healthy workers, at least one in every hundred is found to have significant tuberculosis. Many patients have cancer for months, or even years, before the disease is discovered, and a substantial number of cases remain undiagnosed until cancer has caused death. There is widespread neglect of prenatal care by which both maternal and infant death rates could be considerably reduced.

The reasons for the failure of medicine to apply more widely the known diagnostic and preventive techniques are many and complex. The economic barriers to care are discussed later. Another very important reason is the lack of physical facilities and equipment in many parts of the country. Good medical practice today requires a concentration of skilled personnel and equipment that is found only in good hospitals, medical centers, or group clinics.

Whereas the national ratio of general hospital beds was 3.4 per 1,000 population in the years just before the war, the ratios in such States as Mississippi and Alabama were less than half that. According to the Surgeon General of the United States Public Health Service, 40 percent of our counties, with an aggregate population of more than 15,000,000, have no registered hospitals. Many of the counties with hospitals have poor ones, even though they are registered.

A study conducted by the American Medical Association showed that only 2 percent of the population did not reside within 30 miles of some hospital. Such a study, however, does not indicate the size or quality of the institutions, whether or not they have vacant beds, whether or not patients are financially able to use them, or whether racial barriers or legal requirements concerning residence prevent their utilization by all who live in the vicinity.

## DISTRIBUTION OF PHYSICIANS

Shortages of doctors, dentists, nurses, and other medical personnel are marked in many communities, and, in general, medical personnel are inequably distributed throughout the country. For example, in 1944 Massachusetts had about 3 times as many active physicians in proportion to population as did South Carolina. Similar disproportions exist between other States and between local areas within the same State. Counties with more than 5,000 population may be without a single physician, while other counties in the same State may have 1 active physician for each 1,000 people.

Extensive studies conducted by the United States Public Health Service show that the distribution of physicians is influenced by several interrelated factors, among which are community purchasing power, adequacy of hospital facilities, degree of urbanization, proximity to medical schools and teaching hospitals, and presence of professional colleagues. Of these factors, the first three are probably the most significant, and community wealth is probably the most important of all. In 1938, counties with per capita income of more than \$600 had eight times as great a proportion of physicians to population as did counties with per capita income of less than \$100.

Rural areas are generally less well supplied with physicians than urban areas. Strictly rural counties in 1938 had only about one-third as many physicians in proportion to population as did urban counties. Recent data supplied by the Procurement and Assignment Service show that the 81 counties reported to have no active physician, as well as the 141 counties reported to have more than 5,000 inhabitants per active physician, were practically all rural. The wealthier rural areas are better supplied than are the poorer rural areas, but even the wealthiest group of rural counties in 1938 had 30 percent fewer physicians in proportion to population than urban areas with the same per capita income.

The shortage of physicians in rural communities is not due to less need for medical care than in cities. Studies made by the Farm Security Administration suggest that the burden of illness in rural areas is the same as, or greater than, in urban centers.

## SITUATION GROWS STEADILY WORSE IN RURAL AREAS

Despite this need, medical graduates have shown increasing reluctance in recent decades to settle in rural communities. In North Carolina, for example, the number of doctors in strictly rural areas fell from 1,125 in 1914 to 719 in 1940, although the population in such areas increased from 1,960,000 to 2,597,000 in the same period. In 1940, 73 percent of the population of the State lived in rural areas, although such areas contained only 31 percent of the State's physicians. The burden of caring for rural patients falls increasingly on the old practitioners who, despite sometimes heroic efforts, are frequently unable to do the work demanded of them.

There is no doubt that lack of hospitals and diagnostic facilities is one of the most important factors in keeping doctors away from rural practice. In fact, the presence of hospital facilities alone, independently of such factors as community wealth and size of population, appears to attract physicians. This is suggested by a United States Public Health Service study which shows that among counties with per capita income of less than \$300, those with no general hospital beds had 60 percent fewer doctors in proportion to population than did those with 250 or more general hospital beds.

Many crowded war-industry and extra-cantonment communities are also suffering from a severe shortage of doctors. In some places shortages have been relieved by relocation of physicians through the Procurement and Assignment Service of the War Manpower Commission, but in others the situation remains critical and without hope of relief except through assignment of Public Health Service physicians, a proposal which Congress has rejected. Data submitted by the Procurement and Assignment Service show that at the end of 1943, 553 counties had more than 3,000, 141 counties had more than 5,000, and 20 counties had more than 10,000 people per active physician in private practice. In addition, 81 counties, 30 of which had populations of more than 3,000, had no practicing physician.

The wartime shortages are merely sharper manifestations of the long-standing and steadily growing maldistribution described above. There is every indication that maldistribution will become even more marked after the war unless effective steps are taken to reverse the trend. As the older physicians who remain

in rural communities die or retire the situation becomes increasingly critical. Polls of the opinions of young Army and Navy doctors show that the vast majority want specialist training and practice, preferably with a group. Only 12½ percent indicated a desire for rural practice. We may therefore expect the younger doctors and dentists to continue to shun the countryside unless they are offered good professional surroundings, including modern hospital facilities and an opportunity to earn a good living. Without such positive incentives the opportunity for better distribution presented by release of medical personnel from the armed services will be lost. More uniform licensure laws are also needed.

#### THE MEDICAL CENTER IDEA

Hospitals were formerly considered only as places in which to care for the seriously ill, and even today many hospitals are nothing more than that. Modern programs of hospital construction should have as their aim the ample provision of a more inclusive type of hospital service. The subcommittee has studied with interest the growing trend toward utilization of a relatively new type of facility called a medical center, which combines and coordinates the three major aspects of modern medical care—the preventive, the diagnostic, and the therapeutic services. The medical center brings together doctors' offices, diagnostic and laboratory equipment, hospital beds, and preventive work. It furthers group practice by physicians, surgeons, and dentists; encourages experimentation and research; and stimulates dissemination and exchange of medical knowledge.

This principle of combining the preventive, diagnostic, and curative services of medicine into a single functional unit, here called the medical center, has been advantageously applied on a large scale in certain great university centers and in the Mayo, Lahey, Crile, Ross-Loos, Scott-White, and other group clinics. It is also applicable, however, to the smaller-scale needs of rural communities throughout the Nation. The establishment of a network of "outpost clinics," to use the phrase of a representative of the American Medical Association, the creation of "diagnostic centers," as urged by the Surgeon General of the Navy, and the "expansion of the present functions of the hospital," advocated by the spokesman of the American Hospital Association, appear to be expressions of the same basic aim—the provision of facilities suited to the practice of modern, scientific medicine.

#### PLANNED NETWORK OF FACILITIES URGED

Terminology in this field is far from uniform. The Surgeon General of the United States Public Health Service urged development of a coordinated network of four basic types of medical center facilities—the small neighborhood or community "health center," the "rural hospital," the "district hospital," and the large "base hospital." (See cut facing p. 92.)

The physical structures required for many of these four basic types of units already exist in many areas. Here the primary need is for regional planning and organization of the existing facilities so that they might function in a coordinated manner, rather than for the construction of new buildings. In some places, minor alterations, renovations, or addition of new wings, might suffice to convert existing public or voluntary institutions into units of the coordinated regional plan.

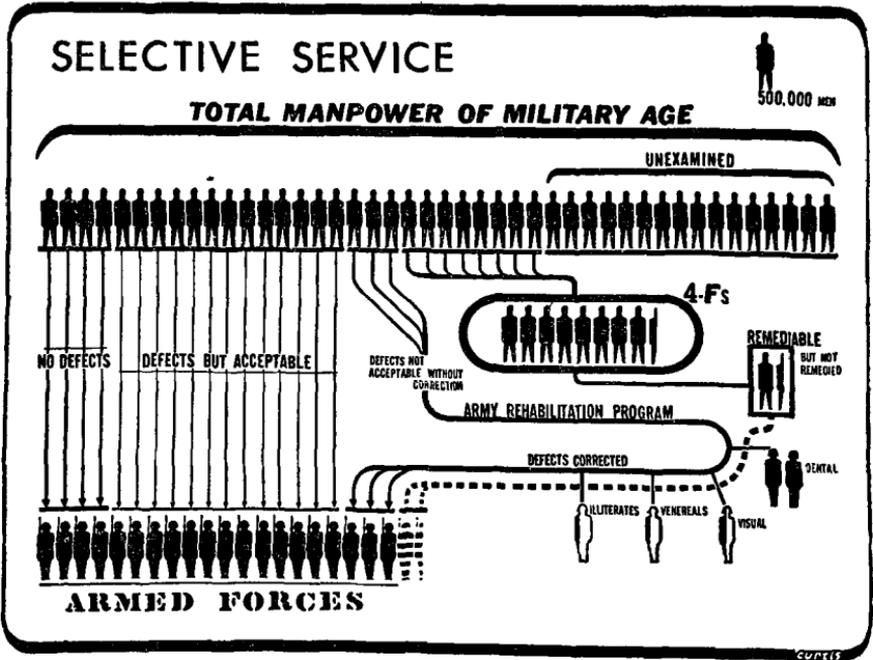
The smallest unit, the health center, might include offices for local physicians and dentists; facilities for emergency medical and surgical work; a small number of beds for obstetrical care; laboratory facilities for X-ray, blood, and bacteriological procedures; and health department offices and clinics where these are not otherwise provided.

The rural hospital, located within easy reach of several health centers, would be larger than the health center and would provide additional basic medical, surgical, obstetrical, and laboratory services. The size of the rural hospital would depend upon the needs of the area it served, but it should be a modern hospital in every sense of the word.

Many of the health centers and rural hospitals probably would serve areas which could not support specialists' services of their own. Therefore, such services would be provided through district hospitals, located so that they could conveniently serve several rural hospitals. Local needs and preferences might determine whether the patients from the rural areas were transported to the district hospitals or whether the specialists from these hospitals visited the small units periodically. In most instances the district hospitals would provide nurse training and instruction for interns, including discussion of complex cases and of medical advances.

BASE HOSPITALS

Finally, as the hub of each major medical service area, there would be a large base hospital. In most cases the major service area would be a State, though some States might have more than one major service area, and in some instances a base hospital might serve two States or sections of two States. The base hospital would be a teaching hospital, staffed with experts in every medical and surgical specialty, equipped for complete diagnostic services, and designed to conduct extensive postgraduate work and research. Besides its general hospital beds, it would have, either on its premises or nearby, facilities for institutional care and study of tuberculosis, nervous and mental disease, contagious disease, and orthopedic and chronic disease. The benefits of the research carried on in the base hospital would be passed on to the smaller units in the network, and there would be constant back-and-forth referral of patients and diagnostic information, as well as interchange of personnel, between the large center and the smaller institutions.



With such graded networks—the health center, the rural hospital, the district hospital, and the base hospital—covering the entire country, facilities would be available through which every person, regardless of where he lived, might receive (a) immediate diagnosis and care for the common, relatively simple ailments and (b) easy access when necessary to the more complicated types of medical service.

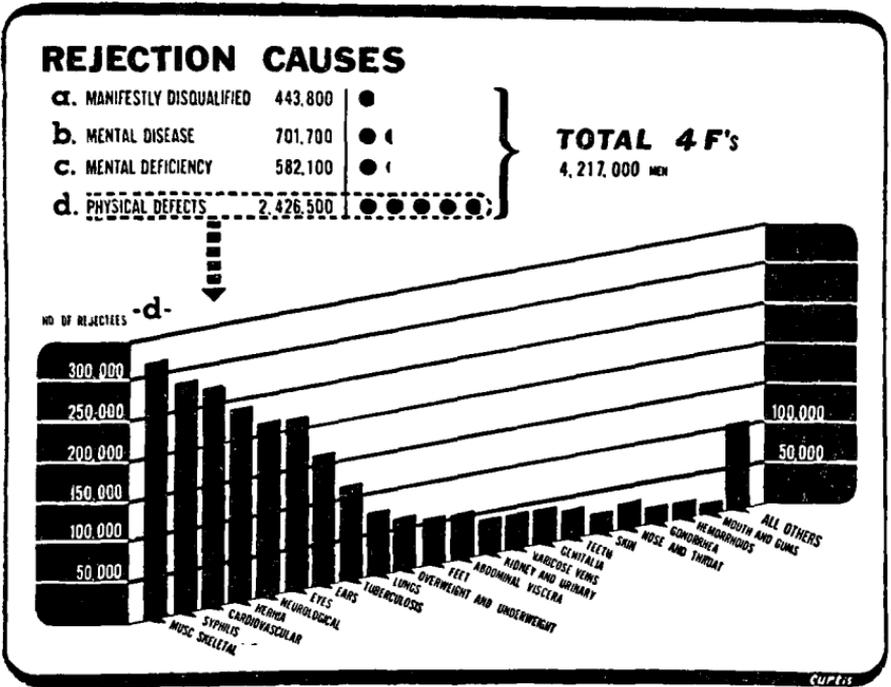
The development of such a network of medical centers would constitute a great step toward the goal of providing a high quality of medical service everywhere in the Nation. It would enable communities to cope much more adequately with the medical needs of war veterans and their families. It would also create opportunities for group and individual practice for the 40,000 medical and dental officers who will return from the armed forces, as well as for returning nurses and other health personnel.

HEALTH DEPARTMENT CENTERS

Local health departments should be moved from the musty basements of county courthouses and city halls to modern, well-equipped buildings where the health officer and his staff could efficiently carry on their very important activities.

The American Public Health Association has proposed the creation of approximately 1,200 public health districts of roughly 50,000 population each, with at least one district health center and one subcenter in each district. These health department centers could in many instances be included in the medical center type of facility described above.

With improved facilities the health departments could undertake expanded public health programs designed to eradicate venereal disease, tuberculosis, malaria, and hookworm; to lower maternal and infant mortality; and to promote health through education. Cooperation would be fostered between the health department and local private practitioners, and both would benefit by a more comprehensive approach to the health problems of the people.



ACHIEVING A HEALTH FACILITIES PROGRAM

According to conservative estimates made by the United States Public Health Service, facilities are needed for 100,000 new general hospital beds, 94,000 new nervous and mental hospital beds, and 44,000 tuberculosis beds. In addition, 66,000 general beds, 97,000 nervous and mental disease beds, and 16,000 tuberculosis beds are situated in hospitals that are obsolete and that should be replaced. Approximately 2,400 modern structures are needed to serve as headquarters for local health departments. No estimates of need for chronic disease hospitals or mental hygiene clinics were given.

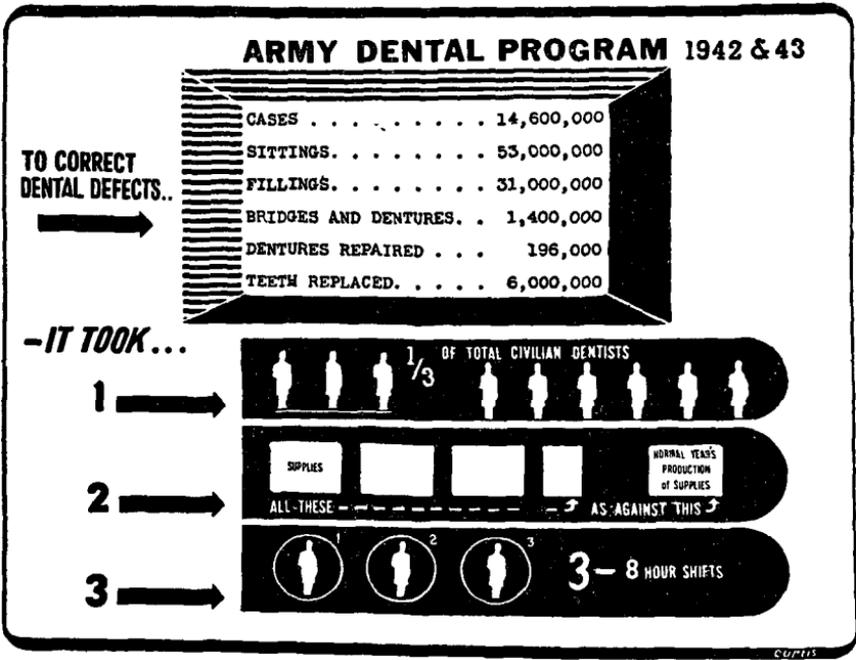
A program for construction of these facilities would have to be well-planned and well-coordinated, in order to avoid the mistakes which characterized the construction boom following World War I. Areas which need hospitals most should be given priorities for building materials and surplus medical supplies. The hospitals should not only be planned and built along modern, functional lines, but should be staffed and maintained so as to assure a high level of operating efficiency. Voluntary and public hospitals should work together in a coordinated manner. Both, in turn, should cooperate with the health department and private practitioners.

The cost of an adequate health-facilities program cannot be borne by the States and localities alone. Federal grants-in-aid to the States on a basis of need will be necessary.

In order to permit local initiative and control, State programs should be drawn up by State health planning commissions in cooperation with local au-

thorities. Such commissions, consisting of representatives of professional groups and the public, could be appointed by Governors in States where they do not now exist. In drawing up State plans the commissions should consider the needs of all sections of the State, should include in the plan all suitable existing public and voluntary hospitals, and should plot the new construction as well as the expansion or replacement of existing facilities needed for adequate service. Before Federal funds could be granted, however, over-all State plans and individual projects should be reviewed and approved by the United States Public Health Service to make sure that they meet certain minimum standards of construction, operation, and complete, coordinated service. There should be reasonable assurance that a new facility will have enough patients to justify its existence. In communities where sufficient income from fees or individual patients does not otherwise appear probable, provision for group pre-payment plans or tax-supported services, or both, should be required.

Grants to both public and voluntary institutions included in the plan would be administered through a State agency, in most cases the State health department. To insure continued representation of the public, health advisory councils should be appointed to confer with the State agency administering the plan.



PAYMENT FOR MEDICAL CARE

Much has been said and written about the financial barriers to good medical care. There is general agreement that good medical care is necessarily expensive; that the burden of illness is unprecipitable and falls unevenly, striking one family much harder than another; that sickness comes unexpectedly and may wipe out the laboriously acquired savings of an entire family; and that for these reasons and others a considerable part of the population does not receive either the amount or the quality of medical care it needs and should have.

In 1942 there were approximately 33.4 million family units in the United States. The following table shows their income distribution and the amounts they spent for medical care; also shown are the income distribution and the amounts spent for medical care by the 41.2 million "spending units," including individual consumers as well as family units:

*Income and medical care expenditures of 33½ million families and of 41 million spending units,<sup>1</sup> 1942*

Aggregate money income during 1942	Approximate number of families in each income group	Approximate number of spending units <sup>2</sup> in each income group	Percentage of total families	Percentage of total spending units	Average amount spent for medical care <sup>3</sup>		Proportion of total income spent for medical care	
					Families	Spending units	Families	Spending units
Less than \$1,000....	6,900,000	10,100,000	21	24	\$42	\$35	Percent 6.8	Percent 6.1
\$1,000 to \$2,000....	9,800,000	12,600,000	29	31	68	62	4.5	4.3
\$2,000 to \$3,000....	6,800,000	7,900,000	20	19	96	94	3.9	3.9
\$3,000 to \$5,000....	6,700,000	7,300,000	20	18	143	141	3.7	3.7
More than \$5,000....	3,200,000	3,300,000	10	8	241	241	2.4	2.6
Total.....	33,400,000	41,200,000	100	100	100	90	3.6	3.5

<sup>1</sup> Based on data from Civilian Spending and Saving, 1941 and 1942, Division of Research, Consumer Income and Demand Branch, Office of Price Administration (Mar. 1, 1943).

<sup>2</sup> The term "spending unit" includes individual consumers as well as families.

<sup>3</sup> Includes medical, surgical, hospital, dental, and nursing service.

The table indicates that even in the relatively prosperous year of 1942, 70 percent of the families in the United States had incomes of \$3,000 or less and 50 percent had \$2,000 or less. The average family expenditure for medical care was estimated at \$100, but families with incomes under \$3,000 spend considerably less than this. Nevertheless, the low-income families spent a larger proportion of their income for medical care than the higher-income families.

#### CARE RECEIVED VARIES WITH INCOME

Other studies, particularly those of the Committee on the Costs of Medical Care, show that low-income families not only spend less for medical care but also receive much less care than those with higher incomes. The highest income group in 1929 received more than twice as much physician's care and more than three times as much dental care as did the lowest income group. Yet it is the low-income group that needs the most medical care. Sickness and poverty go together. In 1935 wage earners in families with incomes under \$1,000 per year suffered about twice as many days of disabling illness as did workers in families with incomes over \$3,000, according to the National Health Survey. Facts do not support the observation that "the poor and the rich receive the best of medical care; only the middle class suffers." High-quality care on a charity or low-cost basis is available to the poor in relatively few places. Even in those places, low-income families are often reluctant to accept charity.

In 1933 the Committee on the Costs of Medical Care estimated that adequate medical and dental care, with proper remuneration for those furnishing the service, could be provided at an average annual cost of about \$125 per family under conditions of group practice. Since this estimate was made, prices of medical goods and services have risen so that the figure would probably be about \$150 if it were brought up to date. Other authorities, basing their calculations on ordinary fee-for-service schedules, have placed the average cost of providing adequate services at a much higher figure. It is evident from studies of family budgets that the 50 percent of our families with incomes under \$2,000 cannot afford to pay \$150 a year for medical care and that this amount imposes hardship upon many families in the \$2,000 to \$3,000 income group. The result is that doctors' bills pile up and many people will not call a doctor until they are seriously ill.

#### FEE-FOR-SERVICE VERSUS INSURANCE

Evidence such as this leads the subcommittee to conclude that the "pay-as-you-go" or fee-for-service system, which is now the predominant method of payment for medical service, is not well suited to the needs of most people or to the widest possible distribution of high-quality medical care. It tends to keep people away from the doctor until illness has reached a stage where treatment is likely to be prolonged and medical bills large. It deters patients from seeking services which are sometimes essential, such as specialist care, laboratory and X-ray examinations, and hospitalization. Individuals with low in-

comes, whose need is greatest, are most likely to postpone or forego diagnosis and treatment.

The solution of this problem will not be easy. Undoubtedly it lies in some form of group financing which would make it possible to share the risks and distribute the costs more evenly. This might be achieved by voluntary or compulsory health insurance, by use of general tax funds, or by a combination of these methods. Insurance methods alone would not be enough, because they are not applicable to the unemployed or to those in the lowest income groups.

In order to meet the requirements of the public and of the professional groups concerned, any method which is evolved should offer complete medical care, should be reasonable but not "cut rate" in cost, should include substantially all of the people, should afford the highest quality of care, should permit free choice of physician or group of physicians, should allow democratic participation in policy making by consumers and producers of the service, should be adaptable to local conditions and needs, and should provide for continuous experimentation and improvement. Insofar as possible, it should also avoid the charity relationship.

#### VOLUNTARY VERSUS COMPULSORY INSURANCE

The way in which these aims can best be achieved is now the subject of considerable debate. Advocates of voluntary health insurance, such as the Blue Cross hospitalization and the medical society prepayment plans hold that such plans will fulfill all needs if given sufficient time, and if supplemented by tax-supported grants for medical care to all recipients of public assistance. Others believe that only a small percentage of the population will ever obtain complete medical care through voluntary prepayment plans, and propose compulsory health insurance along some such lines as those set forth in the Wagner-Murray-Dingell bill (S. 1161, 78th Cong.). Still others maintain that needs would be met most satisfactorily and economically through a universal system of tax-supported medicine. At this stage of its investigation, the subcommittee is not prepared to pass judgment on these differing opinions. It is in agreement, however, with those who feel that remediable action is overdue and should not be long delayed.

Pending the achievement of a solution which will assure complete medical, dental, and hospital care for the whole population, more adequate provision should be made for medical care of the needy. This will require increased appropriations by local, State, and Federal governments. Under the Social Security Act, Federal funds are granted to State programs for aid to the needy aged, the needy blind, and needy dependent children. Federal funds can be used for medical care of individuals in these categories if the State law so provides, and in most States public-assistance budgets make some allowance for medical costs. By and large, however, the payments for medical care are utterly inadequate. Furthermore, Federal funds are not available to State programs for aid to needy individuals other than the aged, the blind, and dependent children. Legislation introduced in the Seventy-eighth Congress provided for amendment of the Social Security Act so that Federal and State funds would be available to help States finance medical care for the needy, regardless of category. Proposals have also been made to alter allotment procedures governing distribution of Federal funds to State public-assistance programs so that more money could be given to States where needs are greatest, and to allow Federal matching in programs which pay the practitioner directly. These measures, if approved, would help relieve the financial load on hospitals and practitioners, who now give a great deal of free care. Such relief for hospitals and physicians would permit them to lower their charges to prepayment plans and thus encourage the enrollment of more people from the group able to bear the average cost of medical care.

#### MEDICAL RESEARCH

Magnificent progress has been made in medical research during the war. The curative powers of penicillin and of the sulfa drugs, the lifesaving value of blood plasma and serum albumin, the efficacy of DDT powder and typhus vaccine, and the development of new malaria-control methods are all fruits of a concentration and expansion of medical research resulting from determination to win the war. Adequate financing, coordination, and teamwork have been the keys to this success. Through governmental agencies such as the Army, Navy, and the Office of Scientific Research and Development, and nongovernmental agencies such as the National Research Council, the universities, and other groups, the Nation's resources for research have been mobilized in a vast cooperative effort.

With victory in sight, we now approach the challenge of peace. Many problems await solution. Much long-term as well as short-term or "practical" research into the causes and cures of cancer, arteriosclerosis (hardening of the arteries), hypertension (high blood pressure), dental decay, and nervous and mental disorders must be undertaken in order to assure further progress against disease.

The Office of Scientific Research and Development has served well as an emergency agency through which to channel Federal aid for medical research. Federal aid must continue if the great possibilities offered by medical research are to be realized. The way in which Federal aid is to be given and administered must now be carefully considered.

Government cannot, and must not, take the place of philanthropy and industry in the sponsorship of research. It is essential, however, for the Federal Government to provide resources for coordinated attack on medical problems which affect the country as a whole. In no other way can science be given full freedom and opportunity to serve the Nation in peace as it has in war.

#### EDUCATION, LEGISLATION, AND ORGANIZATION

The subcommittee recognizes the complexity of the task of providing good medical care to all the people. We believe that there are three necessary methods of approach to this task. One approach without the others would be unrealistic and ineffective.

The first involves education of the people, of the professions, and of the Government. We must collectively accept the fact of widespread existence of disease, disability, and injury, much of which medical knowledge today is able to prevent, alleviate, or cure.

The second approach is through legislation. For example, there is urgent need for modern medical facilities in many places throughout the Nation, especially in rural areas and in crowded war-industry communities. To meet these needs, money must be provided, and Federal financial assistance will be necessary.

The third approach is through better organization of medical services. There is wide agreement that improved organization would result not only in a higher quality of service but in considerable economy of time, effort, and money. The necessary reorganization can best be achieved, and the welfare of the professions and the public advanced, by regional planning such as that provided for in the health and medical center proposal set forth above.

#### RECOMMENDATIONS

On the basis of the preliminary findings outlined above, the subcommittee—

1. Recommends that Federal grants-in-aid to States be authorized now to assist in postwar construction of hospitals, medical centers, and health centers, in accordance with integrated State plans approved by the United States Public Health Service. (See cut on pp. 10-11 and text on pp. 14-17.)

2. Recommends that Federal loans and grants be made available to assist in postwar provision of urban sewerage and water facilities, rural sanitation and water facilities, and milk pasteurization plants, in communities or areas where such facilities are lacking or inadequate.

3. Urges State and local governments to establish full-time local public health departments in all communities as soon as the needed personnel become available. With this aim in view, consideration should be given to rearrangement and consolidation of local health jurisdictions and to amalgamation of existing full- and part-time local health departments with overlapping functions. The Federal Government should increase the amount of its grants to State health departments to the end that complete geographic coverage by full-time local health departments may be achieved and that State and local public health programs may be expanded in accordance with needs.

4. Recommends that the Army consider the feasibility and advisability of expanding its program for induction and rehabilitation of men rejected because of physical and mental defects; and that an emergency program of rehabilitation of IV-F's be undertaken immediately under the terms of the Barden-La Follette Act.

5. Recommends that the medical records of the Selective Service System be preserved and that funds be appropriated for further processing and study of these records.

6. Reports the acute shortage of personnel with training in psychology and psychiatry and the need for immediate steps to increase the output of such personnel with a view to providing child-guidance and mental hygiene clinics on a far wider scale.

7. Recommends that Federal scholarships or loans be made available to assist qualified students desiring medical or dental education; urges that increased enrollment of women in medical and dental schools, and premedical and pre-dental courses, be encouraged in every way possible.

8. Recommends that Federal funds be made available to States for medical care of all recipients of public assistance and that allotment formulas governing distribution of Federal funds to State public assistance programs be made more flexible in order to give more aid to States where needs are greatest.

The recommendations made above should be put into effect as soon as possible. We should begin planning now for the reconversion period. Further delay will postpone orderly solution of our health problems and deprive us of an effective means of aiding industry to maintain full production and employment after the war.

A comprehensive health- and medical-facilities program, planned now and undertaken as soon as materials and labor become available, would soon pay big dividends in improved national health and physical fitness. We have seen what neglect of opportunities for better health has cost us during this war. We should resolve now that never again, either in war or in peace, will the Nation be similarly handicapped.

CLAUDE PEPPER.  
JAMES M. TUNNELL.  
ELBERT D. THOMAS.  
ROBERT M. LA FOLLETTE, Jr.

#### THE NATION'S HEALTH PROBLEM

Senator PEPPER. The subcommittee's third interim report, issued in January 1945, presented a series of facts showing the gravity of the Nation's health problem. Over 40 percent of the Nation's selectees were found unfit for military duty, and at least a sixth of these had defects which were remediable; many more had preventable defects.

In fact, more than 23,000,000 people in the country have some chronic disease or physical impairment. On any one day, at least 7,000,000 people in the United States are incapacitated by sickness or other disability, half of them for 6 months or more. Illness and accidents cause the average industrial worker to lose about 12 days from production a year, a loss of about 600,000,000 man-days annually.

Let me interpolate here, I wish public opinion could become as excited about the 600,000,000 man-days lost through ill health as they do about the relatively small number of man-days each year lost by strikes.

Sickness and accidents cost the Nation at least \$8,000,000,000 a year—half of this amount in wage loss and half in medical costs.

Preventive services are inadequate—40 percent of our counties do not have even a full-time local public-health officer. Sanitation needs are great—846,000 rural homes do not have so much as even an outdoor privy. Hospitals are needed—40 percent of our counties, with an aggregate population of 15,000,000, do not have a single recognized general hospital. Doctor shortages are severe—in 1944, 553 counties had less than 1 active physician per 3,000 population, the "danger line," and 81 had no active doctor at all. Even in 1940, before many doctors were drawn off to war, 309 counties had less than 1 active physician for every 3,000 people, and 37 had no active doctor at all.

Maternal and child-health services are inadequate—it is estimated that half the maternal and a third of the infant deaths could be prevented if known measures were fully applied. Seventy-five percent of our rural counties have no prenatal or well-baby clinics at all under the supervision of State health departments. State agencies had 15,000 children on their lists awaiting crippled children's care in early 1944. They do not even pretend to care for the half-million children with rheumatic fever (the most killing of all diseases for children between ages 5 and 15), or for the tens of thousands of cerebral palsy (spastic paralysis) victims.

To meet such problems, the subcommittee recommended Federal action with regard to certain features of a national-health program, including Federal grants for hospital and health-center construction, sanitation, public health, medical research, education, and medical care for the needy.

The report also expressed dissatisfaction with the prevailing pay-as-you-go or fee-for-service method of payment for medical services, but withheld judgment with regard to the claims that voluntary health-insurance plans offer a satisfactory solution to the problem. This report summarizes the results of our further study of this subject and sets forth the conclusion we have reached.

#### ECONOMIC BURDEN OF ILLNESS

Our latest report then goes on to state that the burden of sickness and medical care falls heavily and unevenly on people. The burden is distributed unevenly, hitting some families so hard they are driven to financial ruin and the haunting misery which accompanies the vicious circle of poverty and ill health.

Sickness is the greatest single cause of families going into debt. Both national and State-wide surveys conducted by small-loan companies themselves show this clearly. Indeed, the results of their various studies are remarkably consistent. Thus, according to the American Association of Small Loan Companies, medical, dental, and hospital bills are the greatest single cause of people borrowing from small-loan companies. This conclusion is based on the record of over 300 small-loan companies. Studies in Illinois and California show exactly the same pattern. Further, the greatest single cause of bond redemptions, according to studies of both farm and nonfarm people, is also sickness and medical costs. I wish to submit these studies for the record also, Mr. Chairman.

The Chairman. It may be introduced in the record.

(Exhibit II referred to is as follows:)

#### EXHIBIT 2

##### SUMMARY OF DATA ON LOANS AND BOND REDEMPTIONS FOR MEDICAL EXPENSES

Source: Pamphlet, *When People Need Money*, published May 1945 by American Association of Small Loan Companies. Information compiled from records of over 300 small-loan companies in representative States: 17 reasons for borrowing listed. 22.50 percent of all loans were made for medical, dental, and hospital bills (next highest percentage is 14.05 for taxes).

Source: Illinois Association of Small Loan Companies survey of all loans made in various sized cities throughout Illinois during 1943: 20 reasons for borrowing

listed, 19.05 percent of all loans were made for medical, dental, and hospital bills (next highest percentage is 16.57 for taxes).

Source: Letter received April 2, 1945, from California Assemblyman Albert C. Wollenberg. Survey made by California Commissioner of Corporations of industrial loan companies (which include Morris plans): 30.8 percent of all loans made in 1944 were for medical, dental, and hospital services.

Survey made by California Bankers Association of the 6 largest banks engaged in the business of making personal loans: 24 percent of all personal loans in 1944 were made for medical purposes.

Source: Small Loan Business, pamphlet published by California Association of Small Loan Companies. Survey of all loans made in 1943 by several companies in various sized cities throughout the State: 19 reasons for borrowing listed, 22.38 percent of all loans made for medical, dental, and hospital bills (next highest percentage is 16.29 percent for taxes).

Source: Analysis of War Bond Redemptions, March 7, 1945, study made by Bureau of Agricultural Economics for Treasury Department. National sample, representative cross section of 2,148 persons: Page 1, "The chief single purpose for which people cash their bonds is to meet emergencies, usually involving medical expenses." Of 358 cases, nonfarm families, 45 percent redeemed bonds to meet emergency medical and health expenses. Of 76 cases, farm families, 32 percent redeemed bonds to meet emergency medical and health expenses.

## THE STORY OF THE SMALL LOAN BUSINESS IN CALIFORNIA

### FOREWORD

The purpose of this booklet is to reaffirm the principles of the California Association of Small Loan Companies, and to achieve a clear public understanding of our business.

The California Association of Small Loan Companies is composed of the majority of lenders licensed under California's small loan laws,<sup>1</sup> subject to regulation and supervision by the California Commissioner of Corporations who is vested with broad powers to prevent and stamp out abuses.

The "Code of Ethics" and "Standards of Business Conduct" reproduced on inside back cover reflect the high purposes and principles of the association which have helped to outlaw the high rate loan "sharks" in the State of California.

### *Why do they borrow?*

	Percent
Medical, dental, and hospital bills.....	22.38
Taxes .....	16.29
To consolidate overdue bills <sup>1</sup> .....	10.89
Assist relatives .....	8.85
Travel expense.....	7.53
Repairs .....	6.13
Real estate mortgages and interest.....	5.55
Business needs.....	4.69
Home furnishings .....	3.89
Clothing .....	3.19
Rent .....	2.29
Moving expense.....	2.26
Automobile expense.....	2.06
Insurance .....	1.44
Food bills.....	.76
Education .....	.70
Funeral expense.....	.70
Miscellaneous .....	.31
Fuel .....	.09

<sup>1</sup> All loans are classified under the heading describing the use to which the larger part of the loan is applied. Where several bills are paid, the loan is classified under the heading "To consolidate overdue bills."

These percentages were taken from a survey of all loans made in 1943 by several licensees in various sized cities throughout the State.

<sup>1</sup> Chapters 952, 953, 1044, and 1045, Statutes of 1939.

THE CALIFORNIA ASSOCIATION OF SMALL LOAN COMPANIES RECOGNIZES ITS RESPONSIBILITIES

Small loan companies, because of the nature of their service, deal mostly with families of average resources, which constitute 60 to 70 percent of our population. They often require cash credit to meet emergencies or for other constructive purposes and usually have little in the way of assets that could be considered bankable collateral.

To provide a self-respecting method by which they can supplement their family dollars at such times is a function of the small loan business that our California companies regard as more than a commercial transaction for profit. It is to them a public trust calling for a business philosophy which emphasizes efficient, constructive service in the public welfare.

Such is the business philosophy that binds together the members of the California Association of Small Loan Companies in a constant search to improve the services of these consumer credit institutions so necessary to our American economy.

THERE ARE TIMES WHEN PEOPLE

*Have to Borrow Money*

Credit is a necessary part of American life. Most people have credit which provides for everyday needs. But people—like businesses and governments—face emergency conditions that require more money than is available at the moment. These conditions, when they arise, are usually beyond the individual's control. Even the most thrifty at times may find themselves unexpectedly with less income or facing an unforeseen expense. There are also times, aside from emergency needs, when borrowing is an advantage—to pay for education, for an important purchase that delay would put beyond reach. Paying cash and gaining a discount can make a loan worth while; and money for tools or transportation to better places of employment is sound borrowing.

These few reasons for obtaining small loans set up the simple fact that there are times when people have to borrow money.

FROM THE RECORD

Who borrows from the State-regulated small loan companies?	Percent	Why do they borrow?	Percent
Occupation:		Purpose:	
Skilled and semiskilled workers .....	49. 24	<i>Medical, dental and hospital</i> .....	22. 50
Office and other nonmanual workers .....	16. 63	Taxes .....	14. 05
Managers, superintendents and foremen .....	10. 17	Fuel .....	10. 08
Proprietors (business for self) .....	8. 45	Sundry overdue bills consolidated .....	10. 30
Sales persons .....	4. 76	Assist relatives .....	6. 14
School teachers .....	4. 04	Repairs .....	5. 36
Unskilled workers .....	4. 00	Travel and vacation expenses .....	5. 33
Professional persons .....	1. 98	Money-making opportunities .....	4. 70
Persons with independent incomes .....	. 63	Clothing .....	4. 48
Not reported .....	. 10	Home furnishings .....	3. 63
Total .....	100. 00	Real estate and mortgages .....	3. 60
		Moving expenses .....	2. 28
		Rent .....	1. 91
		Insurance .....	1. 65
		Automobile expenses .....	1. 44
		Education .....	1. 03
		Miscellaneous .....	1. 52
		Total .....	100. 00

(Compiled from the records of over 300 small loan offices in representative States.)

*Whom does the small loan business serve?*

	<i>Percent</i>
Skilled and semiskilled workers.....	48.27
Office and nonmanual workers.....	23.48
Managers, superintendents, foremen.....	9.79
Unskilled workers.....	5.74
Proprietors (business for self).....	3.99
Sales people.....	3.06
School teachers.....	2.71
Professional people.....	2.13
People with independent incomes.....	.81
Not reported.....	.02

These figures were taken from a survey of all loans made by several offices in various sized cities throughout Illinois in 1943.

*Why small loans are needed*

	<i>Percent</i>
Medical, dental, hospital bills.....	19.05
Taxes.....	16.57
To consolidate overdue bills.....	8.60
Assist relatives.....	7.44
Fuel.....	7.22
Travel expense.....	5.93
Repairs.....	5.78
Business needs.....	5.32
Clothing.....	5.17
Home furnishings.....	3.38
Real estate mortgages and interest.....	3.33
Insurance.....	2.35
Moving expense.....	2.22
Rent.....	1.76
Education.....	1.54
Automobile expense.....	1.41
Funeral expense.....	1.01
Food bills.....	.97
Miscellaneous.....	.92
Not reported.....	.03

Senator PEPPER. Sickness and medical costs are also the greatest single cause of people having to seek charity. Studies of public assistance rolls show this to be true, and we have conducted an interesting analysis of this point which confirms these larger surveys. Each year, as many of you know, the New York Times conducts a great humanitarian campaign for the "Hundred Neediest Cases" in New York City. Case histories of these needy people are published, summarizing the major facts about their cases. We found, from the brief summaries alone, that 85 percent of the families were obviously indigent either as a result of sickness or of medical costs, or a combination of both.

I will submit this study in full for the record also.

The CHAIRMAN. It may be so included.

(Exhibit III referred to is as follows:)

## EXHIBIT 3

## WHY NEEDY?

*An Analysis of the New York Times 100 Neediest Cases*

By Kathleen Lucas and Leslie A. Falk, M. D., staff, Senate Subcommittee on Health and Education, 1946

For the purpose of determining how large a part sickness plays in making people dependent upon private charity or public relief, an analysis of the New York Times Neediest Cases of 1944 and 1945 was undertaken. Illness appeared

to be either the direct cause or a major contributing factor in reducing to dependency 108, or 85 percent, of the 127 families included in the New York Times Christmas appeal in 1944, and 110, or 88 percent, of the 125 families included in the 1945 appeal.

The following table illustrates more concretely the nature of the problem:

*Classification of the hundred neediest cases of 1944 and 1945*

Type of problem	Number of cases		Percent of total cases	
	1944	1945	1944	1945
Physical disease.....	58	85	46	68
Mental disorder.....	34	19	27	15
Accident.....	8	1	6	1
Maternity.....	8	5	6	4
Total.....	108	110	85	88

The story of the L. family, as reported by the Times, illustrates how illness can turn an independent family into a "charity case."

"This family of eight was burdened by two loans, incurred during 1943 because of illness. The father, 38 years old and a steady worker, had hoped to be able to pay off the debts in small installments from his \$36 weekly wage. With the family lived a grandmother, whose \$6 weekly old-age assistance brought the family's total weekly income to \$42. But medical expenses prevented this family from regaining its independence.

"The grandmother, besides being blind, was diabetic. The 12-year girl had been hospitalized with rheumatic fever, the 6-year old son with jaundice; the 5-year old son had had pneumonia the winter before, and was having recurring attacks of tonsillitis. The 2-year- and 4-year-old boys had frequent colds because of undernourishment.

"To purchase adequate medical care even for the emergency needs of this family, the mother would have had to work too. But she had an endocrine disturbance which threatened her heart, and was unable to accept employment. If she had been able to work, there would have been no one to take care of the children. This family needed advice and help on nutrition; it needed fuel; but most of all, it needed medical care and the ability to pay back medical debts."

In 70 cases out of the 108 families whose need for help was based on medical emergencies in 1944, the wage earner himself was unable to work because of illness.

As many as 34 families out of the 127 neediest cases in 1944 and 19 out of 125 in 1945 were dependent upon charity because of mental illness or psychiatric disability of the wage earner or of one or more members of the family.

A typical case of this type was the R. family. The father, a victim of mental illness, was sent to a mental hospital, leaving his wife, one son aged 12, and three daughters aged 10, 4, and 2, without means of support. To quote from the case history:

"He had been their strength, and on the \$45 a week he earned as a laundry worker they had lived comfortably—there was even enough for music lessons for the older children \* \* \* With only \$150 savings, Mrs. R. took part-time cleaning work at \$10 a week and borrowed from relatives until, a few weeks ago, the relatives could help no longer \* \* \* She had had to stop work because her health was breaking and the children needed her.

"In another case the wage earner himself became ill. For years he had ignored the symptoms of a bone disease because he was saving every penny to set up his own printing shop. At last he was able to buy a press and set up his shop, thinking to support his mother, wife, and 8-year old son better than before. But before long the bone disease had developed into a critical stage, and he was forced to give up his shop. Since the wife, who found housework, earned only \$12 weekly, the family became dependent upon charity."

Among the 46 percent whose dependency was caused by physical disease in 1944, and 68 percent in 1945, heart disease and arthritis were the two greatest contributing factors, accounting together for a fourth of this group of cases.

Senator PEPPER. Mr. Chairman, sickness is a great enough tragedy in itself. Is it not a tragic reflection on our Nation that we allow this

natural tragedy to be further exacerbated by financial worries and catastrophes, as well as financial barriers to the receipt of needed medical care?

Do such barriers exist, Mr. Chairman? They most certainly do. In my part of the country this fact is so much in the experience of most families that it hardly needs proof. As I have said one before, most people in Florida no more expect hospital care during a serious illness than they do a trip to Europe in the summertime. Government studies have shown that less than 7 percent of even the lowest income group among rural people—those making under \$500 a year per family—receive any free medical care in the course of a year. Yet can it be said that farmers with mouths to feed, clothes to buy, and insurance to pay can afford the \$100 a year or so it costs on the average to purchase even minimum adequate medical care under our present system? They cannot and they do not. They and their wives and children go without instead.

What is the way out? The way out is prepayment, budgeting, the time-tested, tried, and true American way—insurance. Only through such a mechanism can these burdens be spaced out in time and over a large enough number of people to lighten them properly.

#### VOLUNTARY HEALTH INSURANCE PLANS

For over a hundred years the American people have been trying to insure themselves against the burden of medical costs, but they have still not reached their goal.

The voluntary payment plans have made progress since the first one began about a hundred years ago, but they still cover a comparatively small percent of the population and take care of only a small percent of medical services. It is also becoming clear from experience that reduced costs result from wider coverage, as in any insurance system.

At present, less than 4 percent of the population receives complete prepaid care under voluntary health-insurance plans. Seventy-five percent of the population receives no prepaid care at all, even the most meager and partial. By "complete medical care" I means, of course, only relatively comprehensive hospital services, and doctor's services in hospital, home, and office. I do not even include dental care, home nursing, and drugs. Most of the 25 percent with some prepaid medical care are insured only against hospital bills, or surgeon's bills, or wage loss during sickness.

Now, as to the Blue Cross. Most of the people covered belong to either Blue Cross or commercial insurance plans. The Blue Cross plans have grown very fast in the last 10 years. The latest figures show their membership to be around 20,000,000 people. Whether they will continue to grow rapidly in the next few years or not, I am not prepared to say. Some feel that the wartime period gave the Blue Cross abnormally favorable opportunities for growth. I have been a proponent of hospitalization insurance for a long time, so I am glad that they have grown. However, we should not think that they provide for more than they do. They cover only the hospital bill during ordinary illness, usually for 21 to 30 days, with partial payment for an additional 60 days, at a cost of about \$24 per family a year. Since in any year 1 out of 10 persons is hospitalized for the

kind of illness they cover, this is important. But such hospital bills take only 13 cents—about a seventh—of the average medical dollar. The plans do not cover doctors' bills, which take about 40 cents of the average medical dollar—or three times as much—nor do they cover dental care, preventive medicine, nursing, or drugs.

Early, high-quality doctor care, regular check-ups, and the like, are perhaps the most vital links in the whole medical-care chain. Cancer, tuberculosis, nephritis, hernia, syphilis, arthritis, mental disease and others of our major killing or disabling diseases, can be controlled only by early general practitioner or specialist care. Any prepayment scheme that does not assure their receipt has serious failings.

The commercial plans are of two major types—group and individual. Both pay specified amounts of cash toward medical expenses or wage loss; they do not actually provide medical service. The group plans represent about half the total in terms of premiums paid. Most of them do not cover the employee's family. They pay toward hospitalization for about 8,000,000 people at present. Six million of the eight million are also eligible to receive payments toward surgeons' fees and toward loss of wages—in disabling illness lasting longer than 1 to 2 weeks. But no day-to-day doctor care is reimbursable under any but a very few of these plans, and even these are very incomplete.

The individual type of commercial policy varies tremendously, but the bulk of it consists of cash payments to the insured in the event of accident. Ninety percent of the individual-type policy premiums are for accident policies. The other 10 percent are for sickness policies, which usually begin payment only after 2 weeks of sickness. They do not cover ordinary doctor or dentist care, their major aim being to replace wage loss during prolonged disability. Overhead and administrative costs are high in these plans. Only about 40 percent of all receipts from policyholders is paid back to them as benefits. The rest goes for company expenses and profits.

Obviously, it is always the fine print in these policies that knocks the ordinary person, who thinks himself covered, out of the expected coverage.

The medical society plans are also limited in coverage and scope. They usually cover only surgical care, and obstetrical service after a 9- to 10-month waiting period. They do not cover routine diagnosis, periodic check-ups, or home and office visits. The only major exceptions to these statements are the plans in the States of Washington and Oregon. They cost about \$24 a year per family and included about 2,200,000 people in 1945, or less than 2 percent of the population.

Senator MORSE. May I interrupt at that point? I am glad that the Senator from Florida has mentioned the plan in the States of Washington and Oregon.

I am going to ask the chairman and the committee that is selecting witnesses to appear before this committee at a later date to make certain that we have some representatives from the States of Washington and Oregon as witnesses to testify in regard to Washington and Oregon plans.

I think that there is a great deal of merit in those plans, and I feel that this committee should thoroughly analyze them before it takes a position on any piece of legislation.

The CHAIRMAN. We will be very glad to have those witnesses.

Senator PEPPER. Finally, there are about 3,000,000 people who are members of prepaid medical-care organizations sponsored by industry, consumers, private groups of physicians, or Government. These plans tend to offer the most complete care, especially the group-practice plans, such as the Ross-Loos, Kaiser, Stanacola, Endicott-Johnson, Group Health, and Farmer's Union in Elk City, Okla., groups. Sad to say, this is also the type of prepayment plan which was fought the hardest by organized medicine all during the thirties. This opposition is not entirely past history, despite the Supreme Court decision in the District of Columbia Group Health Association case. Complaints of discrimination against group practice prepayment plans have continued all during the war.

Now, the shortcomings of private or voluntary medical insurance:

We have, therefore, concluded that voluntary, or private, health insurance has serious shortcomings, some of them inherent in the method itself. A few are as follows:

1. Millions of people are not eligible for any plan.
2. The plans usually meet only a small part of the health needs.
3. Many people cannot afford to join.
4. Others feel they do not need medical insurance; or they drop out after a year or so because they "didn't use the plan last year, and don't think it worth while to stay in." High turn-over of membership is a constant problem and raises the cost.
5. People who are sick, or expect to get sick, tend to join the plans most. Accordingly, voluntary plans either have a tendency toward "adverse selection of risk," or they adopt such rigid eligibility requirements that they exclude the very people who need care most.
6. There is much overlapping and duplication, as well as geographical and social gap-leaving.
7. There is a tendency to high promotional and administrative costs.
8. The plans are not well suited to the needs of our increasingly migrant population.
9. With very few exceptions, they have not provided consumer representation on their policymaking boards.

#### TAX-ASSISTED VOLUNTARY PLANS

These defects in private insurance became apparent quite early in our study, and we began to believe that subsidies from tax refunds might overcome them and obviate the necessity of a completely tax-based program. We were fortunate in discovering that experiments along these lines were already in progress, under the postwar program of the Department of Agriculture. Accordingly, we studied this experience very carefully. We have recently issued a monograph embodying the major lessons of these plans. I have already drawn this monograph to the attention of the committee members, and it is available to the interested public.

What we found was that tax-assisted voluntary plans do not offer the basis of a national pattern. They remained subject to what are apparently the inherent defects of voluntary health insurance, although subsidy had obviated certain other defects.

Each plan took the form of a voluntary health association open to all farmers in the country. They offered relatively complete doctor, dentist, and hospital care to the whole family, within the limits of

availability and quality prevailing in these counties. The total cost of the services was \$45 a year, but Government subsidy succeeded in reducing the actual charge to the family to \$20, with a minimum payment of \$13. Yet, despite these low charges and every evidence of good will toward the experiments by the people, only 40 to 50 percent of those eligible to join actually did so. Turn-over was considerable.

Let me say our committee spent a lot of time and a great deal of effort in trying to determine whether it was possible to provide adequately for the health needs of the people of this Nation by any kind of voluntary plan.

#### ONLY COMPULSORY INSURANCE CAN MEET THE PROBLEM

We honestly endeavored to canvass every suggestion and every experiment that was in progress in the whole country. We considered all kinds of compromises and all sorts of meeting of the minds of the various diverse groups in an effort to find some voluntary system that would give the needed help and hospital care to the people of the country, and it was our conclusion that none of these plans will afford coverage to the Nation as a whole. You can cover a certain number, of course, you can cover a certain number by voluntary insurance or commercial insurance, but if you are going to cover the whole Nation, we have concluded that only a national health program, based upon compulsory insurance, is the only way by which it may be achieved.

What, then, is the alternative? The answer is a national plan soundly financed through social insurance and direct taxation. In other words, national health insurance in a national health program.

There is much experience, both domestic and foreign, on which to base such a program. A few years ago, we would have demanded information in detail on how such systems operate in other countries. Now our temper seems to be different. The tides of nationalism have swept so high it almost discredits a speaker to state what foreign experiences and opinions are. I wish only to observe the following—during my recent trip to Europe I talked with many people in many countries about their health organization. In practically all cases, I found them planning to increase the percentage of the population covered and the scope of the medical benefits offered under their health insurance plans. The more democratic the country, the further advanced were the plans, for example, England and Czechoslovakia. In no case was there any desire to give up health insurance and return to the fee-for-service system.

Actually we do not have to go abroad for experience in this subject; for a certain section of the population it has been the "American way" for a long time. Ever since 1798, our merchant seamen have received their medical care through services supported by social insurance and tax funds in a program administered by the United States Public Health Service. It first began through a payroll deduction plan which, as late as 1874, was called by the Public Health Service's Surgeon General "a peculiarly American institution." I think there would be a tremendous storm of protest if the Congress attempted to take this program away from the seamen.

While this is a specialized experience, and of course does not represent the same pattern as one for the whole Nation, it is rewarding for

us to learn from this experience that the health insurance idea was not planted in our heads by Bismarck or anyone else, but dates in our Government from almost the beginning of the Republic.

#### THE PUBLIC SUPPORTS A NATIONAL PLAN

Would the public support the view that neither voluntary plans nor tax-assisted plans can do the job, and that a national plan based on the social security and tax mechanisms can do it? How do the people feel about these matters? We are their elected representatives, and we need to know. Our mail is one way of finding out.

I, for one, have been impressed with the thoughtful, original note struck in the letters to me which favor this bill. I have likewise been struck by the fact that the great majority of letters opposed to it are from medical society representatives or doctors. I have no doubt that the opponents are quite sincere, but it is difficult not to stress that many of them simply parrot unsubstantiated slogans issued by a propaganda organization, financed to a great extent by certain patent medicine manufacturers, namely the National Physicians' Committee. This committee is a successor to the so-called "Physicians' Committee for Free Enterprise"; in turn a subsidiary of the Committee to Uphold Constitutional Government. You will undoubtedly have an opportunity to hear statements of the sort this committee issues during the course of these hearings. You can judge their merit.

Another way of learning what the people think is through the public-opinion polls. They show quite clearly that the American people would favor this bill, if they had to vote on it. These are the results of some of the most representative of these polls:

1. The overwhelming majority of the population feel something should be done to make it easier for people to get medical care when they need it. In a National Opinion Research Center poll 82 percent said "Yes" to this question, only 10 percent "No".

2. The great majority feel something should be done to make it easier to pay doctor and hospital bills. In a poll done for the above-mentioned National Physicians' Committee, 63 percent said "Yes" to this question and only 10 percent said "No"—26 percent were doubtful.

3. A substantial majority favor extending the social-security law to provide for payment of doctor and hospital care, even if this means an increase of 1½ percent taken out of people's pay checks. The National Opinion Research Center polls showed 58 percent in favor, only 29 percent opposed, with 13 percent who didn't know.

We have many other public-opinion poll results in our files which confirm these results.

#### SUMMARY ON HEALTH INSURANCE

To summarize this part of my testimony, I would like to quote from the conclusion of the subcommittee's health insurance report:

To cover everyone, the adverse, as well as the good, risks, the young and the old, the sick and the well, the rural and the city dwellers, the low- and the high-income groups, the poor and the rich areas, all this takes a mechanism as representative and all-inclusive as the Federal Government. Some people will not protect themselves voluntarily even if they are able to do so; others will be able to afford to do so only under a national plan. A national solution by spreading the risk among the whole population, and by equalizing costs

between income groups and areas, will enable all the people to protect themselves at a cost they can afford to pay.

The voluntary plans have served and are serving a valuable purpose, even though they do not provide any final answer to the problem of prepaid medical care for all the people. They have developed useful data on the prepayment of medical costs, and have educated large sections of the public on the value of medical care insurance. Furthermore, they have trained sizable numbers of medical and administrative personnel in the techniques of prepaid medical care. There is no reason why such plans should not continue to perform useful functions within the framework of a national health insurance system.

It is our considered opinion, reached after months of careful study, that the only way complete care can be brought to all is through a national health program, built around a system of prepaid medical care. It must be financed by required contributions to the social-security fund and by payments from general tax revenues. Such a program will satisfy all the requirements set forth above, and will make possible the achievement in the foreseeable future of our goal of high quality health care for all.

Senator SMITH. Will the Senator yield for one little statement?

Senator PEPPER. Yes.

Senator SMITH. I appreciate the care in making this report, but I must object to it appearing as the considered opinion of the committee, because, so far as I know, I have never been asked to attend any meeting or to discuss these measures with the subcommittee. I might be prepared to go along with them, but I have never been asked my opinion on them; therefore, I would like in the record that to appear that until now I have never been considered or asked to consider these issues presented by the able Senator from Florida.

I want to compliment him on the very extensive surveys made. I think the findings of fact have been most important, but I question that we should show that the committee has arrived at conclusions until we have gotten together and had a meeting and decided to agree on the report.

Senator PEPPER. The able Senator from New Jersey is quite correct in calling attention to the fact that there has not been a formal approval of this report by the committee in its publication by the committee. It has been prepared by the staff with the collaboration of members of the committee. It has now for some weeks been in all of the hands of the members of the committee, and the majority of the members have communicated to the chairman their approval of this report. It was that that led me to leave the inference that it had committee approval, but the Senator is quite correct in saying that, in its final form, it has not formally been adopted as the formal report of the committee.

Senator SMITH. He has done a splendid job here, but I think it should appear, without my taking issue, there are very controversial questions, not as to what we want to accomplish, but there are issues as to the way that should be accomplished.

Senator PEPPER. That is correct.

Senator SMITH. I think it is fair and proper that I should be recorded as yet not convinced of the wisdom of the solutions asked for here and simply have that appear in the record. I am open to conviction, and in these hearings I hope to come to a conclusion with the committee. I hope it can develop a fine, sound, over-all national health bill.

The CHAIRMAN. It is proper that your position should be made clear in the record.

Senator PEPPER. I am glad you made that clear.

The cost will not be greater than that of our present inefficient and wasteful fee-for-service system. According to leading experts, the charge to the average family under a national health insurance program will actually be less than it pays now, partly because the employer and the Government will both contribute to the fund. It is noteworthy that the labor organizations, all of whose members are wage earners, are among the staunchest supporters of national health insurance.

Health insurance is often erroneously called "socialized medicine" or "State medicine." As President Truman pointed out in his health message, such a system is one in which the doctors are employed by the Government. We do not advocate this. National health insurance, which we do advocate, is simply a logical extension of private group health insurance plans to cover all the people. It is a joint national endeavor. It will guarantee free choice of doctor or group of doctors and free choice of hospital by the patient, and free choice of patient by the doctor. Indeed, free choice will be extended, because current financial barriers to the actual exercise of free choice will be broken down.

Some aspects of a national health insurance program are, of course, experimental. No legislative framework or administrative plan can be perfect at first. Shortcomings will undoubtedly be uncovered, but they will be overcome as we learn from experience. None of these shortcomings, however, will be anywhere near as costly as the toll of lives and health now being exacted by our failure to have a national health program providing good medical care for all. The need for it is urgent.

The concern of the Federal Government in this matter is clear. If only the national defense were involved, this would be reason enough for the adoption of a national health program. The costly lessons of the selective service rejections and of the armed forces medical discharges have made this apparent.

Today America faces the challenge of world leadership. To a very large extent we bear the principal responsibility for the kind of world we are to live in. America can continue neither prosperous nor secure unless her people are healthy and full of strength. We owe it, therefore, to the Nation, and to every man, woman, and child in it, to open to every citizen the door to the marvels of modern medical care. Only thus can we make our full contribution to a free and happy world, unhindered by the heavy drag of sickness and ill health.

The CHAIRMAN. Let me interrupt here. I regret that I am being called away for a brief conference.

The next witness will be Mr. Miller, Administrator of the Federal Security Administration, and I would like to ask you to take charge of the meeting while I am absent.

(Senator Pepper assumed the chair.)

#### MATERNAL AND CHILD CARE

Senator PEPPER. Now, although compulsory national health insurance is the rock-bottom minimum requirement for an effective national health program, there are certain other aspects of health which such insurance cannot cover. Most important of these additional aspects, in my opinion, is the problem of adequate maternal and child care, particularly for the families who are not covered by the provisions of S. 1606, but to a lesser extent for those who are, but will not be able to obtain adequate services for such care under existing circumstances.

I have long had a particular interest in the health and welfare of mothers and children. Last year, I introduced (for myself and Mr. Walsh, Mr. Thomas of Utah, Mr. Hill, Mr. Chavez, Mr. Tunnell, Mr. Guffey, Mr. La Follette, Mr. Aiken, and Mr. Morse) Senate bill 1318, whose purpose is to provide for adequate maternal and child health and crippled children's services and child welfare services in all the States.

Although all of the provisions set forth in S. 1318 are not specified in this bill to which we are now addressing ourselves, some will be included through amendments which are being proposed. S. 1318 would provide a unified program of health services and medical care of high quality for all mothers during maternity and for all children, administered by the Children's Bureau through grants to State health agencies. It is, in my opinion, imperative that these services be assured to mothers and children under a comprehensive plan. Under the amendments proposed, it will be possible, though not mandatory, for the Federal agencies and the States to place responsibility for all such services in the same State health agency. I earnestly hope that if this legislation is enacted, policies of administration will be adopted to assure the attainment of these objectives and the continuing leadership of the Children's Bureau, to which the Nation which loves its children is so much indebted.

The section of S. 1318 which covers child welfare services is not being considered in the national health program. This is a loss that must be made up promptly in some way. Child welfare services must also be carried forward as part of the total service to the Nation's children in these postwar years. It is folly to make provision for children when they are physically or mentally sick and not make comparable provision for them when they are in need of social services. I am sure the committee will welcome further suggestions from witnesses who are particularly concerned with the health and welfare of children.

I am pleased that public responsibility for the health of mothers and children is now being discussed as part of S. 1606. For instance, the provisions which control sanitation and other environmental conditions in the interest of the health of all people in the community are particularly important for children. The communicable-disease-control clauses are equally important, for such diseases are no respecters of age or person—children and adults catch things from each other. The saving of parents' lives through the insurance medical care plan in this bill means that fewer homes will be broken up and more children given a normal life.

The purpose of our deliberations is to formulate sound public policy with respect to the many problems involved in a program of health and medical care. There must be funds to pay for the medical care which is given to individuals. Doctors, dentists, and nurses, as well as hospitals and health centers, must be within reach of every individual, regardless of his race, color, or creed. All persons in the population must be covered in one way or another. The long-established policy of the expenditure of public funds by public agencies responsive to the will of the people must be continued.

Let me reemphasize that we have a special stake in our children as the future of our Nation. If the time of their childhood runs out before something is done for them, we cannot retrieve what has been lost. There must be no distinction between the medical care provided for children of insured and noninsured individuals.

Under this proposal for a national health program, the President has placed major responsibility for the financing of personal health service benefits on the insurance fund, with coverage based on em-

ployment. The President, however, has set before us a complete objective in terms of children—

that no American child shall come to adult life with diseases and defects which can be prevented or corrected at an early age,

and that the—

health of American children, like their education, should be recognized as a definite public responsibility.

I am calling your attention, therefore, to the limitations on benefits and coverage within the insurance system which will affect children. Premature infants, for example, may need hospital care beyond 60 days, and therefore beyond what can be paid for under the prepaid personal health service benefits of this act. Some children will be ineligible for benefits, because neither of their parents have met the conditions of employment prescribed for coverage. In order that all children may receive full health and medical care, certain amendments are being proposed to title I, part B, which will assure care for those excluded from title II, and provide the additional care needed by all beyond the limitations imposed in the insurance section.

The benefits which an individual receives under the insurance provisions will necessarily depend on the medical facilities in the place where he lives. We know that the kind and quality of medical care which can be obtained by mothers and children at this time varies greatly from State to State, and between city and farm. We also know that, on the whole, health and medical care is less plentiful and of an inferior quality for the minority groups and for migrant families. The purpose of including a maternal and child health plan as part of the national health program is to assure that health and medical care of good quality will be made available to mothers and children—whoever they are, wherever they live, whatever their income.

Under title I, part B, the State health agency will keep informed about qualified doctors, dentists, nurses, and other professional people to whom parents can take their children. If there are places in the State where good medical and hospital care is not available for mothers and children, the State health agency will arrange for it. Sometimes this will mean taking steps to encourage doctors and dentists who have skill in providing care for mothers and children to locate in certain areas. Sometimes it will mean setting up community clinics, to be financed from maternal and child health service funds. It may mean working out a school health program in a local community, covering all children through high school. Such a program will include correction of defects found at the medical examinations. The ingenuity of the State health agency will be directed to the task of making it possible for mothers and children to have access to the services of specialists and to modern methods of care as they need them.

All this will be worked out within the maternal and child health program as a service in the community. There will be planning by the State health agency with the schools and other community agencies, and with the Government agencies paying for personal health services for insured mothers and children. The work will be coordinated with the hospital and health-center construction program to be sure that the special needs of mothers and children are met. Opportunities will be created for doctors, dentists, nurses, and others who are serving mothers and children to become more skilled in the

handling of their special problems through postgraduate education. A good program can go forward only as fast as trained personnel becomes available.

Unless there is a centralized responsibility for over-all planning, the objective of complete care for every child—preventive, diagnostic, and curative services linked together—will almost certainly fail. I want this kind of care for mothers and children to become a reality. I am sure there are many millions of parents in this country who agree with me in this. It is our goal to accomplish this in the next 10 years.

I want to give you briefly just one example of what will be done under the maternal and child health program. Figures show that about 5 percent of the total number of babies born in any one year are born prematurely. Approximately 30 percent of the infant deaths in the first year are attributed to premature birth. There are many practical steps which are necessary if we are to save the greatest possible number of these babies' lives. There must be special nursery units equipped with incubators and special heating arrangements in all hospitals taking maternity cases. There must be incubators available in the health centers for use in the baby's home when he is not born in a hospital. Special ambulance service is necessary to take a premature baby to the hospital. Nurses and doctors must be given special training in the care of premature infants to provide the services needed. Specialists who can give consultant service must be within reach. It will be a responsibility of the State health agency, in accordance with its approved State plan under title I, part B, to see that each and every one of these steps are taken.

Under a national health program of which insurance is the cornerstone, it is of the utmost importance that there be a sustained effort on the part of public agencies to make sure that medical care of good quality is available for use. I am glad that the sponsors of this bill have included title I, part B, which provides grants to States for maternal and child health services under the direction of the Children's Bureau, which has been responsible for the setting of standards for maternity care and for the health and medical care of children under the Social Security Act.

I have been intimately acquainted over a period of years with the work of the Children's Bureau in the health and welfare fields, and know that its primary concern is the public interest. It has striven consistently for health and medical care of good quality for all mothers and all children and youth. The Children's Bureau is now responsible for the administration of the emergency maternity and infant care program under which well over 1,000,000 wives and babies of servicemen have been given care during the war. The Children's Bureau will bring to an extended maternal and child health program the wisdom of its past experience.

(Senator Murray resumed the chair.)

Senator PEPPER. I would like to summarize what these proposed amendments are.

In order to make the provisions of title I, part B, of this act more effective, to remove certain ambiguities, and to provide for better coordination in the administration of the provisions of title I, part B, and title II, certain amendments are proposed.

These amendments provide that—

(1) The Children's Bureau and the State health agencies, through the provisions of title I, part B, will be responsible for providing and

maintaining services and facilities to promote the health of mothers and children, and by children I mean those under 18 years of age, including adequate maternal and child health services in the community.

(2) The cost of personal health services benefits for insured persons and their dependents, including maternity care and medical care of dependent children, will be met through the provisions of title II (within the limitations on those benefits) administered by the Surgeon General of the United States Public Health Service.

(3) The cost of maternity care and medical care of children under 18 years of age in noninsured families that elect to participate, and also the cost of supplementary personal health services for insured maternity patients and children, will be met through title I, part B, administered by the Children's Bureau and State health agencies.

(4) To the extent feasible, the Surgeon General will utilize, and the Chief of the Children's Bureau will make grants to, the same State health agency.

(5) The State health agency may provide personal health services under its approved maternal and child health plan through payments to persons or institutions furnishing care, through direct provision of such care, or through arrangements with the Surgeon General to utilize the insurance system. Reciprocally, the Surgeon General may utilize the State agencies and make payments to them for personal health services provided by such agencies for insured persons.

(6) Specific sums are authorized for the initial year of the maternal and child health services beginning July 1, 1946, in the amount of \$50,000,000 for maternal and child health, and \$25,000,000 for crippled and otherwise physically handicapped children, and thereafter the authorizations are for sums sufficient to carry out the purposes of the programs.

Let me interpolate here that some of the States which have separate crippled children's agencies, such as a crippled children's bureau, have complained that in the maternal and child-welfare bill we may be dispossessing them of their jurisdiction. We have let them know when we come to the actual formulation of this measure an effort will be made to wed them into the plan. We do not want to discourage the good agencies that already exist. We want to provide adequate coverage for all of the people by the supplementing, when necessary, of deficiencies in the present structure.

(7) Provision is made for the appointment of technical advisory committees to advise the Children's Bureau in its administration of the program.

(8) Provision is made to allow opportunity for fair hearing to any mother or person acting in behalf of a child or to any physician or agency participating or desiring to participate under a State plan.

(9) Provision is made to allow a State agency receiving funds under two or more parts or titles of this act to pool such funds provided the State accounts for the funds to the Federal administrative agencies in a way that affords reasonable assurance that the funds are expended for the purposes of the respective parts or titles of the act.

I would like to submit as a part of my statement, the proposed amendments in technical form.

The CHAIRMAN. They may be carried in the record.

(The amendments are as follows:)

1. Page 13, line 24, insert after the word "children" the words "under 18 years of age."

2. Page 14, line 1, insert after the word "services" the following: "in the community, by providing supplementary personal health services needed by maternity cases or children entitled to personal health service benefits under title II of this Act, and any personal health services needed by maternity cases or children not entitled to such benefits."

Page 14, line 3. Insert after the word "demonstrations" the following: "research."

3. Page 14, delete lines 5 and 6 and substitute the following: "to be appropriated for the fiscal year ending June 30, 1947, the sum of \$50,000,000, and for each fiscal year thereafter a sum sufficient to carry."

Page 17, delete lines 3 and 4 and substitute the following: "authorized to be appropriated for the fiscal year ending June 30, 1947, the sum of \$25,000,000, and for each fiscal year thereafter a sum sufficient."

4. Page 14, line 18, insert at end of line: "Provided, That to the extent feasible, the plan shall be submitted by the same State health agency as that utilized by the Surgeon General in furnishing services under title II, section 203 (e)."

Page 14, line 17, delete the word "the" before the word "State" and substitute the word "a."

Page 14, line 18, delete the word "the" before the word "State" and substitute the word "a."

Page 38, line 4, change period to comma and insert: "Provided, That the Surgeon General shall, to the extent feasible, utilize the same State health agency as that submitting, and having approved, plans under title I, part B, section 121."

5. Page 16, line 1, insert the word "community" before the word "services."

Page 16, line 4, delete the word "and" at the end of the line, and add subsection (9), as follows:

"(9) provide that as personal health services are furnished under the plan they shall be available to all maternity cases and to all children in the State or locality who are not entitled to such services as benefits under title II of this Act and who elect to receive such services under the plan."

6. Page 16, after new subsection (9) insert new subsection (10) to read as follows:

"(10) provide for granting to any mother or person acting in behalf of a child whose claim with respect to care or services under the plan is denied, or to any physician or other person, organization, or institution, participating or desiring to participate in furnishing services or facilities under the plan, an opportunity for a fair hearing before the State health agency."

Page 16, line 5, change the numbering of old subsection (9) to subsection (11).

7. Page 24, line 3, insert after the word "members" the following: "and, as necessary, technical advisory committees."

8. Page 25, after line 2, insert the following:

"(d) Under a State plan approved by the Chief of the Children's Bureau with respect to section 121, personal health services may be provided through (1) payments to the persons or institutions furnishing such care, or (2) direct provision of such care, or (3) through arrangements by the State agency with the Surgeon General of the Public Health Service for services furnished under title II of this Act, on the basis of equitable payments to the Personal Health Service's account established under title II of this Act, or through any combination or modification thereof."

Page 25, line 3, change "(d)" to "(e)."

9. Page 37, line 3, insert the following at the end of the line: "including payments to State agencies for personal health services given in accordance with arrangements made by the Surgeon General with such State agencies under plans approved under title I."

10. Page 78, line 7, insert new section 301 as follows:

"SEC. 301. Whenever funds are paid to a single State agency under two or more parts of title I, or under one or more of such parts and also under title II, the State agency may commingle such funds and account therefor by such accounting, statistical, sampling, or other methods as may be found by the Federal administrative officer or officers authorizing such payments to the State

agency to afford reasonable assurance that such funds are expended for the purposes of the respective parts or titles of this Act."

Page 78, line 7, change numbering of "Sec. 301" to "Sec. 302."

Senator PEPPER. Let me add only that those amendments are proposed after long consultation and most sympathetic cooperation among the sponsors of the two bills. I happen to be one of the sponsors of the maternal and child welfare bill and am in favor of its passage, but I am equally strong in my support of the pending measure, the Wagner-Murray-Dingell bill, and we have worked together, the Children's Bureau and others who are sponsors of the maternal and child welfare bill, so that these amendments might be fitted into 1606, and if 1606 should be adopted, then it would cover, essentially, what appears in the maternal and child welfare bill, also.

If the unfortunate event should occur that 1606 should not be adopted, why then, of course, 1348, the maternal and child welfare bill can be considered as a separate matter.

Now, Mr. Chairman, I have just this: I realize there are a lot of people in the country who are conscientious in their opposition to this bill which you gentlemen have sponsored, yet I cannot believe that they have made a survey as our subcommittee has of the health needs of the Nation and the deficiencies in the present structure for meeting those health needs. I cannot believe that they who value human life and emphasize human welfare would be unwilling to experiment, if needs be, with this proposed legislation correcting defects as experience might disclose them, rather than to continue the inadequacies of the present system which not only every year and every month and every day and every hour, but every minute and second, are taking a terrible toll of the lives and the health of the people of this Nation. And so I say: Godspeed your great efforts, and hope that the Congress will catch the spirit of the American people which is crying out for this legislation too long delayed and enact it at the first opportunity.

The CHAIRMAN. Thank you for your very able statement, Senator Pepper. I am sure it will be of real value to this committee.

It is now 10 minutes after 12, and we will suspend here.

Tomorrow morning we will meet again at the same time and in the same committee room, and Mr. Watson Miller, Administrator of the Federal Security Agency, will be the first witness, and will be followed by Dr. J. W. Mountin, Medical Director of the United States Public Health Service.

We will suspend now.

(Thereupon, at 12:10 p. m., Tuesday, April 2, 1946, the committee recessed until Wednesday, April 3, 1946, at 10 o'clock a. m.)

# NATIONAL HEALTH PROGRAM

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WEDNESDAY, APRIL 3, 1946

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

The committee met at 10 a. m., pursuant to adjournment, the Honorable James E. Murray (chairman) presiding.

Present: Senators Murray, Ellender, Aiken, Morse, and Stanfill.

The CHAIRMAN. The hearing will be in order.

Mr. Watson Miller is the first witness this morning. I am glad to see you here this morning, Mr. Miller.

Mr. MILLER. I am glad to be here, Senator Murray. Do you wish me to proceed?

The CHAIRMAN. Yes.

## STATEMENT OF WATSON B. MILLER, FEDERAL SECURITY ADMINISTRATOR

Mr. MILLER. Mr. Chairman and members of the committee, I am glad to have this opportunity to appear before you in behalf of the national health program, as it has been proposed by the President and as it would be activated in large part by the national health bill, S. 1606.

### ENDORSEMENT OF THE BILL

Individually and as spokesman for the Federal Security Agency, I stand squarely behind this program. It is necessary. It is practicable. It is long overdue.

Because it covers the entire Nation, and because it deals with an aspect of our common welfare in which our day-to-day practice has lagged far behind our standards, our knowledge, and our resources, the proposal is necessarily comprehensive and therefore has the appearance of complexity.

But in reality, the basic issue is simple: The health of the people is the strength of the Nation. Health protection, for himself and his family, is implicit in the guaranties which the American democracy makes to every citizen. As a fundamental need of all the people, health is a proper responsibility of the National Government, as of the State and local governments. To help meet this need, Government has a twofold task—first, to provide, insofar as possible, a healthful environment, to see that the communities in which people live are free from the needless threat of disease-breeding hazards; second, to assure to every individual safeguards against the manifold and universal disasters which illness may entail.

Stripped to essentials, the rationale of the national health program

is as simple as that. Its principles—its goals—have, so far as I know, never been challenged. I reiterate them here, and I ask your permission again to place them in the record at this point, because, in the discussion of methods, they are too often lost to view.

We cannot afford obscurity on an issue of such vital and urgent importance. I am sure—and indeed I hope—that these hearings will explore the highways and perhaps even some of the byways which might be considered as pointing toward this goal. I welcome the opportunity of presenting the main points in the Federal Security Agency report on Senate 1606, as already transmitted to the chairman.

I intentionally exclude from my remarks the findings based on the extensive researches carried on in the Federal Security Agency, since these will be ably covered in the testimony to be offered by Dr. Mountin, representing the Public Health Service, who follows me, and by Chairman Altmeyer of the Social Security Board, who will appear before you tomorrow. There are other points contained in the bill which I would like to discuss—in particular, aid to medical research and education. Though it has my support, I shall pass over this provision without further mention since it is to be covered by the authorities on this subject whom you have called in.

In discussing the specific provisions of this bill, I think it is important for all of us to keep in mind that it represents the keystone, rather than the whole structure, of the national health program. The measures set forth here are the core of such a program, but they can be considered in their true proportion only as we bear constantly in mind their integral relationship with other segments of the over-all plan. These are embodied in other measures now before the Congress—the hospital construction bill, the mental health bill, and the provisions for compensating against wage loss resulting from temporary or permanent disability.

This is the general setting within which I want to comment on some of the specific provisions in Senate 1606. Its first proposal, for example, would appear to deal primarily with the environmental aspects of health and to implement that part of the President's health message calling for expansion of public health services.

#### PUBLIC HEALTH GRANTS

On the assumption that this is the intent of this section, I wish to endorse not only the extension of general and specific public health services it envisages, but also its provisions with respect to grants-in-aid. Illness has little regard for political boundaries; as long as any county or community lacks adequate health protection—and there are too many of them that still do—we are all in jeopardy.

It is to the interest of the entire country to remove, as the bill proposes, the present statutory limitations upon the appropriations that Congress may authorize for public health grants to the states. It is equally to the interest of all to employ a formula permitting variation in Federal grants for this purpose within the range of 50 to 75 percent, according to the fiscal capacities of the several States. I strongly favor both these principles.

I might add at this point, however, the suggestion, made in more detail in our report, that, whatever the particular formula for variable grants eventually adopted, the same provisions should apply for public health under this section and for the two other grant programs contained in title I. This appears necessary in order to avoid making any one program financially more favorable than the others and thus running the risk of throwing State plans out of proportion.

With the remaining sections of this title, the bill begins to address itself to the second part of the Government's twofold task—that of assuring medical care to individuals—in this case for maternal and child health services and for medical care to the needy. Both of these are groups for which public responsibility has long been established in principle, and the necessity of measures to make this principle a reality has not, I believe, been seriously questioned. The Federal Government could contribute to no better cause.

If specific legislative provision is to be made for maternal and child health care and for services to crippled children, these measures for dealing with this need through grants-in-aid on a variable formula seem appropriate. We have, as you know, accepted the amendments to this portion of the bill proposed by Senator Pepper. I shall not, however, go into more detail with respect to these services, since I assume that our mutual agreement on them will be discussed more fully by the Secretary of Labor and the Chief of the Children's Bureau when they appear before you.

The proposal to make Federal financial aid available to the States to help them provide medical care for needy persons is generally sound and desirable. The provision that State and local agencies may arrange to have this care furnished to the needy through the health insurance system which the bill would establish seems to me particularly important. It would have the advantage both of encouraging better care for the needy, and of promoting more effective coordination among the several parts of the national health program.

#### PREPAID HEALTH SERVICES

But the main provision for individual medical care contained in the bill—and indeed the backbone of any national health program worthy of the name—is a system of prepaid personal health service benefits to cover the majority of the country's workers and their families.

The provisions for this purpose in title II are in accord with the President's recommendations and are, on the whole, workable. This applies to methods of administration as well as to the system of benefits itself.

#### SAFEGUARDS TO PERSONAL FREEDOMS

Appropriate safeguards, for example, would assure, as the President has rightly insisted, that people remain free to choose their own physicians and hospitals, that doctors remain free to accept or reject patients and to participate in the system full time, part time, or not at all. Speaking for myself, and with deep personal conviction, I

would not be a party to any plan which intruded between the physician and the patient, or failed to preserve and guarantee the professional independence of medical practice.

#### DECENTRALIZATION OF ADMINISTRATION

Since ready access to medical care for people in all parts of the country is the prime purpose of such a system, another point on which there is general agreement is that administration should be decentralized as far as practicable, and that the State and local governments should assume their full share of administrative responsibility. State and local participation in administration would follow the pattern already well established by our existing public health services. If this pattern were to be continued with respect to the system of prepaid personal medical care, it would have the great advantage of building upon a very solid base of experience, and of promoting the effective coordination which is essential as between community preventive services and individual care.

Along with this decentralization, however, full consideration should be given to the possibilities of making services available on an area basis where this proves desirable. The fact that medical services must be localized and accessible should not—and need not—impose arbitrary barriers.

People everywhere should have ready access to whatever services they need, even if this means crossing state and local boundaries. Such an arrangement would make it possible to take geographical and population areas into consideration in planning services. It would also be in the interest of sound economy, since it would make it unnecessary to duplicate specialized hospital care and other costly services, and would spread the benefits of such care more evenly.

I shall pass over the highly important question of the specific benefits which would be available under the plan, since this is a technical matter on which the experts scheduled to appear before the committee are best equipped to testify.

#### COVERAGE OF THE BILL

Coming to the equally important matter of coverage, I want to say at once that we regard the provisions of S. 1606 as feasible, and believe that they represent a substantial advance toward the ultimate goal of the national health program. That aim—and I am deliberately repeating what I have already said, because it is the crux of the whole issue—is to make medical, hospital, and related services readily available to every person who needs them—to make them available without regard to where he lives, or the kind of work he does, or his source of income, or his financial rating. The President prefaced his recommendation on prepayment of medical costs by stressing this principle. You will recall that he said, “*Everyone* should have ready access to all necessary medical services”—and though the emphasizing of “*everyone*” is mine, I think we can read no reservations into this recommendation so far as our ultimate goal is concerned.

The coverage provisions of S. 1606 come near this goal. As it stands, about 75 or 80 percent of the population would automatically be eligible for prepaid health services—either as workers or their dependents, or as beneficiaries of other parts of the social insurance system. As has already been pointed out, special provision is made elsewhere in the bill for personal health services for mothers and children not covered by the insurance system and for the needy.

But as the bill is presently drafted, three large occupational groups would not be automatically eligible for these benefits—railroad workers, Federal employees, and State and local employees—though for some of these groups special arrangements for participation might be made by their employers.

I should like to see at least Federal workers and railroad workers brought within the automatic coverage of the system. In the case of State and local employees, action of State legislatures might be necessary. Neither railroad workers nor Government employees are immune from the hazards of ill-health. There seems no good reason why they should be penalized because of the nature of their employment—particularly in view of the fact that the mobility of our working people might take an individual in and out of the system repeatedly if such an arbitrary dividing line were to obtain.

With this addition, the bill would come near to the President's goal of making medical care accessible to everyone. And these changes, like the basic proposal, are, I believe feasible.

Whatever coverage Congress may provide, the national prepayment health insurance plan would offer no inconsistency with existing provisions of law for medical and hospital service to members of the armed forces, veterans, merchant seamen, and the beneficiaries of Federal and State workmen's compensation laws. Special facilities and services designed to meet the particular needs for such groups would, of course, continue to be required. But the members of these groups and their dependents are also subject to the general health risks common to us all—risks which, by and large, are not wholly covered by the special protections which have properly been afforded them.

In particular, the national health program would provide needed care for their dependents for whom services related to occupational hazards can obviously offer little or no protection. The general health insurance plan would clarify and complement these necessary special provisions. It may safely be assumed that, like the rest of us, these groups and their families would get their money's worth for whatever contributions they might make to the over-all system.

Since everyone is subject to the risk of ill health, it seems to me essential to enable as many people as possible to participate in an insurance system designed to offer protection against such risks. In fact the President has described the objective of the national health program as "the broadest possible coverage for the insurance system."

As I understand the insurance principle, it simply means that people pay premiums, in advance, to obtain protection against a common hazard. It is a way of spreading the costs incident to a

particular risk over a period of time and among a group of people all of whom are subject to the same hazard. Since it is a fact, as pointed out by the President, that we are already spending, on the average, about as much on medical care as the estimated over-all cost of the health benefits proposed, it seems reasonable to look to individual contributions for a substantial part of the necessary revenues. But if general revenue financing is also to carry any considerable part of the cost of the health service benefits, further question might well be raised as to the equity of excluding any groups from the individual health benefit system. These are, of course, questions for the consideration of your committee and for final determination by the Congress as a whole.

The goal—Nation-wide provision for national health—admits of no alternative. When all the evidence is in, the Congress will have a solid base—of fact, of experience, and of that particular American quality of creative vision which we call know-how—on which to make its determination of specific methods.

Mr. Chairman, I have concluded what I desire to present formally for the committee, and I am at your disposal.

(The letter dated March 14, 1946, is as follows:)

[Not for release until April 3, 1946]

FEDERAL SECURITY AGENCY,  
Washington, March 14, 1946.

Hon. JAMES E. MURRAY,  
Chairman, Committee on Education and Labor,

United States Senate, Washington 25, D. C.

Dear Mr. CHAIRMAN: This letter is in response to your request for a report on S. 1606, a bill "to provide for a national health program."

The bill would remove the present money limitations upon the grants to the States for general public health work, for maternal and child health services, and for services to crippled children; would introduce a statutory formula for these grants, such that the poorer States would receive a larger proportion of their expenditures than the wealthier States; and would specify the conditions with which States desiring grants must comply. It would authorize grants to the States for medical care of needy persons. Finally it would establish a national system for the prepayment of medical costs for the people of the country.

On November 19, 1945, President Truman presented to Congress a program designed to assure to the whole population "the right to adequate medical care and the opportunity to achieve and enjoy good health." I interpret S. 1606 as intended to carry out a large part of the President's national health program.

The Federal Security Agency is in full accord with the objectives of S. 1606. The services authorized would contribute substantially toward improving the health and well-being of the American people. Other measures pending in the Congress would deal with other phases of a complete health program, including provision for grants-in-aid for the construction of needed hospitals and health centers and for income against temporary and permanent disability, both of which were included in the President's recommended national health program.

It is the opinion of the Federal Security Agency that a national health program, such as that advocated by the President and implemented in part by S. 1606, is long overdue.

Over the past several years, this Agency has been carrying on studies on national health needs of the American people. As a plan for meeting those needs, the Public Health Service in its annual report of 1944 proposed a six-point program. This program included:

1. Extension to every citizen of the protection afforded by modern environmental sanitation by safeguarding food and milk supplies, constructing and

improving, as necessary, water supplies and sewage-disposal facilities and utilizing effective measures for the control of insects, rats, and other disease vectors;

2. Construction of hospital and health centers in order to achieve an equitable distribution of hospitals and health facilities, to encourage physicians to establish practice in areas where their services are needed, and to aid doctors to practice medicine of high quality;

3. Expansion of public health services so that health departments may be established in every part of the country and public health services made available to everyone, no matter where he may live;

4. Encouragement of more public and private research to discover means of preventing and curing diseases and remedying conditions which sap the national vitality, and to make these findings available quickly to the whole population;

5. Provision of an educational program so that medical personnel may be trained well and in sufficient numbers to meet the needs, and to permit the continual retraining of doctors, nurses, dentists, and other health workers so that they may keep abreast of the latest developments in medical sciences;

6. Institution of a medical-care program to provide medical and hospital service to everyone who needs it, regardless of his ability to pay, and to insure all of the benefits of medical science to the whole population.

The Social Security Board has recommended for several years in its annual reports a compulsory medical-care insurance system.

"Neither the course of present developments in this country nor experience in other countries which have tried voluntary health insurance gives any indication that comprehensive and adequate arrangements to insure medical costs can be made in any way except through a compulsory insurance system. In this aspect of health security the United States faces a situation not unlike that in old-age security a decade ago. At that time, many employers had established sound retirement systems for their workers; some persons had banded together to provide for themselves as a group or had made adequate individual provisions through annuities or other forms of commercial insurance. It was clear then, however, as it is clear now for medical care insurance, that those voluntary arrangements could not be expected to extend to even a majority of the population in need of insurance or to the groups whose needs were greatest.

"Medical care insurance would enable self-supporting families to pay for and get needed medical services without any important alteration because of the insurance system in present forms or organization of medical practice. Moreover, families dependent on public funds could be covered through payment of contributions on their behalf by the agencies administering assistance. They thus would receive care in the same way in which others receive it; the stigma and, typically, the inadequacy of 'poor-law medicine' could be wiped out." (Ninth Annual Report, p. 30.)

#### TITLE I OF S. 1606

The proposals of part A of this title, generally, appear most desirable.

Certainly, availability of the basic public health services to every community is a prime requisite in a national health program. The Federal Government should assist the States in reaching this goal through provision of more liberal grants-in-aid than are now available.

Federal grants-in-aid to States now amount to not more than 10 percent of the total sum expended for public health work. S. 1606 would remove the present ceiling of \$20,000,000 on Federal grants for public health services, and would obligate the Federal Government to supplement State funds (through a specified grant-in-aid formula) as necessary to provide these services. The occurrence of disease and illness anywhere in the country affects the whole country. Yet, as the President has pointed out, approximately 40,000,000 citizens live in communities which lack full-time public health services, largely because community financial resources are inadequate to provide them. The principle that the resources of the whole Nation should be available toward equalizing the opportunities of all its citizens to obtain public health service was clearly recognized as a national policy with the passage of the Social Security Act in 1935. The wisdom of this policy has been repeatedly demonstrated since that time. The significance of S. 1606 in this regard is that provision is made for effectuating this policy in fact for the country as a whole.

While I approve the proposal to remove the present statutory limitation upon the total amount of Federal funds which should be made available to the States for public health work, and to entitle each State to a predetermined percentage of its expenditures in this field, this approach requires that the definition of "public health work" be scrutinized with care, since the definition would determine which of the expenditures by a State would give it a call upon the Federal Treasury. We have not had opportunity to complete our study of the implications of the definition in the bill, but the two following comments may presently be made:

1. The definition overlaps, in certain respects, services for which funds could be granted under part B and part C of title I, and services which would be provided under title II of the bill. Authority is provided in the bill for the Federal agencies concerned to enter into agreements for the coordination of the several parts of the program, and it may be that duplication could thus be avoided; but I believe the bill should be closely examined from this point of view. I assume that parts A and B of title I are intended to deal primarily with the community aspects of health services, and to leave individual care to be provided mainly under title II. In this connection I wish to invite your attention to the President's statement:

"Of course, Federal aid for community health services—for general public health and for mothers and children—should complement and not duplicate prepaid medical services for individuals, proposed by the fourth recommendation of this message."

2. I recommend that that part of the definition of "public health work" which excludes the maintenance and operation of hospitals be so modified as to permit funds under this part to be made available for hospitalization of the chronically ill. Title II provides hospitalization for only a limited period, the maximum duration of benefit being 60 to 120 days a year, and care in mental and tuberculosis institutions is specifically excluded. This leaves the problem of chronic illness largely untouched. Provisions for more adequate care of the chronically ill are needed by all States—desperately by some. Many institutions for all or special categories of chronic illness give little more than custodial care. The problem of caring for the chronically ill, moreover, is increasing as the average age of the population advances. Federal assistance in meeting these problems is urgently needed.

Since demonstration and training of personnel are closely related to the development of the whole public health program, it may be wise to remove the \$5,000,000 ceiling upon expenditures for such activities after the first year and to earmark for demonstrations and training of personnel a specified proportion—perhaps 3 percent—of the total annual Federal and State public health expenditure.

Finally, the bill should be designed specifically to encourage the local participation which is essential to public health programs. It should be a requirement that State plans encourage local administration and financial participation under State standards. However, in order that required local financial participation shall not impede the development of adequate services, especially in communities with insufficient financial resources, the bill should require that the States shall provide for such distribution of funds within the States as to ensure meeting in full the needs of all localities, in accordance with standards established by the States. Such a requirement, as a condition for approval of State plans under section 101 (with respect to section 314 (f) (2) of the Public Health Service Act) would be in accord with the principles that underlie Federal grants adjusted to the economic resources of the States.

If specific legislative provision is to be made for maternal and child care and for services to crippled children, the provisions of part B of title I seem appropriate for dealing with this phase of public health services. I assume that they will be discussed fully, and their appropriate relationship to title V of the Social Security Act will be indicated, by the Department of Labor. I have already called attention to the duplication between parts A and B, and to the desirability of a better dovetailing of these provisions.

The proposals of part C of this title, making Federal financial aid available to States to provide medical care for needy persons, are generally sound and desirable. The provision that State and local agencies may arrange to have care furnished to needy persons through the health insurance system established

by title II is of particular importance, because of the encouragement this gives to the provision of high quality care for needy persons and to the effective coordination of the several parts of a national health program. Of course, if provision were made for universal coverage under title II there would be no need for the special provisions of part C of title I.

I shall wish to make some further recommendations later with respect to part C, especially concerning the treatment of inmates of public institutions.

All three parts of title I contain provisions for grants varying between 50 percent and 75 percent of State expenditures, depending on the per capita income of the States. I am strongly in favor of a variable matching provision. The formula contained in the bill is one of several formulas which achieve the general result of varying Federal grants in accordance with the economic and fiscal capacities of the States. I believe it is a sound formula. Whether or not this precise formula is used, however, I think it important that the formula for the three parts of title I be identical, in order to avoid financial incentive to the States to include particular services or groups of persons under one part of the program as against another.

#### TITLE II OF S. 1606

This title would establish a system of prepaid personal health service benefits, including medical, dental, hospital, nursing, and laboratory services. The provisions are generally workable and in accord with the President's recommendations.

Under the provisions of this title, a large part of the population—probably something like 80 to 85 percent—would be eligible for prepaid personal health services on the basis of automatic coverage as workers or dependents, or as beneficiaries of other parts of the social insurance system. The bill also provides for supplementary coverage of groups not covered automatically, through voluntary arrangements made by public agencies on their behalf. The bill thus goes a long way toward meeting the objective stated by President Truman of "the broadest possible coverage for the insurance system." It falls short of the President's recommendations with respect to three large occupational groups.

The President said: "I believe that all persons who work for a living and their dependents should be covered under such an insurance plan." S. 1606 fails to cover automatically railroad workers, Federal workers, State and local government workers, and their dependents. I recommend that title II be amended to include the first two groups, through deletion of the exclusions in section 217. Questions have been raised as to the compulsory coverage of State and local employees under the present old-age and survivors insurance system, because of doubt as to whether the Federal Government can, under our Constitution, require the States to pay premiums as employers. That question does not necessarily arise under S. 1606, since the bill contains no provisions as to the method of financing. Nevertheless, I would recommend that coverage of this group be extended through voluntary agreements unless, of course, there were universal coverage.

The proportion of the total population who would be eligible for prepaid personal health services might be further increased through a broadening of the definition of dependents of insured workers to include all persons actually dependent on the worker for support. Dependent nondisabled children over 18 and dependent sisters, brothers, aunts, and relatives-in-law would be among the groups not now covered under S. 1606, who could be brought within such coverage.

I believe, however, that the goal of a national health program should be to assure medical, hospital, and related services to every person who needs them, without regard to his employment, source of income, or ability to pay; and that no individual should be excluded from ready access to needed health and medical care. Complete coverage, moreover, though not the only possible method, would be the simplest and most effective way of assuring that medical service would not be stratified so that certain segments of the population, such as the needy, would receive a lower standard of care. It would also make for simplicity, efficiency, and economy of administration, and would eliminate the procedures necessary to establish eligibility. The greater simplicity would conduce to more ready and fuller utilization of the services by the people, as well as to lesser costs of administration. Finally, if general revenue financing is to carry any considerable part of the cost of the health service benefits, the equity of excluding any groups from

the benefits may be questionable. In view of the above considerations, I would recommend that the Congress also give consideration to making the provisions of title II applicable to the entire population. If this be done, the provisions of title I, part C, would become unnecessary.

Regardless of the extent of the coverage which Congress might provide, there would be no inconsistency with existing provisions of law for medical and hospital service to particular groups, such as members of the armed forces, veterans, merchant seamen, and the beneficiaries of Federal and State workmen's compensation laws. Special facilities and services designed to meet the special needs of particular groups would, of course, continue to be required; but all of these groups would become entitled to many services which either they or their dependents do not presently enjoy. It may safely be assumed that they would get their money's worth, or more, for any contributions they might be required to make to a health insurance system.

The basic "methods and policies of administration" set forth in the bill are in accord with the President's recommendation. As the President said, people must remain free to choose their own physicians and hospitals, and doctors must remain free to accept or reject patients and to participate in the system full time, part time, or not at all.

It is generally agreed that the administration of such a program as is contemplated by title II should be decentralized to the maximum extent that is practicable, and that the State and local governments should assume their full share of administrative responsibility. Likewise, the values of regional organization of services should be assured so that patients everywhere can readily cross State and local political boundaries when necessary to obtain professional services in other localities.

The provisions of S. 1606 which require that the Surgeon General give priority and preference to utilizing the facilities and services of State and local governments are in keeping with Federal policy generally. At the same time, it is essential that the availability of benefits and adequacy of services be assured for the entire country by Federal authority. S. 1606 very properly places on the Federal Government the responsibility to see that the services are available, and authorizes it to specify minimum standards to insure satisfactory quality of services, whether provided through State or local agencies or directly by the Federal Government.

State and local participation in the administration of the program is in the already established pattern of public health. If this pattern continued under title II of S. 1606, it would have the great merit of bringing preventive and curative services under effective coordination.

It must be recognized that the utilization of State and local agencies in the administration of this title will call for some measure of Federal control over the expenditures within a State or a political subdivision, in order to avoid the possibility of excessive costs either for administration or for the actual provision of services. For this reason I suggest that the bill be amended to establish or to authorize the Surgeon General to establish appropriate limitations upon the amounts which would be made available to agencies cooperating in the administration of the program.

By providing that the Surgeon General of the Public Health Service shall administer the program, the bill gives assurance that there will be coordination between the preventive, curative, and public health aspects of health legislation.

Section 204 would establish an advisory council to advise the Surgeon General on "questions of general policy and administration." In my judgment the bill is wise in providing that the council's functions in the program shall be purely advisory.

In his message, the President stated that research in medicine and allied fields is an essential part of a general research program to be administered by a central Federal research agency, and that it is also an essential part of a national health program. He called attention to the need for coordination of the two research programs, and pointed out that legislation dealing with medical research should provide for such coordination. Section 213 of the bill, which provides specified sums for the first 2 years and thereafter a proportion of the amount expended for personal health service benefits for grants-in-aid for medical education and research, is in accord with the President's recommendation.

S. 1606 contains no provisions for the raising of revenue. It seems to me wise to consider the benefits to be provided by such a bill separately from the nature of the premiums or taxes which, once the benefits have been decided upon, may be found necessary to finance them. For this reason I shall confine my remarks to one general observation.

As the President pointed out, the people of the United States have been spending, on the average, nearly as much for medical, hospital, and related services as the estimated cost of the health benefits to be furnished under the bill. I believe it is sound policy that individual contributions, in the form of earmarked taxes, should provide a substantial part of the revenues necessary to finance the program.

We are continuing our study of the bill, and hope to have available for your committee in the near future more detailed comment and suggestions with respect to particular provisions of this legislation.

We are advised by the Director of the Bureau of the Budget that, while there is no objection to the presentation of this report to your committee, this advice should not be construed as involving any commitment as to the relation to the program of the President of our alternative proposal to afford universal entitlement under the medical care insurance plan.

Sincerely yours,

WATSON B. MILLER,  
*Administrator.*

#### IS THE BILL SOCIALISTIC?

The CHAIRMAN. Mr. Miller, it is charged by some that this insurance program proposed in this legislation is socialistic. Have you anything to say about that?

Mr. MILLER. I wish that I understood more about what the term means. I realize that the words "socialized medicine" have been used so much, and sometimes carelessly. I think, that they have almost become a dictionary term. I think that we are a social nation, and as far as this proposal being a socialistic one, it cannot be more than democracy in its highest essence because this program cannot be inaugurated, and if it were inaugurated it cannot flourish without the consent and support of the American people. If democracy means socialism, I accept the soft impeachment.

The CHAIRMAN. Well, do you think that it is a proper function of the Government to undertake a program which will be of such benefit to a large section of the country that at present is unable to secure the medical care and attention necessary for the preservation of their health?

Mr. MILLER. Mr. Chairman, Lincoln had a lot of quaint methods of expressing truisms. Once he said that his conception of government was to do for the people only the things that they were unable to do for themselves. I have great pride in the advance of American medicine. I think perhaps you and the other Senators here present, some of you at any rate, will recall that for perhaps two decades before coming to the Government I at least stood on the threshold of medicine, although I had brains enough not to try to invade the profession or try to practice it or prescribe for people.

However, I learned something, as much as a layman should be trusted with, about medicine, and I have great pride in American medicine and American medical people and in the advances in research and in the understanding of ideological factors and diagnostic pro-

cedure, and of course the very marvelous and brilliant advance in therapeutic measures. Nobody is more zealous than I am for the high ethics of American medical practice.

I would not be a party to attempting to force down the throats of American medicine or the people anything not right. But I believe with all of the advances which have been made and with a fairly certain knowledge of the successes and failures of the voluntary systems, that now is the time for the Central Government to spearhead this effort. I think that we can no longer wait.

With great credit to American men and women physicians, the vast amount of free service they do, and the great support that they give to the communities and to our democratic aspirations and advances on all levels, I think that we want to make sure that an anguished mother with a sick child in her arms does not have to go some place and knock at a door and grovel to get the attention that she wants for that baby. That that is a little extreme, I will have to admit, but it is the core of what we are talking about.

Too many of us because of that reason trust too much to optimism that nature will take care of us. There are so many other things in our budget that are so important, and the person has the feeling, "I will get along all right," and that extends even to giving the kids music lessons when they suffer because they do not get medical attention early enough.

#### ADVANTAGES OF THE BILL TO BUSINESS

The CHAIRMAN. Would the establishment of such a system as here proposed be of benefit, also, to business and industrial interests of the country?

Mr. MILLER. Oh, yes, without doubt. I think that the figures of absenteeism were rather completely exposed to the committee by one of the Senators, perhaps Senator Pepper, but I have pulled together a few figures here.

In the critical year of 1942—our first full year of war—illness in one way or another cost American industry 4,000,000,000 workdays, the equivalent of a full year's working time for 13,000,000 people, or more than the total strength of our armed forces.

Senator AIKEN. You say that 4,000,000,000 workdays were lost in the full year in the war from illness?

Mr. MILLER. Yes.

Senator AIKEN. Do you happen to know how many days were lost by strikes in the same period?

Mr. MILLER. I have read the figures but actually I do not have them offhand.

This figure breaks down into 500,000,000 lost workdays of absenteeism caused by illness and accident, the equivalent of 1,000,000,000 lost days due to permanent disability, and a billion and a half due to premature death, and still another billion attributed to the reduced efficiency of those who stuck on the job when they were really too sick to work. Somewhere around 7,000,000 men and women in this country are too sick to work on the average every working day in the

year. The price we paid for sickness and disability in 1943, the wages lost by workers and the costs to business, added up to not less than \$15,000,000,000.

The CHAIRMAN. Thank you, Mr. Miller, for your statement here this morning. I am sure that it will be of benefit to the committee.

Mr. MILLER. I regard these hearings as the most momentous that I have been privileged to attend in two decades or more.

Senator AIKEN. I was interested in Mr. Miller's observations on socialistic ideas. Am I right in the understanding that when a so-called socialistic idea is approved by the majority of the people, through their duly elected representatives, that in your opinion it becomes part of our democratic processes no matter what it was called before?

Mr. MILLER. I do not think that it can fail to do it, the electorate having the right to reverse themselves.

Senator AIKEN. So long as it expresses the desires of the majority of the people, you would call it a democratic process?

Mr. MILLER. Using the term in its best sense, although I am a member of that party that spells it with a capital letter.

Senator AIKEN. The first socialism that I heard of was when I was just old enough to remember it, when it was first proposed to have the RFD routes established, to have the mail delivered to the country people the same as it was to city people, and the charge of "socialism" was made against the RFD at that time. And then the parcel post was a socialist idea, and then the Postal Savings Bank—that was very definitely socialism.

But according to you, when it was accepted and voted for by the majority of the people, I understand that you would take it out of the realm of socialistic ideas, out of that category?

Mr. MILLER. Still admitting that I do not understand the word "socialism," that it may be rather a complex mosaic, I am not sure that I would recognize a Communist and I hear that name a good deal, if I saw one behind the gooseberry bush in the garden, I do sincerely think that this would be democracy in action.

It is pretty difficult for people to realize that when selective service came along, that it really was not a drafting, using the term in its most objectionable sense, but a spectacle of the entire Nation volunteering, and that is what it came out to be.

Senator AIKEN. That was established 150 years ago, I would say.

The CHAIRMAN. The free public school system was very bitterly opposed in this country when it was first proposed, is that right?

Mr. MILLER. Yes. There is so much evidence and I do not want to detain the committee too long. We have never objected, so far as I know, to medical students who have gained their medicine through tax-supported institutions, and that could well be termed "socialized medicine," or "socialized medical instruction." We have a social country here.

The CHAIRMAN. Dr. Mountin is the next witness.

**STATEMENT OF DR. J. W. MOUNTIN, MEDICAL DIRECTOR, UNITED STATES PUBLIC HEALTH SERVICE****INTRODUCTORY REMARKS**

Dr. MOUNTIN. Dr. Parran, whom you invited to appear before you today, asked me to express to you and to the committee his very deep appreciation of the opportunity for the Public Health Service to present testimony with respect to S. 1606.

As he has informed you, Dr. Parran is in Europe, serving on a committee to form an international health organization under the United Nations Organization. He has designated me to appear in his stead, and to express the point of view of the Public Health Service.

Yesterday, Mr. Chairman, when presenting your opening statement you inserted in the record the President's message, on a national health program and expressed the deep interest of the President in this measure. Now, on behalf of the Public Health Service and, in fact, on behalf of public health workers generally throughout the Nation, I want to say how deeply we appreciate the President's interest and his having brought this matter so forcibly to the attention of the Nation. He has, in fact, elevated human health to the position of a major social objective.

On this occasion, too, Mr. Chairman, we wish to record our appreciation of the work of your Committee on Education and Labor and its subcommittees. The facts revealed and, the reports based upon these facts, are classics in their respective fields. They have served in great measure to crystallize the health issue in its present clear-cut form and to rally support for remedial measures.

Yesterday, the authors of the bill gave us their interpretation of its provisions. They told us, also, that additional measures to complete the President's program were contained in other bills now before the Congress. The hospital survey and construction bill, for example, which has passed the Senate and which is now before the House, authorizes funds for the construction of physical facilities essential in a comprehensive health program—not alone hospitals, but health centers, laboratories, and the accessory utilities that go with these main structures. As I recall their statements, a bill is before the House to expand the provisions of the Social Security Act, and to take up the remaining item in the President's health message—compensation for wage loss due to illness and disability.

In this connection, too, I should mention other pending legislation, perhaps not directly related to personal health services or medical care in the restricted sense, but which is very important from the standpoint of public health. I refer to sanitation legislation, particularly those bills that are designed to remedy the rather disgraceful pollution now being added to our inland and coastal waters.

Senator AIKEN. Is there any program being worked out to eliminate stream pollution? Is your agency working with other Government agencies on any program to eliminate stream pollution through

the country? I agree with you that it is disgraceful, and it is also unprofitable to let it continue.

Dr. MOUNTIN. A specific program of remedial measures, no, but basic studies and field surveys are in progress. Additional legislation is needed which will take us beyond the study and the survey stages, into actual aid on the construction of needed facilities.

Senator AIKEN. I have not heard this matter mentioned by any witness up to now, and I am particularly interested in it, because I think it is one of the most important undertakings that the country can embark upon.

When we see our little streams polluted as they are, carrying disease and spoiling the fishing, it strikes me that it would be one of the most profitable undertakings that we could engage upon, and not only from the health standpoint, but the recreational standpoint, the industrial standpoint, and every other standpoint. It could be worked in in some cases with flood control. It is so very important that it is a mystery to me why we have not been doing something about it before now, and why we delay any longer in undertaking it.

Dr. MOUNTIN. In addition to the point you have raised, Senator, there is one still more serious. On account of the pollution now going on many streams that otherwise would be suited as sources of water supply are rendered not available for that purpose. It is a serious economic situation. I am, perhaps, dragging in this subject at an inappropriate time since it is not up for consideration, let me therefore return to S. 1606.

Senator AIKEN. It is tied in with the entire subject of rural sanitation, as well as urban sanitation.

Dr. MOUNTIN. That is correct.

At the outset, I should like to record that the Public Health Service is heartily in sympathy with the type of program that is envisaged by S. 1606. I have a prepared statement which I shall be glad to read if you choose, Mr. Chairman. If the committee would agree, however, I would prefer to submit it for the record and then proceed to an informal discussion of some of the high points, at the same time answering the questions that you might raise.

The CHAIRMAN. Of course, if you desire, it will be incorporated in the record, and then you can dwell on the high points in the statement. (The statement is as follows:)

STATEMENT OF JOSEPH W. MOUNTIN, M. D., MEDICAL DIRECTOR, U. S. PUBLIC HEALTH SERVICE, ON S. 1606, BEFORE THE SENATE COMMITTEE ON EDUCATION AND LABOR

#### OBJECTIVES OF THE BILL

The Public Health Service interprets the bill before this committee, S. 1606, as a vehicle to put the major elements of the President's national health program into effect. The objective—the goal—of the President's program and of this bill is to assure every citizen "the opportunity to achieve and enjoy good health." In its underlying philosophy this program recognizes the fact that good health for all our people is a national asset, in peace as well as in war, and that investments in health yield handsome returns in national vigor and productivity.

But it rejects the notion that health is a commodity which can be nicely calculated and distributed according to the standards of market-place economics. Rather, its fundamental premise is that ready access to health service and medical care is not a luxury to be bought only by those who can pay, but the right of every American—wherever he may live and whatever he may earn. Unlike most previous health legislation proposals, therefore, this bill does not confine itself to a single facet of our national health program. Instead, its sponsors have taken the broad measure of our health needs as a whole and have boldly proposed action designed to meet these needs.

I have underscored this question of goals because I believe it is fundamental to the consideration of the bill before this committee today. Unless the objectives of this bill are first compared with those of more restricted proposals, the merits of its specific provisions cannot be fairly appraised.

As the Federal agency primarily responsible for the protection and promotion of the Nation's health, the Public Health Service believes that public recognition of this goal of good health service for all our people is long overdue. We further believe that this goal is within our power as a nation to achieve as soon as a program is adopted which is based on a forthright appraisal of needs.

I am sure it is not necessary here for me to review in detail the facts surrounding our national health needs or to demonstrate that the American people are not now enjoying the full benefits of modern medicine. The Public Health Service on several previous occasions has submitted to the Congress comprehensive studies of our health deficiencies, and this committee has summarized these needs in its own publications. There are several salient points, however, that I should like to recall to the committee's attention because of their direct bearing on the issues underlying S. 1606.

All of us—laymen and medical men alike—derive a large measure of satisfaction from reviewing the progress made to date in the battle against disease and preventable death. Through the combined efforts of scientists, medical practitioners, and public health officials, the average life expectancy at birth has been steadily extended from 49.7 years in 1900 to 65.1 years today, as indicated by chart I. The progress represented by these statistics is indeed gratifying, and we all have reason to be proud of these accomplishments. But I am afraid many people are prone to assume that these favorable trends have some magic capacity to project themselves automatically into the future, and that time alone will extend the conquest of disease.

Unfortunately, this comfortable fatalism is not supported by the facts. Even a brief analysis of our progress will demonstrate why we cannot rely on present momentum to overcome all obstacles to good health. As chart II shows, improvement in life expectancy at birth has not been paralleled by a corresponding improvement in the expectancy of persons who have reached the age of 40. In fact, the remaining life expectancy for people at this age has been extended only a little over 3 years since 1900. Thus, the average life expectancy of most of us here today has increased very little over that of our grandfathers in 1900, even though babies born today have a much greater expectancy than those of us born around 1900.

The age factor in life expectancy is particularly important when we recall that our national population as a whole is becoming older. In 1900, 1 person in 25 was 65 years of age or older; today, 1 person in 15. By 1980, the ratio will be 1 to 10. At our present rate of progress, more babies will live to maturity, but the years of maturity will be extended only slightly, if at all.

This conclusion is partly explained by a comparison of diseases which have already been brought under control with those for which the death rate is increasing. I believe that the representative sample of diseases in these two categories portrayed in charts III and IV will serve to indicate the significant features of this comparison.

Chart No. III shows the trend in death rates for four diseases—typhoid fever, diarrhea and enteritis, diphtheria, and tuberculosis—which have been substantially reduced or even virtually eliminated since 1900. Also included in this category are such diseases as smallpox, yellow fever, and pellagra. It is largely through progress in control of such diseases that the life expectancy for people under 40 has been so strikingly improved.

This progress has, for the most part, resulted from new scientific knowledge applied through organized programs of mass prevention or treatment. Typhoid fever, diarrhea and enteritis, malaria and yellow fever were conquered by environmental sanitation; diphtheria and smallpox by immunization; pellagra by

nutrition; and tuberculosis is now being steadily overcome through programs for the early discovery, isolation, and treatment of the disease.

Turning to chart IV, however, we find three examples of a group of diseases which are accounting for an ever-increasing number of deaths. The date rate from cancer in 1943 was almost double that of 1900. More than twice as many people died from diabetes in 1943 as died from this disease at the turn of the century. Despite the great progress made in many fields of medical science, 23 persons in 1943 succumbed to heart disease to every 10 in 1900. In addition to these three diseases, arthritis, rheumatic fever, peptic ulcer, hypertension, and nephritis continue to take a heavy toll in disability or death.

The increasing death rate for these diseases, most of which strike men and women in the peak productive years of life, is the principal reason why so little improvement has been made in the average life span of people in the older age groups.

If any significant progress is to be made in this health area, means must be developed for insuring the application of present scientific knowledge to the control of diseases of maturity. This does not mean, however, that we can apply the traditional public-health techniques of control to this disease category. Unless medical research reveals some new methods of attack—and probably even then—the only effective means of helping the victims of these diseases is to provide them with adequate medical care through full personal health services. Even without specific preventive measures, much can be done to reduce the severity of these diseases and their disabling effects by insuring that their victims could have the full benefits of present medical knowledge and skills. Early diagnosis and treatment would in many cases prevent serious developments, and in every case would at least minimize or postpone the disabling effects of these diseases.

I do not want to give the impression that the need for a medical-care program is based entirely on the health needs of people over 40 years of age. Although the traditional public health techniques have been effective in reducing sharply the death rate among infants and young people, there are still many diseases which continue to threaten our youth and which are not amenable to mass controls. Rheumatic fever, for example, remains a major health hazard of the young. So do appendicitis, pneumonia, and poliomyelitis. It is only through the provision of adequate medical care on an individual basis that it will be possible to reduce the harmful effects of these diseases. Adequate medical care for all people—old and young alike—must be the cornerstone of any program designed to meet the health needs of the Nation.

While this brief review of our health needs is by no means complete, I believe it will serve to illustrate the need for a comprehensive and closely coordinated national health program. No single method or approach will do the job. Great medical advances have been made through scientific research, but scientific discoveries must be brought to all those who need them before they can be completely effective. It has been proved that mass attacks through traditional public health techniques can reduce some diseases to insignificant proportions. But such programs still leave a broadening sector of the disease front to be attacked through improved medical care—by personal health services as contrasted with mass services. It is because S. 1606 is designed not only to strengthen present programs, but to supply the missing link of personal health services, that the program outlined in this bill has the endorsement of the Public Health Service.

In general, the bill provides for a three-pronged approach to our national health problem. First, through grants-in-aid to States, it makes possible the expansion of public health services, maternal and child health care and the medical care of needy persons; second, through grants-in-aid to nonprofit institutions, it provides for the expansion of medical research and of professional education. Finally, it establishes a Nation-wide program of medical care, which is based on need for services rather than on ability to pay.

The Public Health Service recognizes that not all of the features of the President's program are covered by the bill. However, such missing elements as the construction of hospitals and health centers, aid for the provision of sanitary facilities and for the abatement of stream pollution, together with protection against loss of wages from sickness and disability are contained in other measures now pending before the Congress.

In order to consider more specifically the provisions of S. 1606, I shall discuss each of its principal features briefly,

## EXTENSION OF PUBLIC HEALTH SERVICES

Proposals for the expansion of public health services, contained under title I, part A, generally appear most desirable. I am sure we all recognize that the availability of the basic public health services to every community is a prime requisite in a national health program. The occurrence of disease and illness anywhere in the country affects the whole country. Yet, as the President has pointed out, approximately 40,000,000 of our citizens live in communities lacking full public health services, largely because community resources cannot provide them. The time has arrived when the States should require every community to establish and maintain such services to minimize the risks of illness. It is appropriate for the Federal Government to assist the States in reaching this goal through provision of more adequate grants-in-aid.

Federal grants to the States now amount to less than 20 percent of the total sum expended for public health work. S. 1606 would remove the current ceiling of \$20,000,000 on Federal expenditures for general public health services, and would obligate the Federal Government to supplement State and local funds, through a specified grant-in-aid formula, as necessary to provide these services. The significance of S. 1606 in this regard is that for the first time provision would be made for effectuating Nation-wide establishment of local health services.

## SUGGESTED PUBLIC HEALTH SERVICE AMENDMENTS

In order that the provisions of title I, part A, might be most effective in carrying out the purposes of the bill, the Public Health Service would like to suggest two additions to this section for the consideration of the committee.

First, we suggest that the definition of public health work be amended so as to permit maintenance and operation of hospitals for the treatment of chronic disease, including mental disorders and tuberculosis. In this way, assistance may be given from public health funds to meet in part the costs of hospitalization of persons suffering long-time illnesses.

Because of the importance of these activities, the section of part A which provides for demonstrations and for training of personnel shall be amended to remove the \$5,000,000 ceiling after the first year and to earmark for demonstrations and the training of personnel a specified proportion—perhaps 3 percent—of the total annual Federal and State public health expenditure.

Since the provisions of title I, part B, calling for increased grants to States for maternal and child care will be discussed more fully by representatives of the Children's Bureau, I shall comment only briefly on this part of the bill. The Public Health Service believes that health services for mothers and children need to be extended under both titles I and II. It may also be desirable to amend title I, part B, to make clear that personal health services as well as preventive services will be authorized for any mothers and children who may not be covered under title II. The proper coordination of services for mothers and children under title I, part B, with those provided for the rest of the population requires that the Children's Bureau and the Public Health Service be placed under a single administrative authority. We believe that the unified administration of a health program is of the utmost importance; that a single Federal agency should direct the program at the Federal level; and that the policy of a single administrative agency also should be followed through, as far as possible, at the State and local levels.

Federal grants to support medical care for the needy, as provided by part C of title I, are to be administered by the Social Security Board. The Public Health Service is in agreement with the principle that provision of adequate medical care of the needy is a public responsibility in which the Federal Government should share, but I shall leave a detailed analysis of this part of the bill to representatives of the Social Security Board. The only question I should like to raise on this point deals with the relation of this part of the program to the provisions of title II. My discussion of part C is therefore deferred until later in this statement.

## GRANTS FOR MEDICAL RESEARCH

Since the proposals covering grants for medical research and education which are contained in section 213 of title II are closely related to the public health provisions of the bill, I should like to comment on them briefly before proceeding to a more detailed discussion of the medical care provisions of that title.

I need not explain to this committee the contributions of scientific research to past victories over disease, or its vital role in any future program for a healthier Nation. Other provisions of the bill are directed toward making available to all our people the benefits of the best medical knowledge and skills. But medical science has yet to find defenses against many of our worst disease enemies. As I pointed out earlier, there is particular need of research into the causes and cures of heart disease, hypertension, cancer, arthritis, and other maladies to which people in the middle or advanced years are so susceptible. In addition, research efforts toward the conquest of the common cold, mental disorders, dental disease, and residual impairments must be redoubled. Nor should research be confined simply to causes and cures. New and better methods for preventing disease must also be developed.

Scientific investigations conducted under the bill need not duplicate in any sense the type of research to be carried on under the National Science Foundation, proposed by the President. Rather, the investigations would be directed particularly to problems arising out of the operation of a national health program, and would include not only laboratory and clinical studies but also administrative research into the best methods of providing medical care.

#### MEDICAL EDUCATION

Section 213 of title II also authorizes Federal grants to nonprofit institutions to provide support for expanded educational programs for medical personnel—physicians, dentists, nurses, and auxiliary personnel. That more medical personnel are urgently needed today is too conspicuously evident to require documentation here. Even with the return to civilian practice of large numbers of trained personnel from the armed forces, many needs will still be unfilled. Furthermore, many of these personnel have indicated a desire for intensive study before reentering civil practice. It is gratifying to note that the bill gives priority and preference to the educational needs of veterans during the 5 years following the effective date of the program.

The bill also recognizes that opportunities for graduate education should be provided for all medical personnel—even those with many years of practical experience. Advances in scientific knowledge cannot be fully effective unless all practitioners are kept up to date on new discoveries and on the best methods of applying these discoveries in clinical practice. For the doctor, the dentist, the nurse, and the laboratory technician, professional education must be a never-ending process. This bill properly seeks to encourage and support such self-improvement by providing financial assistance to medical, dental, and nursing schools and other institutions which must provide the facilities and teachers for this continuous educational program.

It is for these reasons that the Public Health Service generally approves and endorses the provisions of S. 1606 for the extension of medical research and education.

#### CASH BARRIERS TO ADEQUATE MEDICAL CARE

Despite the importance of organized preventive health services, of research and education, and indeed of widespread hospital and health-center construction contemplated in other legislation, the effectiveness of all these measures must be limited unless another basic problem is solved. This is the problem of providing adequate medical services for all who need them.

We must face the fact that a highly inequitable cash barrier now keeps medical care from millions of our citizens. Despite the frequently unrewarded service of physicians to the poor and the excellent provisions of many public welfare medical programs, the private family-by-family system of paying for medical services means that, on the whole, only those services can be obtained which the family is, at the time, in a position to pay for. As a result, we find that medical services received bear only a casual relationship to health needs. The lowest income groups, among whom illness occurs with greatest frequency and longest duration, actually receive the smallest volume of medical services. It has been stated that "the rich and the poor get adequate medical care and only the middle income group suffers." Nation-wide studies conducted under the technical supervision of the Public Health Service do not bear this out. They show that medical services follow the call of the dollar sign with unflinching consistency, while disease and disability strike in the opposite direction. This is forcibly illustrated by charts V and VI. Chart V shows that, as measured in terms of days of disability, the burden of illness falls most heavily on persons in

the lower-income categories. But, although their needs are the greatest, persons with low incomes do not receive their share of medical services, as is indicated by chart VI. You will notice, in fact, that the benefits of doctors' and dentists' services, as well as hospital care, depend upon the income of those who are in need of care. In other words, medical care in the United States today is a matter of being able to pay the price.

Much of the difficulty in obtaining needed medical care is related not merely to inadequate income, but to the inability of an individual or family to budget for medical costs. In all income groups, medical costs strike highly unevenly. In any one year, medical expenses appear to constitute no overwhelming problem to a majority of families; an unfortunate minority, however, are crippled with high medical costs. In which group any family will fall cannot be told at the beginning of a year. It is, therefore, practically impossible to budget on a family basis.

#### MALDISTRIBUTION OF MEDICAL SERVICES

Chart VII illustrates another unfortunate consequence of this relationship between purchasing power and medical services—namely, a serious maldistribution of medical resources among different sections and communities. In other words, people who live in areas of high average income have more medical personnel and facilities to serve them than the people who live in low-income areas.

Because service has depended primarily on individual or family ability to pay, it has been natural and inevitable for physicians to settle in areas where local purchasing power has been most ample, where their skills could be most fully utilized and they could make the best living. The same has applied to dentists and other health service personnel. The maldistribution of medical resources has been especially pronounced between the cities, with their higher average income levels, and the rural areas, with their lower average income levels. As the costs of medical care or, put in another way, the costs of financing the skills of physicians, have risen, this maldistribution has grown increasingly more severe. There are hundreds of counties throughout our country today supplied so poorly with doctors that millions of people in them are simply unable to get medical attention in time of need. What is more, there are no signs of improvement, and the pattern of settlement being elected by thousands of physicians and dentists leaving the armed services is serving further to exaggerate present disproportions. There seems to be no prospect of solution of this crisis facing rural areas, unless steps are taken toward equalizing the financial support for medical services in all parts of the Nation.

Likewise, there has been a natural tendency to build hospitals in areas where they can be best utilized and financially maintained. As a result, as indicated by chart VII, the disproportions in the supply of hospital beds between areas are no less severe than those relating to physicians. Other legislation receiving the attention of the Congress is designed to correct some of these deficiencies, but it is clear that—no matter how many structures may be built—hospital services cannot be made available to people in relation to their needs without a pooling of resources.

#### VOLUNTARY INSURANCE PLANS

Over the years, the American people have accumulated considerable experience in this pooling of resources through applying the insurance principle to the costs of sickness. Organized groups representing industry, labor, farmers, and fraternal organizations have pioneered in the protection of people against the financial hazards of illness. More recently, hospitals and professional societies have offered the protection of insurance to cover the costs of certain categories of medical care. These groups have pointed the way to the future because they have demonstrated that the insurance principle can be applied to the economic problem of illness.

Voluntary insurance plans in this country vary considerably as to the form of benefits provided to their members. Some reimburse the patient in cash for all or part of specified medical expenses; others provide benefits in the form of direct services. The scope of benefits varies even more. Some plans cover hospital services only, while others include one or more categories of medical, dental, or nursing benefits. All contribute toward easing the economic burden of illness, but all suffer from numerous inherent shortcomings.

First of all, the premiums charged by voluntary plans for anything approaching comprehensive services are too high for persons in the lower income groups—the very persons needing protection most. With few exceptions, premiums or

their membership fees are based on scope of benefits, with little or no adjustments for families in different income brackets.

Second, to guard against unfavorable risks, voluntary plans have found it necessary to restrict their services in many ways. While benefit provisions vary from plan to plan, all exclude care for some type of illness. Most common among these exclusions are treatment of conditions which existed before enrollment, chronic sickness, maternity care during the first 10 months of membership, home calls, nursing care and dental service. Thus, many vital health needs are not met through the services provided by voluntary plans.

Third, the development of voluntary health insurance plans on a community, county, or State basis tends to limit the scope and content of services in proportion to the average per capita wealth of that area. A voluntary prepayment plan developed in a poor rural community could never offer its members the range or quality of services of a plan developed in a wealthy metropolitan area. Voluntary plans provide no mechanism for equalizing the capacity of different areas to support necessary medical services.

Fourth, because of their small-unit operation and the recurring task of "selling" plan memberships, most voluntary plans incur relatively high administrative costs.

These contentions are not mere theory. We may look at the actual record of voluntary health insurance in the United States and abroad. In practically every other industrialized nation, the development of voluntary health insurance plans has served as a prelude to the establishment of compulsory insurance programs—not because the voluntary plans did not perform a useful function, but because they did not perform service of sufficient scope for enough people and for those who need service most.

In the United States, the most successful application of the insurance principle has been with respect to hospitalization. From its beginning 17 or 18 years ago, the most extensive group hospitalization movement has grown rapidly to cover about 20,000,000 persons.

An evaluation of this program compels me to point out, however, that despite the unprecedented economic prosperity of the last few years, membership in these plans is largely concentrated in a few industrial States and that some 85 percent of our population remains without this hospitalization protection. Moreover, the insurance protection offered under this program encompasses hardly more than the 15 percent of the total medical care bill of the average American family.

As for comprehensive medical care insurance, experience in this country so far gives even less reason to be sanguine for a significant future expansion. Despite a history that dates back to the Nineteenth century, insurance for anything approaching general medical and hospital services—rarely indeed including dental care, home nursing or other special items—encompasses less than 3 percent of our national population.

#### ADVANTAGES OF A NATIONAL PROGRAM

All of these considerations have led the Public Health Service to the conclusion that only a Nation-wide program of medical care, under official auspices, holds the promise of assuring adequate medical care for all the people.

On a Nation-wide basis, the cost of medical care would be related to ability to pay, and services would be provided in accordance with health needs. Administrative costs would be lower; payments for professional services would be more ample. There would be equitable spreading of funds between areas of varying wealth. Rural sections, with their generally lower income levels and their greater medical care needs, would be particularly benefited. The scope of health services would be considerably broader and the quality more uniformly high.

Passage of a national health bill would not, of course, create adequate medical care for all persons overnight. It would, however, make immediately accessible to all insured persons the medical personnel and facilities at hand in their communities. More important, the medical services furnished an individual would be determined by his need of them and not by his bank balance.

Moreover such a program would go a long way to encourage a better distribution of physicians and dentists around the Nation. Existing institutions as well as institutions to be built under the proposed national hospital construction program would be assured of proper financial maintenance. Medical and allied personnel would no longer have to concentrate in larger cities to make a living,

and the people of our great rural districts would become supplied with their fair share of doctors and other health workers.

I should like now to turn to a more specific discussion of the provisions of Senate bill 1606 which relate to the establishment of a Nation-wide program of medical care.

#### UNIVERSAL COVERAGE PROPOSED

As eligibility and coverage are now defined in S. 1606, it is estimated that from 75 to somewhat over 80 percent of the population would be covered, depending upon the economic condition of the country. The Public Health Service would like to see this program assure medical services to 100 percent of the population. We believe that this would be not only more equitable but also less complex administratively and, in the long run, more economical.

If coverage were made universal, there would be no need for special programs of personal health services for particular groups such as the "needy" and mothers and children, as now called for in parts B and C of title I of this bill.

The character of medical benefits provided in S. 1606 has the heartiest endorsement of the Public Health Service. The provision of medical benefits in the form of personal service, rather than as cash indemnification, is the best assurance that beneficiaries will, in fact, get the medical care they need without financial handicaps.

#### NEED FOR COMPREHENSIVE SERVICES

Provision of comprehensive services—including the services of physicians and dentists, hospitalization, laboratory services of broad variety, and home nursing—is the only sound approach to health needs. To provide some types of service without others would be poor health practice; it would also be poor economics. To be protected against hospital costs alone, for example, while not enjoying the certainty of physicians care, is the very opposite of a preventive approach. When a person is ill, he should not have to wonder if his illness is serious enough to warrant the expense of a doctor's care. The financial as well as the human cost represented by a hospital case might often be avoided entirely by the early attention of a physician. The need for medical treatment of systematic disease might often be avoided entirely if dental care were provided. Comprehensive services obviously makes the best sense.

At the same time it is well to recognize that certain controls over services and some limitations must be incorporated, even in a national program of comprehensive medical care, if sound and economical use of funds is to be assured.

The bill realistically leaves considerable leeway, for example, with respect to dental care, home-nursing, and "laboratory benefits" (including clinical laboratory services, diagnostic and therapeutic X-ray, physiotherapy, refractions and eyeglasses, supplies and commodities). It recognizes the dependence of a full scope of such benefits on the sufficiency of funds and the adequacy of personnel and facilities. Services which are more or less optional, or for which facilities and personnel are limited in some respects, must await financial experience and provision of adequate personnel and facilities before their ultimate scope can be finally determined. An example is drugs, which might be provided as a type of supply and commodity among the "laboratory benefits."

One fundamental question related to the matter of benefits probably requires clarification. The ultimate objective and responsibility of the National Government must be to achieve a universally high quality of medical care in all parts of the Nation in the shortest possible time. This cannot, however, be done overnight with respect to all categories of service. It can be done in some places sooner than other. Any legislation should recognize that there will be some delay before a uniform quantity and quality of medical care can be furnished to all eligible persons.

#### PROBLEMS OF ADMINISTRATION

One of the most important issues in the formulation of a national health program is, of course, the method of administration. As a physician, I am acutely aware of the personal nature of medical services. I am also aware of the prerogatives of the medical profession and of the importance of having its cooperation in any medical care program. No program could operate effectively which did not recognize these facts.

It would be medically undesirable and administratively impossible to operate a program of personal health services entirely out of Washington. Decentralization must be the rule. There must be flexibility to take account of different facilities, personnel, customs, and attitudes in different places throughout the Nation. For this reason, the Public Health Service is pleased to find the provision in S. 1606 that "the Surgeon General shall, insofar as practicable, give priority and preference to utilizing the facilities and services of State and local departments or agencies on the basis of mutual agreements with such departments or agencies." The Public Health Service has had a gratifying experience in just such relationships for many years, and there is every reason to believe they will continue.

At the same time, it is clear that the Nation-wide scope of this program and the Nation-wide origin of funds to finance it create the necessity for certain national standards. If adequate services are to be assured everywhere, the Public Health Service must obtain assurances that State and local agencies to which it delegates authority are, in fact, willing and able to bear responsibility commensurate with this authority. The Public Health Service would not be averse to the stipulation of standards for administration which the Surgeon General might apply in determining the desirability of delegating responsibilities to a State or local agency.

Aside from providing for participation in the administration of this program by units of State and local government, S. 1606 calls for the negotiation of "co-operative working arrangements \* \* \* with private agencies or institutions, and with private persons or groups of persons, and with combinations thereof, to utilize their services and facilities and to pay fair, reasonable, and equitable compensation for such services or facilities." The Public Health Service interprets this to mean that the Surgeon General will be free to utilize the services of voluntary associations that have already accumulated experience in health service plans of different types in the administration of personal health services.

All organizations engaged directly in the provision of medical care—such as group practice clinics or industrial health establishments—would obviously be looked to for the continued provision of integrated medical services. They would derive their main financial support for the care of insured persons from the national personal health services account rather than from private individuals themselves, as in the past.

Organizations not engaged directly in the provision of medical care, but serving currently as middlemen between a number of providers and a number of consumers of medical care, might also play a role in the program. It would be necessary, of course, for them to demonstrate that they can contribute to its operating efficiency and economy. Included among these organizations, on the one hand, might be those representing primarily the providers of medical service, such as medical society prepayment plans or group hospitalization plans and, on the other hand, organizations representing primarily consumers of medical care, like some fraternal lodges or farmers' cooperatives. Under a national health program, financed through social insurance and taxation, it is clear that one major task of these organizations—the collection of prepayment contributions from members—would cease to be necessary. But organizations primarily representing providers of service may continue to act as agents of professional personnel or institutions.

Certain other administrative problems should be given attention in considering legislation of this kind. I refer to such matters as the definition of "physician," standards for participation of hospitals, authority to apply "controls over abuses," on a local rather than a Nation-wide basis, and sanctions to make possible the discharge of Public Health Service responsibilities. Some consideration might also be given to providing specific inducements for the settlement of physicians and dentists in rural areas—in order to assure equal opportunity for health services to our great farm and village population.

#### SAFEGUARDS TO FREEDOM

The ultimate test of this program, of course, is how it will operate for the individual patient and the individual doctor. I am sure we are all aware that a satisfactory personal relationship between doctor and patient is an essential feature of any national program of medical care. The Public Health Service is convinced that such a program will not in the least injure such relationships but will

actually enhance them by eliminating the cash barrier between the patient and the doctor.

As I read S. 1606, it seems to me to preserve the customary freedoms in American medicine. When an insured person gets sick or feels the need for medical care, he will, of course, have freedom to see a doctor or not. If he desires medical care, he will be able to go to a physician or dentist of his own choice. There will be no need for an official "authorization" for service of any kind; the patient will go directly to his doctor exactly as he does now. Only the problem of paying the bill out of his pocket at the time will be eliminated. He may have to present a simple eligibility card—something like a Social Security card—which would be issued to each covered person perhaps once a year. Even this simple step would be unnecessary if 100 percent of the population were covered.

All physicians, dentists, hospitals, nurses, and others will at the same time be free to participate or not to participate in the program. Even if a doctor chooses to participate, he will still be able to maintain an independent private practice, if he wishes. He may, for example, continue to serve privately persons who are not covered by the program. He will continue to have freedom to reject any particular patient entirely, just as he may do now.

Participating doctors and dentists in any area will have freedom to choose the method by which they will be paid. A majority vote in each area will determine the preference of the local general practitioners, whether they wish to be paid by a fee for each service—as they usually are now; by annual amount for each person choosing them as his family doctor (the capitation method); or by a full-time or part-time salary. On the other hand, the minority of practitioners in any community may still be paid by the method of their particular choice, if this is administratively feasible. Specialists may work out their method of remuneration by agreement with the Surgeon General. Fees and salaries need not be nationally uniform, since the bill provides for variations to take account of many factors that govern doctors' incomes today.

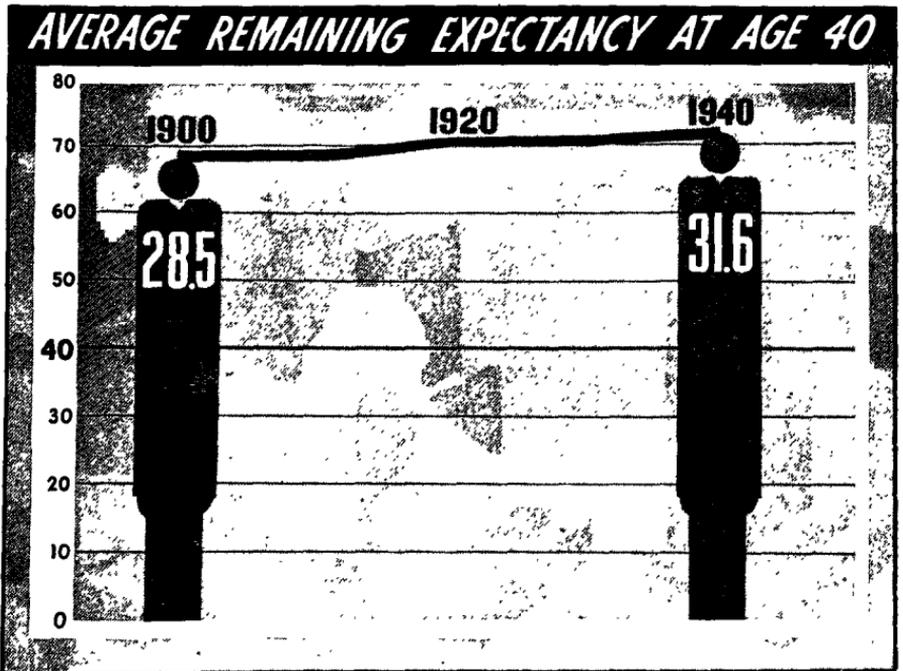
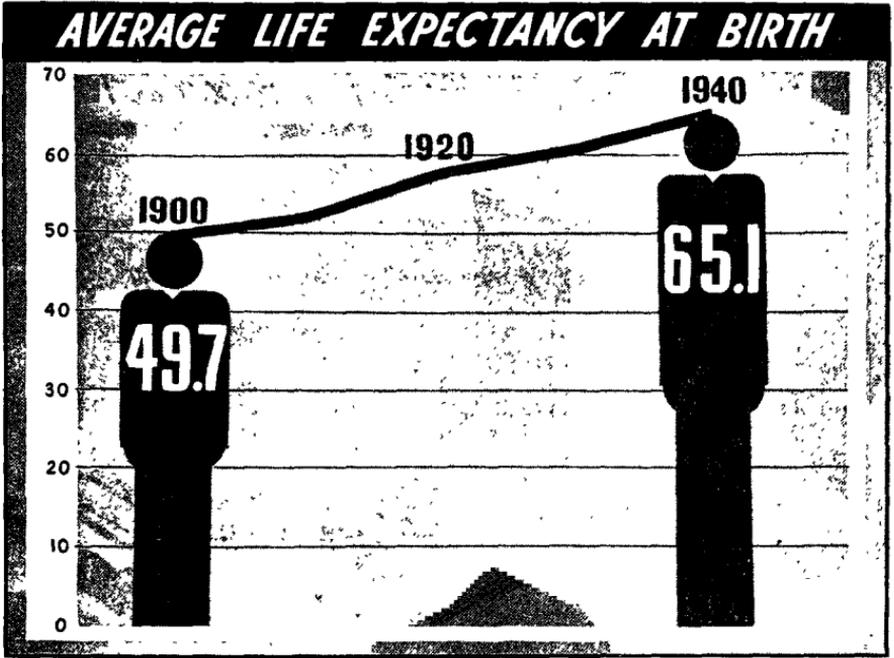
Under the fee-for-service method of payment, the doctor will submit his bills for payment to a local area office, perhaps monthly. Confidential medical information acquired in the course of administration will not be divulged. Bills will be paid promptly, probably more promptly than is often the case in private relationships. The net payment for all services rendered will probably be better than it was in any normal year. If capitation or salary is the chosen method of remuneration, payments will be made regularly without the submission of bills for service.

The doctor's professional judgment will continue to govern his treatment of patients and the methods of diagnosis and treatment to be used. The quality of his work should, in fact, improve with the elimination of financial restrictions on the performance of thorough-going scientific medicine. When laboratory tests are indicated, he will be free to have them performed without having to ask the patient if he can afford the price. If X-ray examinations are necessary to establish a diagnosis or follow the course of a condition, they will be made. If the case calls for a consultation or the assistance of a specialist, suitable referrals may be made. If the patient requires hospitalization, it will be arranged for without delay. I know that the availability of many of these special services will depend to a large extent on the accessibility of personnel and facilities, but the very operation of this program should stimulate the development of these resources where they are lacking now.

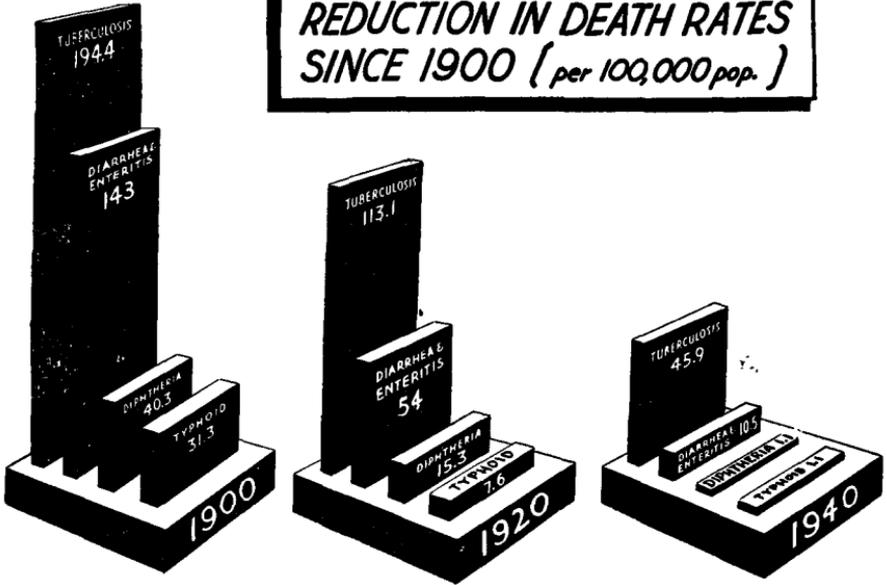
In carrying the responsibility of administering a national health program, the Public Health Service would require the advice and consultation of professional groups and representatives of the public throughout the Nation. It is gratifying, therefore, to find that S. 1606 calls for well-balanced advisory bodies to guide and assist responsible public officials at all levels of administration, from Federal to local. Such bodies are the surest guarantee that the entire program will be administered judiciously and democratically, taking into account the best interests of all concerned.

#### ENDORSEMENT OF BILL

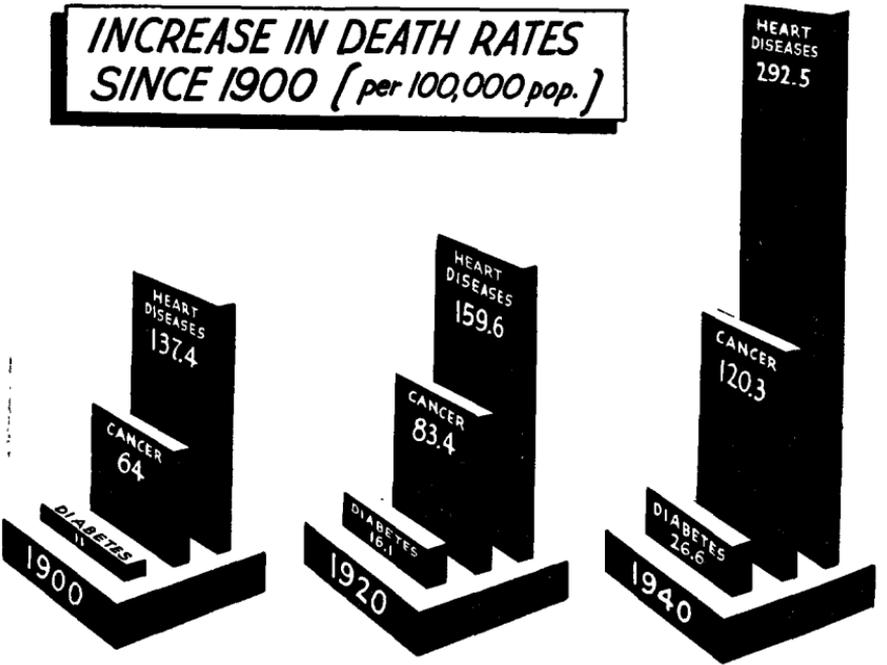
The Public Health Service strongly urges the enactment of legislation for the adoption of a comprehensive national health program. Although we are fully aware of the heavy responsibilities it would place upon the Service, we are confident that such a program can be effectively administered. Finally, we believe that, with appropriate modifications, S. 1606 provides the basic legislative framework for putting this program into effect.



**REDUCTION IN DEATH RATES  
SINCE 1900 (per 100,000 pop.)**



**INCREASE IN DEATH RATES  
SINCE 1900 (per 100,000 pop.)**



## RELATION OF SICKNESS TO INCOME

ANNUAL FAMILY INCOME

DAYS OF DISABILITY PER PERSON

UNDER \$1,200



\$1,200 - 1,999



\$2,000 - 2,999



\$3,000 and OVER



## INCOME DETERMINES MEDICAL SERVICES RECEIVED

ANNUAL FAMILY INCOME

PHYSICIANS' CALLS

DENTAL CASES

GEN. HOSPITAL CASES

per 1,000 pop.

per 1,000 pop.

per 1,000 pop.

\$10,000 and OVER

5321

867

97

\$5,000 - 10,000

3977

517

78

\$3,000 - 5,000

2995

347

62

\$2,000 - 3,000

2509

248

58

\$1,200 - 2,000

2268

186

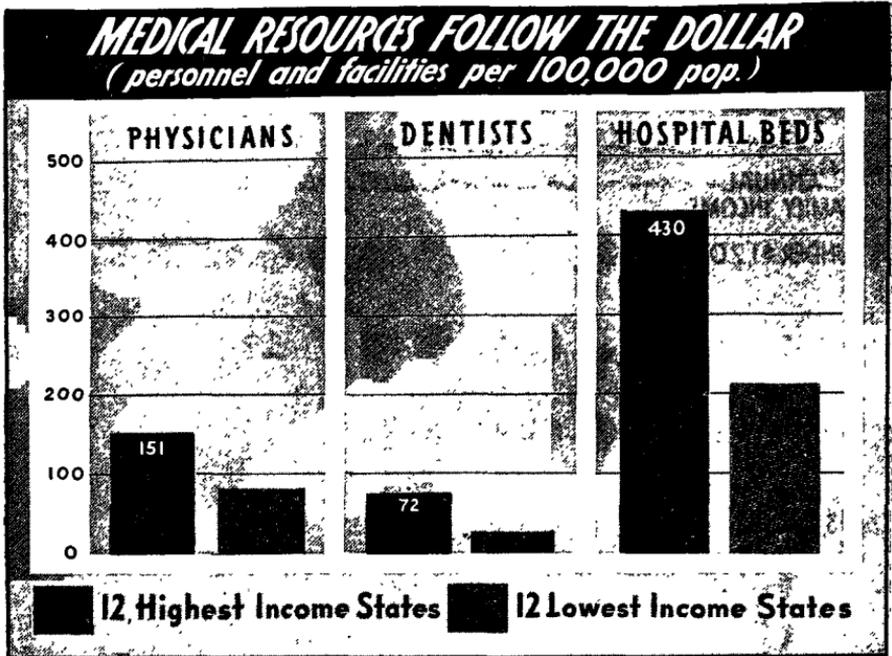
51

UNDER \$1,200

2169

115

55



Dr. MOUNTAIN. I recognize fully that the title of this bill which has aroused greatest interest and controversy, and which is most important from the standpoint of its social implications and the money involved, is title II, Prepaid Personal Health Service Benefits.

However, I hope that we shall not overlook certain other features of the bill which are complementary to title II. In themselves they are quite important; they are also necessary to complete the program.

For example, let us consider Title I, Part A, Grants to States for Public Health Services. This section in a sense amplifies what is now going on. For a number of years the United States Public Health Service has administered financial grants and has otherwise cooperated with States and localities to establish and improve public health departments. These departments now exist primarily for the purpose of giving the fullest possible application to preventive measures. Under the proposed act, they would serve another very important purpose—that is, they would furnish a framework of organization through which other parts of the health program would operate.

Title II of S. 1606 expresses a distinct preference for the utilization of State and local governmental agencies in carrying out the personal health service benefits of the bill. In other words, State and local health agencies would constitute the administrative machinery. But first we need to perfect that machinery.

At the present moment, that machine is far from satisfactory. About one-third of the counties are without local full-time health organizations under the direction of competent medical authority. This is an obvious defect and should be corrected. Perhaps, not every county would need a full-time health officer of its own—some of them are sparsely populated, or are low in economic resources. Such coun-

ties might be combined into districts that would represent a more substantial base on which to build the type of structure that is needed for giving full application to preventive measures and for administering a medical care program of the magnitude that is proposed.

Much of the gain we have already made in lengthening the span of life has been due to the prevention of diseases such as typhoid fever, diphtheria, malaria, and in reducing infant mortality. All such gains need to be maintained. Here I should sound a note of warning. Even though these conditions have been brought under control, they can arise again and they very definitely will if the controls are relaxed.

Many European countries before the war, for example, had reached a very high state of sanitation and were practically free of typhoid fever. With the break-down of sanitation and community organizations, typhoid fever has reappeared. Under a similar breakdown in sanitation, I am sure the same situation would quickly occur in this country, because the causative organisms have not been completely eliminated. Malignant diphtheria also has become a great problem in Europe and tuberculosis has taken on epidemic proportions.

We have protected our people; we have reduced the chances of infection, but once protective measures are relaxed, the same conditions will arise again, and then we will have not alone the burden of ordinary illness which I shall describe in a moment, but many preventable conditions also. For humanity's sake and for the purpose of cutting down the costs of this program, we need to expand and to utilize prevention to the utmost.

So, you see, this feature of the bill—public health services—very definitely should not be overlooked. Since other who come to testify may fail to stress prevention, because of their interest in medical care, I am perhaps spending more time on that section than I otherwise would.

There is one new feature in the public health section of the bill that I might mention. At present, Federal grants-in-aid are given under a variety of formulas. Congress may appropriate sums of money which varies from year to year, fortunately these have been gradually increasing, and these sums in turn are parcelled out to the States in accordance with criteria specified in the statutes.

This bill goes much further than that. It recognizes a continuing partnership between the Federal Government, the States and the localities, and it establishes a single matching ratio. In other words, the Federal Government will go along with the States on their expenditures within the matching range described in the bill. That is a very important feature of the bill, and I shall be glad to discuss it further if you wish.

#### PROPOSED AMENDMENT

The other point that I would make regarding title 1, part A, is in the nature of an amendment. The bill, as it is now written, limits public health services to the ordinary preventive work of health departments, health education and other activities commonly spoken of as community-wide services. We would recommend that that definition be expanded so as to include the support of hospitals for chronic diseases, especially tuberculosis and mental disorders.

These conditions are excluded, or virtually so, from the benefits under title II of the bill. There are sound administrative reasons for

such exclusion, but this leaves programs for the care of these conditions without any Federal support.

Senator AIKEN. They are not covered under other legislation.

Mr. MOUNTIN. Partially so, but only in a general way. There is in our present Tuberculosis Control Act a provision whereby tuberculosis sanatoria could be aided. The sums appropriated, however, are only sufficient to carry on case-finding and general preventive work.

Senator AIKEN. If it appeared that this bill would not be enacted into law, would you favor existing legislation to cover the situations which you have just presented to us?

Dr. MOUNTIN. Tuberculosis hospitalization could be covered under existing law, but I would question whether we could include grants for mental hospitals under existing authority. A mental health bill has passed the House, but that features research training of personnel and community clinics in the interest of mental hygiene.

Senator AIKEN. You mean the bill that we have already had hearings on before this committee?

Dr. MOUNTIN. Yes, aid to mental hospitals, perhaps, could be handled by it but some clarification or even amplification of the intent of the bill very likely would be necessary. There is a very definite need for bringing the Federal Government into the whole chronic disease field on a broad base. Now, the States are required to support these institutions themselves. There is wide variation among the States, in the extent to which they have developed these institutions. That variation is determined directly by their economic resources. That is true of mental and tuberculosis hospitals as it is of other aspects of medical care.

The second part of title I, part B, provides grants to States for the support of maternal and child health services. It is my understanding that representatives of the Children's Bureau will give testimony later on this phase of public health work, and I shall not go into it in any detail.

#### RELATION BETWEEN ADMINISTRATIVE AGENCIES

There are, however, certain administrative aspects of part B on which I should like to express the point of view of the Public Health Service.

Yesterday, you will recall, Senator Pepper introduced certain amendments which would more closely integrate maternal and child health work with various parts of this bill. The proposed amendments also would incorporate into S. 1606 some of the features of the bill which he had introduced for maternal and child health services, S. 1318.

The point I wish to make and to stress is the essential unity of all public health work which should be maintained at Federal, State and local levels. This essential unity should include financial support, administration, and the actual delivery of services.

At the present time, we have the anomaly of two important health agencies set up in different departments of the Government, the Children's Bureau in the Department of Labor and the Public Health Service in the Federal Security Agency.

Perhaps that separation has not been so important in the past because the sums of money, at the disposal of each agency were not

large, and in any event the funds were brought together at the State and local levels. But now, much larger sums are proposed, together with great expansion in the scope of service. The need which has existed previously for closer integration will be increased many times. I understand that governmental reorganization is now being considered by the President. Perhaps this is not the occasion upon which to discuss the details of reorganization, since it is not part of this legislation.

However, I trust I am not out of order in saying we hope that this committee will consider provisions for integration in any redraft of the bill, so as to bring about unified administration of all Federal health services under a common over-all authority.

There is no question about the need for expansion of maternal and child health programs. This also applies to other special phases of public health work—such as programs in the fields of venereal disease, tuberculosis, cancer, geriatrics and mental hygiene. In other words, there will be certain phases of the general program at different stages of its evolution which will need to be sharpened up and brought into closer focus through specialized programs. All specialized programs, however, should operate within the same general framework of organization.

Senator AIKEN. This may not be the time and the place, as you said, Doctor, but do you think that health, security, and education are closely related so that they could well be administered under the same head, or maybe you still think that this is not the time and place to answer that.

Dr. MOUNTIN. Some phases of education have little or no relation to health, while others are closely identified with it.

Senator AIKEN. You have got medical inspection in the school, and dental correction, which you can hardly separate from education.

Dr. MOUNTIN. I would hope that when this bill is enacted, school medical services would be brought into the general scheme of health organization, since they constitute a medical service to a particular age group, and are commonly administered by health departments. I might say, too, Senator, that the need for developing these services in the educational framework has largely risen out of past neglect by health agencies. Educational departments, quite appropriately, stepped into the breach and have endeavored to make up for the deficiencies in the health organization. This whole program has been deficient in that there are few provisions for doing much about defects of childhood after they are discovered—no follow through to correction.

I think that as we develop and piece out those deficiencies, the need for education in the administrative picture will lessen.

However, there is another phase of health in which cooperation between health and educational authorities is needed very much, and that is health education. A large part of that very definitely should be carried out through the framework and under the administration of school authorities. Also supplementary feeding through school lunches and that sort of thing, obviously, is more closely identified with education from a functional standpoint.

Senator AIKEN. We know that when a child has good health and good eyesight, that the work of the truant officer is cut down, and the work of the sheriff is probably cut down in later years.

Dr. MOUNTIN. That is right.

Senator AIKEN. I was a school director for 15 years in my town, so I know when children are healthy they study better, and they learn more, and I have felt for a long time that we should have a new department of the Government covering it. Health education, and I wanted to find out how far you thought we should go and how much you should include under such a new department if it were established, as I hope it will be.

Dr. MOUNTIN. I am not sure that all I have said is applicable at the Federal level; I was speaking of the integration of services at the operating level.

Senator AIKEN. I do not see how you can separate child health from education.

Mr. MILLER. Could I interject there that the President in making some studies of reorganization, and that there is an agreement between the Secretary of Labor and myself, that functionalizing should be brought together. As to the exact complexion of such pulling together, we have nothing to offer at the moment because the matter is now being considered for later presentation to the Congress.

The CHAIRMAN. You may proceed.

Dr. MOUNTIN. I started to mention another phase of public health; that is, geriatrics, in which medical men are commencing to specialize and which I anticipate will grow in importance.

In a sense, it complements pediatrics. Pediatrics conditions the growing human organism for the environment in which it lives. Geriatrics conditions the declining human organism to the environment in which it has to live. Altogether too many people are now dying around forty-five years of age, largely because they have not learned how to live with their infirmities and how to adjust to declining physical resources. Geriatrics addresses itself to the disease problems of later life. But again I would repeat that specialization or sharpening up of programs had better be done within the general framework of administration for a comprehensive program, rather than segregating out the particular problems for separate administration and independent financial support.

There is another part of title I, part C, which concerns grants to States for medical care of the needy. Mr. Altmeyer will give testimony on that item tomorrow, but there is just one passing comment that I would like to make. I hope in the provisions of the act relating to approval of State plans there will be expressed a strong preference for integrating this service with the general medical care program. I am hoping such an arrangement will be carried out because it would be unwise socially and administratively to set the needy apart from the general population. Mr. Altmeyer may have some comments to make on that and other related subjects in reference to part C of title I.

#### IMPORTANCE OF RESEARCH

With your permission, Mr. Chairman, I should like to change the order here a bit and say a word about grants for education and research before discussing personal health benefits. First, let me mention research. A medical care program and, in fact, any human enterprise, is bound to become sterile, routinized, and spiritless unless there is infused into it a well thought-out, aggressive, and substantial

plan of research. And this bill very wisely makes provision for that. A specific sum is authorized for the first 2 years, and thereafter a percentage of the personal health service fund may be used for education and research.

There are innumerable subjects that need to be explored. Some of the most common ailments are not understood; consequently we do not know what to do for them. There is, for example, the cold, the most common of human ailments, and we are utterly helpless in doing anything about it that is really effective.

Dental disease is another malady that is universal. We have a little inkling as to what may cause tooth decay, but the mystery is by no means solved. Everybody has it, practically, and yet we do not know what to do except to fill the cavities and replace teeth. That gives one a chewing surface to work on, but what we need to do is prevent the cavities from forming.

Cancer is another disease that needs exploration from many angles.

Senator AIKEN. What diseases are on the increase?

Dr. MOUNTIN. Notably, those of later life—cancer, diabetes, heart diseases are three striking examples.

Senator AIKEN. Are they increasing in actual numbers or percentages?

Dr. MOUNTIN. They are increasing in actual numbers and in percentages, too, but let me explain: The population is aging. There are more people over forty-five than before, and more over 65 than before. In increasing numbers we are reaching what we speak of as the diabetes and the cancer age. It is also the period of life when the heart starts to give out or when the arteries become brittle. Because of that, alone, we would naturally expect more people to be afflicted with those conditions and to be dying from them.

There is some evidence to suggest an absolute increase in the occurrence of such conditions quite aside from the age factor; but the fact remains there is a very striking over-all increase. Mortality from the three diseases that I have mentioned has more than doubled since 1900. We have reason to believe that the true incidence of the disease itself has increased in proportion to the mortality.

Those are the groups of diseases that are increasing; the so-called degenerative diseases—the diseases that are closely identified with the aging process. Infections, for the most part, are being brought under control; dietary disorders, too.

Senator AIKEN. What is the status of arthritis? Is that increasing? The reason I ask that is, a good many servicemen call on us in getting assistance in regard to a larger disability allowance, or help in some way because they are suffering from arthritis.

Dr. MOUNTIN. Arthritis is really a group of diseases. Almost anything that happens to the muscular and skeletal system which causes pain on movement, is included under the broad term of "arthritis."

Senator AIKEN. Is it on the increase?

Dr. MOUNTIN. Perhaps not except in respect to the age factor. The joints become less mobile, the muscles less pliable, as we get older, and because of the increasing age of the population one would expect a corresponding increase in arthritis.

Arthritis, while not a prominent cause of death, shows up prominently in the causes of illness. It is one of the most disabling of conditions. It looms up very large in the total illness burden, and in the total disability burden, too.

SÉNATOR AIKEN. Would it naturally increase as the result of the war?

Dr. MOUNTIN. It might. Exposure under combat conditions might have caused some increase. I wouldn't know for certain.

I want to say this about research; research needs to be carried on on many fronts. There are fundamental facts that need to be disclosed dealing with broad questions of physiology.

Better remedies are needed since many we now have are very unsatisfactory. Additional preventive measures present great possibilities. I mentioned dental decay; also the common cold. A remedy or a preventive for those diseases would represent a great advance.

Then we will need a substantial program of what we might call administrative research in connection with a comprehensive health program for finding out the causes of disability in different groups of the population; also to determine the best and most economical methods of carrying out the various measures that are encompassed among the benefits.

Many questions in addition to those enumerated need to be studied and restudied. It is the sort of thing on which you are never through. Knowledge is never fully probed. There are always possibilities for new developments. Take, for example, penicillin. It has reduced the days of disability and the days of hospitalization, and correspondingly has reduced the cost.

On education, too, I am hoping that the committee will see fit to make strong recommendations. I am speaking now particularly of medical education simply, because I have more familiarity with the education of physicians than with that of the other professional groups involved. The situation, however, is somewhat comparable for all the professions that contribute to medical care.

Medical education is a very expensive process. It costs the school alone some \$1,200 or \$1,500 a year to train a medical student. Tuition returns to the school some \$400, or thereabouts; roughly, one-third. The remaining about \$800 has to be secured elsewhere. Up to now schools have been able to draw very largely on endowments, but as a resource, endowments are not as generous or as satisfactory as they used to be.

I am not including in that \$1,200, please understand, Mr. Chairman, any of the personal cost of the student, bed and board, clothing, and so on. I am only talking about direct educational cost.

Medical education, many think, is really facing a serious situation because of the cost, unless something like what the bill proposes can be done. Because of the long process of education, the high tuition, and personal expenditures of the individual, many boys and girls of limited circumstances will not be able to go to school unless these costs can be reduced or perhaps something can be set up in the way of fellowships.

I might add to that less than one-third of medical schools are identified with State universities. The remaining schools are supported by endowments and tuition. So you can see the rather difficult problem of financial support confronting basic medical education.

There is another phase of medical education which is, perhaps, the most neglected of all, and that is picking up the doctor after he has graduated, and providing for continuation study. Many of the things he learned in school will be forgotten if he does not have the opportunity to put them into practice continuously. New remedies are coming in, new diagnostic procedures, new instruments, and he needs to have the opportunity to refresh himself on these developments. Otherwise, deterioration will go on, and the very fine doctors now graduating from our medical schools will be not so good rather shortly unless some scheme is provided which will afford opportunity for continuing education.

Now, I want to come back to the medical care—medical care provisions in title II of the bill. That is prepaid personal health services benefits.

The CHAIRMAN. Page 35.

#### THE PHILOSOPHY OF HEALTH INSURANCE

Dr. MOUNTIN. Page 35. The full significance of this bill, I believe, is not fully realized. We do a lot of talking and arguing as to whether the quality of medical care will be improved or whether it is going to deteriorate; whether the doctors are going to be satisfied, and a lot of similar points; but the true import, I think, is somewhat overlooked. There is a definite philosophy in this bill, and it is this: Heretofore the individual out of his own pocket, has had to finance his illness costs. This bill would change that fiscal arrangement. It would lift the cost of illness off of the crippled backs of the sick and place it on the broad shoulders of a robust society.

It is somewhat analagous to the change that was made in the support of education upward of a century ago.

I think we all should recognize this fundamental change in philosophy and appreciate the fact that as a result of our growing social consciousness, wider use is being made of Government framework to carry out the will of the people and to provide essential services which they cannot provide for themselves through their own resources.

In the testimony that has already been presented I think the need for such a change has been quite fully stressed, but if I may just impose on you for a moment I shall briefly review some of the characteristics of illness that are particularly pertinent to this discussion.

Illness is unpredictable as to the time of occurrence, severity, duration, and the cost entailed. Nobody can tell for himself or his family during any period of time what the illness experience may be.

However, for a large group of the population it can be foretold with accuracy. In other words, it is an insurable commodity. By applying the law of averages to illness, for a significant group of the population, and certainly for the Nation as a whole, you can predict the course of events with a high degree of accuracy. I might even go so far as to say that, within the limits of diagnostic accuracy, statements bordering on infallibility can be made. Likewise, the cost can be computed.

Because we as a Nation have not recognized that principle, and because we have not utilized the insurance mechanism, the sick continue individually to pay the cost of their own illnesses. If everyone had the necessary funds it would not be too bad. But since some do not have funds, they do not get the care. All situations are not clear-

cut, but vary within a wide range. Those that have ample funds will choose their physicians and hospitals wisely and get the finest care, because the best of our institutions in this country are among the finest in the world. People of limited means or those still further down on the economic scale get less and less medical care.

The fact that they get less is due to two factors: First, they do not have the funds to pay for care; second, since they do not have the funds, facilities and personnel likewise, are not located where such people are. These are available in proportion to a people's ability to pay for medical service. Thus, in many communities, there are few or no doctors. The doctors in depressed industrial areas and agricultural communities usually are older men who for one reason or another are staying. Few or no younger better-trained doctors are going into those communities.

The same is true of physical facilities. Hospitals have been located in accordance with that same guiding economic principle. In other words, they are responsive to that same economic force.

Hospital beds are not necessarily located where people reside, but where the funds are. Conversely, where funds are limited there may still be many people but they will have few or perhaps no hospitals. Furthermore, the hospitals that are there are often of such low quality that they do not meet the standards of the American Medical Association for registration, or those set up by the American College of Surgeons. This situation has been explained to the committee over and over again. Your own publications have expressed it magnificently; and I do not think that I need to take up any more time reviewing your own evidence.

#### HOSPITAL CONSTRUCTION

Senator ELLENDER. Doctor, do you think that the passage of this bill would stimulate the building of more hospitals by private concerns; or do you think it will be necessary for the Congress to provide funds to expand these facilities?

Dr. MOUNTIN. There are two elements necessary to correct the condition.

Senator ELLENDER. I understand that. You have gone through that.

Dr. MOUNTIN. One is in this bill, and another in another bill.

Senator ELLENDER. The Senate passed the Hill-Burton bill some time ago. Do you think the funds provided in that bill will be sufficient to meet hospital needs necessary to take care of the situation should this bill go through?

Dr. MOUNTIN. The ceiling placed by that appropriation somewhat limits its usefulness. I have some doubt as to whether it will cover the whole need, but it will go a long way.

Senator ELLENDER. The point that I want to make is that if you provide our citizenry with the funds and the doctors and everything else, you may be lacking in facilities to meet the emergency so that the sick can obtain adequate hospitalization.

Dr. MOUNTIN. The two need to go on together.

Senator ELLENDER. Together; yes.

Dr. MOUNTIN. We need a fund to aid in construction. We also need a fund to help pay medical cost. The hospital construction bill, however, was designed to meet only one expense, and that is the construction expense.

Senator ELLENDER. I understand.

Dr. MOUNTIN. But the annual operating cost of a hospital is something in the neighborhood of a quarter to a fifth of its original construction cost. So you have an annual expenditure which needs to be met, and that could be accomplished by this prepaid medical service fund that title II seeks to establish.

Senator ELLENDER. Well, you do not think that the fund would be sufficiently large, do you, so as to also take care of the facilities? The scheme planned in this bill.

Dr. MOUNTIN. Not unless it were specifically incorporated in the bill. Furthermore, I think that the initial capital outlay is an appropriate item for direct appropriation; and I would prefer such an arrangement to having someone assume the risk of building a hospital and then trying to liquidate his obligation by an excess charge on the service rendered.

Senator ELLENDER. Would you venture an opinion as to the amount of public funds that would be necessary in order to provide sufficient facilities to make this bill workable, as you have just said it ought to work?

Dr. MOUNTIN. I do not have the figures in my mind. I think they were given to the committee at the time of the hearings on the Hospital Survey and Construction Act.

Senator ELLENDER. I thought maybe you had them.

Dr. MOUNTIN. No, I do not have them at the moment. I am sure they have been given; or, if not, we will see that they are.

(The matter referred to is as follows:)

*Latest estimates of U. S. Public Health service non-Federal health facility needs<sup>1</sup>*

Type	Units needed	Estimated unit cost	Total estimated cost	
			New	Replacement
<b>General hospitals:</b>				
New beds (deficit).....	<sup>2</sup> 169, 579	\$6, 000	\$1, 017, 474, 000	-----
Replacement beds.....	<sup>3</sup> 83, 889	6, 000	-----	\$503, 334, 000
<b>Tuberculosis hospitals:</b>				
New beds (deficit).....	<sup>3</sup> 65, 189	5, 000	325, 945, 000	-----
Replacement beds.....	<sup>4</sup> 17, 313	5, 000	-----	86, 565, 000
<b>Mental hospitals:</b>				
New beds (deficit).....	<sup>4</sup> 208, 963	3, 000	626, 889, 000	-----
Replacement beds.....	<sup>5</sup> 99, 583	3, 000	-----	298, 749, 000
<b>Chronic hospitals:</b>				
New beds (deficit).....	<sup>5</sup> 270, 173	3, 000	810, 519, 000	-----
<b>Total cost:</b>				
New (deficit).....			2, 780, 827, 000	-----
Replacement.....			-----	888, 648, 000
<b>Both.....</b>				3, 669, 475, 000

<sup>1</sup> Includes the 48 States, District of Columbia, Alaska, Hawaii, and Puerto Rico.

<sup>2</sup> On the basis of 4.5 beds per thousand 1940 State population and after deducting existing general and allied special beds listed in the 1943 hospital number of the Journal of the American Medical Association.

<sup>3</sup> On the basis of 2.5 beds per tuberculosis death as applied to the average annual number of such deaths in each State during the 3-year period 1941-43 and after deducting existing tuberculosis beds listed in the 1945 hospital number of the Journal of the American Medical Association (with the 1942 Directory of the National Tuberculosis Association used as a check).

<sup>4</sup> On the basis of 5 beds per thousand 1940 State population and after deducting existing mental and nervous and mental beds listed in the 1945 hospital number of the Journal of the American Medical Association.

<sup>5</sup> On the basis of 2 beds per thousand State population estimated by the U. S. Census Bureau as of July 1, 1944. Since no deductions were made here for existing beds, this is a gross need figure, balanced to some extent by the deduction of existing allied special beds from the gross need figures for general beds. See footnote 2.

<sup>6</sup> Based on the assumption that 25 percent of existing facilities in each State need to be replaced, with that 25 reduced by any excess in existing facilities over the standard ratios.

Dr. MOUNTIN. Another point in respect to the need for this prepaid medical service arises out of the changing character of illness. I mentioned that many of the preventable diseases that loomed up large as causes of death at the turn of the century have now pretty well been controlled. We are confronted more and more with the diseases of older life that require a high degree of medical skill, high development of physical facilities, and a staff organization for diagnosis and treatment.

Therefore, we are now at the point where we must face frankly, and I might say heroically, this whole problem of medical care.

There are a few more points with respect to the administration of this act that I hope we might clarify, as well as some of the criticisms that have been made of it.

It has been alleged that doctors will be surrendering whatever freedoms they have, that they will be subjected to an over-all Government authority; that hospitals cannot operate or might not be able to operate as they think appropriate; in other words, it is a thoroughly regimented system that is proposed here. I fail to see that in the bill.

It is true that it does provide for a Federal fund. The details of finance are not spelled out in the bill, but I infer that it contemplates pay-roll deductions, a direct tax on income of self-employed people, and contributions to the fund from other groups that might seek to utilize this mechanism for the provision of their medical care.

That part of program is centralized. I see no way of decentralizing it except by considering an entirely different bill—in other words, a series of State plans, or some aid of one sort or another to voluntary organizations or something else entirely different from what we have before us.

#### VOLUNTARY HEALTH INSURANCE

Senator ELLENDER. Have you given thought to any other proposal to make it more or less on a voluntary basis instead of an obligatory deduction of 3 to 4 percent, as I understand the plan provides?

Dr. MOUNTIN. Up to 3 percent, but that is incorporated in other legislation.

The CHAIRMAN. Another bill. It was originally in this bill and it was separated.

Dr. MOUNTIN. The use of voluntary agencies brings up another question. If the Federal Government makes this deduction and collects these taxes and a fund is established, would seem to me that the Federal Government has a responsibility for seeing that the benefits enumerated in the Act are actually delivered.

I am afraid that if they are not delivered the average citizen would not accept the excuse that we expected somebody else to do it—the States or the localities. I am quite sure that they would come to the Federal Government, which collects the money and maintains the fund. That is one point.

The next point is, can voluntary effort accomplish the task entirely by itself. Is that the point you wish to make?

Senator ELLENDER. Yes. Of course, I have not made a very close study of the bill. I read it casually, and that is one of the features of the bill I am opposed to; I will be frank in saying that. I was in hopes that we could work out some voluntary method of accomplish-

ing the task. And I am wondering the extent to which you and others have studied these voluntary methods.

Dr. MOUNTIN. We have studied them rather extensively and intimately. Voluntary effort is going on now, of course.

Senator ELLENDER. Could we employ that in some way? Have you given it sufficient thought to give us your views?

Dr. MOUNTIN. It could be employed, certainly; but the question is, Is that the best way of going at the job? Should we prop up voluntary effort, or face the whole job and use the framework of government for accomplishing it?

Senator ELLENDER. Personally, I would much prefer that we devote some time in trying to find a voluntary method, rather than to have the Government have its hands in it. I would want us to be as far removed from Government control as possible.

Mr. MOUNTIN. I understand your point of view, Senator.

Senator ELLENDER. That is why I was so insistent on the Congress providing funds so as to build a system or a chain of hospitals and clinics throughout the country, and let that be the extent of our obligation. Through a voluntary system of insurance these hospitals and clinics could be utilized for the purpose which you say is necessary for good health, at the State level. Now, what plans on a voluntary system, if any, have you worked out that you think will be workable, and that will improve the present voluntary system?

Dr. MOUNTIN. There is no clear-cut plan that we have to present to you at the moment. You have not one voluntary organization, but literally hundreds of them.

Senator ELLENDER. Yes.

Dr. MOUNTIN. You would have to deal with that number, or by some process of elimination get down to a smaller number, or, perhaps, give an exclusive franchise to someone. That process would be rather painful, and I am not sure it could be accomplished. I think they would all seek Federal funds. In fact, that has been the experience in foreign countries. You could not start by setting up one voluntary agency; literally there would be hundreds of them clamoring for support.

To get a national program operating through hundreds of agencies organized under a variety of auspices with no direct responsibility, as most of them now are, to any elected official, would be truly a Herculean task.

The CHAIRMAN. Doctor, if the voluntary system would have to be financed by the Federal Government then it would not be a voluntary system.

Dr. MOUNTIN. Then it would not be a voluntary system.

Senator ELLENDER. What I have in mind is that if Congress provides the money for the facilities, it strikes me that the communities ought to be willing to make use of those facilities by interesting themselves in a voluntary plan of insurance for their upkeep and operation, as is now in effect in many communities. The States and counties could probably be induced to help their operation so as to take care of the indigent. What bothers me is that the proposed plan will eventually lead in the Government's taking entire charge of it. And in time when this scheme gets well in operation, it might be so broadened as to have some bureaucrat up here from Washington—

maybe of a different type from my good friend, Watson Miller, here—to take charge, and it may result in being a little hard on the medical profession. This is just a start, you know, and there is no telling the extent to which it will expand.

Dr. MOUNTIN. Well, this goes quite a way, too.

Senator ELLENDER. It goes almost the full way from the beginning.

Dr. MOUNTIN. Yes.

Senator ELLENDER. And that is what I do not like about the plan. It is too far reaching.

Dr. MOUNTIN. It is quite comprehensive.

Senator ELLENDER. Oh, yes.

Mr. MOUNTIN. However, if we have any criticism, it is that it does not go the whole way. It takes in 80 to 85 percent of the population now, either directly or indirectly.

Senator ELLENDER. Who is left out? What does the 15 percent represent?

Dr. MOUNTIN. Some of them are enumerated in the bill. Government employees, railroad groups, State employees, religious bodies, and a few others.

Senator ELLENDER. Yes.

Dr. MOUNTIN. Although some of them could be brought in by compact.

Senator ELLENDER. Why were they left out?

Dr. MOUNTIN. I know of no reason from the standpoint of the delivery of medical service. As a matter of fact, I should like to see them brought in. I believe there are other reasons, tied in with the basic Social Security Act. Is that correct, Mr. Chairman?

The CHAIRMAN. The theory would be that they would be permitted to come in.

Dr. MOUNTIN. That is right.

The CHAIRMAN. As you say, by compact.

Dr. MOUNTIN. That is right.

The CHAIRMAN. That was the hope and the expectation.

Senator ELLENDER. Is that through the Railroad Act, Senator Murray?

The CHAIRMAN. That was because they already had a system; and the desire was to avoid forcing this upon them unless they voluntarily come in and announce it under an agreement.

Senator ELLENDER. Does the same thing prevail as to Federal employees and State employees?

The CHAIRMAN. No. They would, of course, be entitled to come in under the act as it is unless they had some system similar to the railroad system. If they had, then they, too, would come in under a compact.

Senator ELLENDER. The only reason why those were left out, then, as I understand it, is that they already have some system of their own?

Dr. MOUNTIN. That is not true of Government employees. It is tied in with the coverage provisions of the basic Social Security Act.

The CHAIRMAN. The studies that have been made of voluntary systems have come to the conclusion that it would be impossible to have a voluntary system that would cover the country adequately to give the American people the service that they should have in modern care.

Senator ELLENDER. As I was just informed by Mr. Miller, one of the reasons why Federal and State officials were not put in was because of inability of taxing them from a constitutional standpoint.

Dr. MOUNTIN. I think that was one of the reasons.

Senator ELLENDER. But the bill has covered as many as it is possible to cover under the law; is that not true?

Mr. MOUNTIN. I believe the railroad people could be brought in, and Government employees, by act of Congress. Is that correct, Mr. Chairman?

The CHAIRMAN. Surely.

Senator ELLENDER. Let us put it this way, then: as to all those that have a system of their own, and as to the others left out, the reasons you do not have them in are because of legal impediments?

Dr. MOUNTIN. I do not think that is quite correct. I think the Government people do not have a system of their own.

Senator ELLENDER. I said as to those that have systems of their own.

Dr. MOUNTIN. Excuse me, sir.

May I answer your question, Mr. Chairman?

The CHAIRMAN. Surely.

Dr. MOUNTIN. With respect to voluntary agencies, under their present scheme of financial support, I think we can say categorically that there is no hope of their setting up and carrying on a comprehensive type of medical care program. The only way that they might do it would be through an extensive scheme of public support. That might be accomplished.

Then there is a big question of public policy, as to whether the government might prefer to assume its own risk, as it does in other enterprises, or whether it would attempt to discharge an obligation through a private organization it has to support. Judging from experience abroad, the government would eventually support it for the most part, too.

The CHAIRMAN. The voluntary systems that have been set up all vary in amounts?

Dr. MOUNTIN. Oh, yes.

The CHAIRMAN. That would then be a very difficult situation for the Government to undertake to finance them or aid them.

Dr. MOUNTIN. I assume Government would have to require a uniform type of benefits, and that would change the existing situation very much.

The CHAIRMAN. And the study seems to indicate, then, that one singular system administered by the Government would be the most effective system.

Dr. MOUNTIN. That is right.

Senator ELLENDER. Well, there is no doubt about that, you cover all you can. If you could get it and impose it on all, and force them to it, you would accomplish your end. The point I am making is, I do not like to go that far. It strikes me that as to those unable to obtain medical care and attention, something should be done for them. That is, we should go as far as the traffic will bear so as to help those unable to pay for proper and adequate medical attention. But in your effort to accomplish that end you cover everybody in the country, and those left out are those you really cannot reach, as I understand the bill.

## SAFEGUARDS UNDER THE BILL

Mr. MOUNTIN. I think there are a few points here that are a little bit misunderstood. First of all, there is the question of imposing this program on anybody. I would assume, in our democratic process, that the people will express their will at these hearings and in other ways, and that when Congress votes upon the bill, their action will be a reflection of the will of the majority of the people.

Senator ELLENDER. What I mean by imposing is, the Government will just take from me 3 or 4 percent, whether I want to or not.

Dr. MOUNTIN. If it should be the will of the majority I would presume we might regard it as an imposition.

Senator ELLENDER. You mean enacted through Congress?

Dr. MOUNTIN. This bill could not be enacted except through Congress, and it obviously would be the will of the people.

The next point I think I should make clear is that it is not proposed here that the Federal Government set up a whole network of facilities throughout the land, hospitals and health centers, which it would directly operate, and that physicians would be placed upon the public pay roll, and certified as to specialty and all the rest of it. This bill only has to do with financing, and it seems to me that the bill now contains sufficient democratic safeguards. If the Committee or Congress sees fit, it can provide additional safeguards.

It is true that in the act certain administrative authorities are set up. The Surgeon General happens to be mentioned here as the principal figure in the administration.

The CHAIRMAN. Some have suggested that the bill setting up the Surgeon General and providing for the administration of this act would create a dictator under the Surgeon General. Have you studied that?

Dr. MOUNTIN. I hope that we servants in Government would not rise to that position. We in the Public Health Service have always regarded ourselves as responsive to the will of Congress. I hope that that is our record.

The CHAIRMAN. Is there anything in the bill that would permit him to become a dictator?

Dr. MOUNTIN. He is appointed by the President; he is confirmed by the Senate; he is under the control of the Administrator; he has to make a report to Congress annually; he has to come before Congress for his appropriations. If anything went wrong and a substantial body of citizens or even a few individual citizens had complaints, I am sure Congress would very quickly transmit those complaints to us, as they do on occasion, and ask us to give an account of the facts.

Senator ELLENDER. Doctor, I have been in the Senate 10 years, and I can give you a little inkling of some "cloakroom gossip" to the effect that there is much complaint that many laws are enacted for certain purposes, but they are administered in such a manner by some of the authorities in Washington—some of these authorities are designated as "bureaucrats"; I guess that is a good name for them—that many things are done that Congress never dreamed of. As this bill is drafted it may have a certain objective and the purpose may be for "this, that, and the other," but you will find in its administration that a lot of fellows who have charge of it usually go beyond what was intended by Congress. I have had a few instances myself, in

recent months, with my good friend Mr. Miller. I will not go into that. My complaint has been worked out to some extent, but not to my entire satisfaction.

Anyway, I do not believe all of us are satisfied with some of the action taken by OPA, from all you hear in the paper and over the radio. All of this is aside from the issue under consideration.

Let me ask you this question: You say that the beneficiaries of this plan would have the opportunity of selecting a doctor of their choosing?

Dr. MOUNTIN. Certainly.

Senator ELLENDER. And he would be paid out of the fund provided?

Dr. MOUNTIN. Certainly.

Senator ELLENDER. Suppose it was necessary for me to be operated upon, and I selected a doctor whose charges were about four times what the administrator says it should be, what then? Would I be permitted to select that doctor?

Dr. MOUNTIN. The arrangement, as I interpret it, would be subject to the authority of the Surgeon General.

Senator ELLENDER. Yes.

Dr. MOUNTIN. Of course, he would not look into every case.

Senator ELLENDER. Yes.

Dr. MOUNTIN. Agreements would be entered into with doctors in States and localities with respect to methods of payment and to fee schedules that would take into account not alone the kinds of service that the patient required but the degree of competence and skill that are necessary in the performance of specified services. Within those restrictions, what you would get out of the fund should pay your bill.

Senator ELLENDER. As you know, we have a lot of doctors here in Washington—in fact, I know we have in my own State—whose charges vary, because of skill and experience. Some will operate, say for the removal of tonsils, and charge \$50 according to the fee made by the administrator. In order to obtain that skill you speak of I may not want to trust this \$50 doctor; I would want one who would charge \$150, because of the skill and reputation he has. So as to obtain that extra skilled doctor I would be obliged to pay the whole bill or the difference between the fee fixed by the administrator and the charge made? Am I right?

Dr. MOUNTIN. If in your particular case you had such an unusual case of bad tonsils and it required a very unusual degree of skill, I would expect that it would be provided.

Senator ELLENDER. Doctor, the point I want to make is this: you know yourself that you have in all communities famous surgeons, famous lawyers, who might do the same work for a citizen, but charge considerably more than what that citizen could obtain similar services from other sources. Is not that true?

Dr. MOUNTIN. It is true, and I might even say unfortunately true.

Senator ELLENDER. I see. In other words, what would happen, as I see it, is this: The administrator could fix a system of fees that could be charged by the doctor who is in business for a year or two at the same rate as one who has been in business for 25 years and who has acquired that skill that many of us wish to pay for.

Dr. MOUNTIN. No; that is not so. I think in my earlier statements I discussed the kinds of contingencies or situations you have been describing.

Senator ELLENDER. Does the law provide for that?

Dr. MOUNTIN. Yes; it says that the Surgeon General shall arrange with physicians and groups of physicians as to rates of pay; methods of pay.

Senator ELLENDER. Are the amounts fixed?

Dr. MOUNTIN. Groups of physicians would be certified as to the competence of their members, and then adjustment of these rates of pay would be made according to the competence of the individual.

The CHAIRMAN. Doctor, you have not referred to the National Medical Advisory Policy Council, which has been set up here, and the work that the Advisory Council has done in establishing professional standards.

Dr. MOUNTIN. That is what I had in mind in making those remarks, but I want to make one more point, Senator. Under the present scheme of remuneration physicians now give a lot of service for less pay than they really should get, because of the economic circumstances of the patient. Many physicians also give as much as 25 to 30 percent of their time to charity service.

Senator ELLENDER. That is free work.

Dr. MOUNTIN. In order to compensate for services that they give free, or for less than what they are worth, they frankly have to overcharge those that are in better economic circumstances. I think that is unfortunate. I do not blame the physician; he is just the victim of a circumstance.

Although, under the provisions of this program, these very high fees would be leveled down somewhat, they would not be uniform. Uniform fees are not contemplated in the bill at all. Uniformity would be most unjust, and it would be stultifying if it were incorporated in the act.

But by leveling up the fees at the bottom the total income of physicians could be increased under this scheme of support, as is contemplated in title II of the bill.

Senator MORSE. Doctor, is it true that the Veterans' Administration is at the present time trying to encourage the treatment of veterans by doctors in their local communities?

Dr. MOUNTIN. I understand they are working out those contractual arrangements as may be feasible. I do not have the details. I understand that a representative of the Veterans' Bureau is coming before this committee later. Is that not right, Mr. Chairman?

The CHAIRMAN. Yes.

Dr. MOUNTIN. I do not have the details, but I understand that they are endeavoring to work out those contractual arrangements, utilizing local doctors, local hospitals, in the places where the veterans live for certain types of conditions.

The CHAIRMAN. You may proceed with your statement.

Dr. MOUNTIN. I am about through. I wonder if I have overlooked any point.

The CHAIRMAN. Would you explain that Advisory Council which is to be set up under the bill, and what their jurisdiction would be?

Dr. MOUNTIN. It provides that the Surgeon General shall set up at the Federal level an Advisory Council. I do not have the exact wording, but, in general, the Council shall be representative not alone of the professional bodies but of the institutions that are concerned

with care, and with groups that are concerned with receipt of service. So we would have both the point of view of the producer and that of the recipient of service.

The bill also requires that the Surgeon General shall consult with the Council on matters of policy, and that he shall report to Congress on the use that he has made of this council. The bill also provides for local councils that parallel the national one in many respects, so that you would have balanced participation of professional and consumer groups all the way down the line in the administration of the act.

Senator ELLENDER. Who selects this Council? Does not the Surgeon General do so?

Dr. MOUNTIN. Yes; but subject to approval by the Administrator.

Senator ELLENDER. The Administrator. So that he could have persons of his own choice?

The CHAIRMAN. It is on page 41, section 204.

Dr. MOUNTIN. Approved by the Federal Security Administrator.

The CHAIRMAN. But they are selected from panels of names submitted by the professional and other agencies.

Dr. MOUNTIN. That is right.

The 16 appointed members shall be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical, dental—

and so on. So the nominations come from these groups.

The CHAIRMAN. With that kind of circumstance i would no be possible for the Surgeon General to set himself up as a dictator, inasmuch as he is required to take advice from this Council on matters of policy, and that he has to make reports to them.

Dr. MOUNTIN. I do not see how he can. As I said before, I have been in the Government upwards of 30 years; about 12 of that here in Washington. We feel that we are accountable to Congress, and I hope that our record with you is such that you can say that we have been responsive to your will.

I can see no reason why, simply because we are dealing with somewhat larger sums of money than we have in the past, our relationship with you should be changed in the least. You certainly have the authority to "bring us to book" any time you see fit. I know you do it; and we are glad you do.

Senator ELLENDER. You don't have as much power now under the Health Service as the Administrator would have under this bill.

Dr. MOUNTIN. Well, unless you put money and power in the same category, or say that money is power,—

Senator ELLENDER. You will not disagree with that, will you?

Dr. MOUNTIN. As far as I am concerned, I think that, although our appropriations have been increased over the years, we have felt the same degree of responsiveness to Congress. In fact, I know Congress has in recent years looked more intimately into our affairs than it did when we were the small Marine Hospital Service, and I am sure it will look still more carefully as we get into this type of service relationship with the general population.

The CHAIRMAN. Have you concluded your statement?

Dr. MOUNTIN. I believe I have. Unless you think of some other points that might be brought out.

There are innumerable details, of course, but I would judge by the questions that your chief concern is how the thing would operate. Will a patient be able to select his own doctor under given circumstances? Can he have his own doctor? Can his doctor prescribe for him the kinds of remedies that he thinks are appropriate? Will the doctor get paid without too much red tape and paper work? And will the plan operate on a personal physician-patient relationship?

I should think the whole scheme would operate more smoothly, because the financial difficulty, or the financial barrier, between the patient and doctor, will have been removed. The doctor will not have to ask himself when he wants an X-ray, "Can the patient really afford it?" Or, if he would like to have an additional one, "Will he think I am imposing on him?"

There should be no hesitancy on the part of patients to call on physicians or to seek the kind of service that they need. Now, unfortunately, they call the doctors when they are sick; and, in fact, quite sick. Often they have reached a stage where the doctor can do little for them.

We want to make that patient-doctor contact earlier so that patients will call their doctors before they are seriously sick. They should have periodic examinations. When they feel that something is going wrong, they can be examined and be advised by their physicians what care they require, if any.

I would hope that the relationships all along the line would be facilitated, simplified, and, all-in-all, made more satisfactory than they are now. In fact, if the program does not operate that way I am sure it will break down. But I certainly do not anticipate failure, because I think it is inherently sound.

The CHAIRMAN. Do you think, doctor, that it is only by a national system of this kind that modern medical care could be made effective to the great mass of the people?

Dr. MOUNTIN. To the great mass of the people; yes, sir.

The CHAIRMAN. And under such a system the health of the Nation would be greatly improved, business could be bettered, industrial conditions would be bettered by it; and without it we will continue in the haphazard method we have been operating where some people get the very finest care and the people who need it most get the very least?

Mr. MILLER. Could I say a word?

Senator ELLENDER. I would like to provide for those who need it the most.

The CHAIRMAN. This is the only way it can be provided.

Senator ELLENDER. That is why, as the chairman can say, we worked long hours on the Hill-Burton hospital bill. Not only will hospitals be established under that measure but small clinics as well, so that a good deal of preventive medicine can be practiced, as you have just indicated a while ago.

Dr. MOUNTIN. Yes, sir.

Senator ELLENDER. Which is, to my way of thinking, a good way to proceed in order to keep our people healthy.

Mr. MILLER. That is right.

Senator ELLENDER. You are bound to get that.

Mr. MILLER. I think those schedules might be roughly defined by the State groups themselves subject to national standards. I have talked

to some of the leading figures in the more widespread and successful voluntary organizations, and the California Physicians' Service told me they had no difficulty getting an acceptable fee schedule for the major and recognized medical or surgical procedures satisfactory to the medical elements in the community.

Senator ELLENDER. I presume we are going to have evidence before this is over to show how you reached the 3 percent figure, as to whether or not that would take care of the situation that you are now trying to remedy. Do you know why it is 3 percent? Have you made any estimate?

The CHAIRMAN. That will all be brought out in testimony here.

Dr. MOUNTIN. It is roughly contemplated that some \$26 per capita would be involved in delivering the benefits that are provided for in the bill, as I recall the estimates.

Senator ELLENDER. \$26.

Dr. MOUNTIN. Something of that order.

Senator ELLENDER. That would be 26 times our entire population?

Dr. MOUNTIN. That is right, if the entire population should be covered.

Senator ELLENDER. That would be the amount required?

Dr. MOUNTIN. That is right. That is out of this fund.

Senator ELLENDER. Will that percentage produce that much money?

Dr. MOUNTIN. That is my recollection.

The CHAIRMAN. Estimates have been made, also, of the cost of medical care to the people of the Nation under the existing system, the present system.

Dr. MOUNTIN. That is right. There are some benefits, we should remember, that are not fully covered in this bill. Full dental benefits are not provided for at the outset, and this also applies to nursing services, so it is deficient in that respect. However, the bill does provide that special studies of these categories of service will be made in the few years immediately following enactment of the bill, and that appropriate recommendations for the inclusion of these benefits, as well as methods of financing them, will be made on the basis of the findings of these studies.

The CHAIRMAN. Under the bill it is provided that the Advisory Council shall advise the Surgeon General with reference to questions of general policy and administration in carrying out the provisions of this title, the establishment of professional standards, and the designation of specialists and consultants; so that they would set up specialists and consultants under this bill so that for whatever might be required there would be a list of specialists available.

Dr. MOUNTIN. That is right. There are, Mr. Chairman, specialty boards now set up covering most of the specialties. Some others are in the process of organization. All the applicants have not as yet been examined. Examinations have been interrupted somewhat by the war, but as they get to them the specialty boards are certifying physicians that qualify. Obviously the Surgeon General will consult with these specialty boards and other types of certifying authority in determining the competence of individual physicians, and likewise in determining the fee differentials for the various specialties.

The CHAIRMAN. Well, thank you, Doctor, for your very valuable statement you have made here this morning. I am sure it will be of

great help to the committee. Your full statement, of course, will be carried in the record, as well as your oral statement.

Dr. MOUNTIN. Thank you, sir.

The CHAIRMAN. We will meet again tomorrow morning at the same hour.

Mr. Arthur J. Altmeyer, Chairman of the Social Security Board, will appear at that time.

We will suspend now.

(Whereupon, at 12:10 p. m., Wednesday, April 3, 1946, the committee recessed until Thursday, April 4, 1946, at 10 a. m.)

# NATIONAL HEALTH PROGRAM

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THURSDAY, APRIL 4, 1946

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

The committee met at 10 a. m., pursuant to adjournment, Hon. James E. Murray (chairman) presiding.

Present: Senators Murray, Ellender, Aiken, and Donnell.

The CHAIRMAN. The hearing will come to order.

The first witness this morning is Mr. Arthur J. Altmeyer, Chairman of the Social Security Board.

Mr. ALTMAYER. Mr. Chairman, I have submitted a formal statement here, rather lengthy, and I do not propose to read it all. With your permission, I would like to read those parts that seem to point up what I am trying to say.

The CHAIRMAN. I have been glancing over it, and I notice that it is a very comprehensive statement, and yet it is necessary for us to cover every feature of this proposed legislation, and we do not want you to skip anything that is important for us to hear.

Mr. ALTMAYER. May I have the entire statement put in the record and then cover those parts that seem to summarize the various points?

The CHAIRMAN. That may be done.

## STATEMENT OF ARTHUR J. ALTMAYER, CHAIRMAN, SOCIAL SECURITY BOARD

Mr. ALTMAYER. The interest of the Social Security Board in national health is fundamental to its responsibility under law for administering social security programs and for "studying and making recommendations as to the most effective methods of providing economic security through social insurance \* \* \*" Health is basic to the security of the men, women, and children—the families—of America. Sickness and premature death are among the most important causes of insecurity. Progress in national health is essential to progress in social security. Protection against the costs and the losses that follow upon sickness is an integral part of social security.

### HOW HEALTHY ARE WE?

We have been told that we are the healthiest country in the world. If we are, why do we need a national health program? No one would deny that we have made outstanding health progress over the past 50 years. Since 1900, our general death rate has been cut by about 40 percent. Our achievements in sanitation, in communicable disease

control, and in medical science in general have been notable. We have among the finest hospitals, the best-trained and the most skilled physicians in the world.

Still we are not the healthiest nation; we have by no means done as well as some other countries in protecting health, and we are far from doing what we can do. Although we are the wealthiest among the nations of the earth and have high standards of well-being, we have not yet attained for all our people that level of security of life which has been achieved in some nations with smaller economic resources.

When we use mortality rates as an indication of our state of health, two important factors must be kept in mind. First, the general rates are averages for the country as a whole. Within these averages are concealed rates which are alarmingly high for modern times. Second, we must bear in mind that a large part of the reduction in death rates that occurred in the past 20 or 50 years has been largely due to reduction in deaths from infectious diseases—typhoid, diphtheria, malaria, and others—that are susceptible of mass control.

At present a much larger part of the burden of ill health and postponable death comes from illnesses which are not susceptible of mass control, but which require the highly individualized services of physicians, hospitals, laboratories, and technicians. These are the services for which the American people now pay, when they receive them, as individuals.

While we have achieved high standards in medical and hospital care, this high-quality care is not within the actual reach of large numbers of our people. Putting it bluntly, there are many Americans this very minute who are suffering and dying needlessly for lack of medical care.

#### BARRIERS TO ADEQUATE MEDICAL CARE

Many barriers stand between the individual and the medical care he needs. Briefly, these are: Lack of recognition or neglect of illness; unpredictability of illness; maldistribution of medical personnel and facilities; the unpredictability of medical costs; and the inability of a large proportion of families to pay for needed care.

I will not take the time to review the evidence on these points. It is summarized in the document, "Need for Medical Care Insurance," which we furnished the committee, and which you already have available to you as your Committee Print No. 4 on the National Health Act.

#### BUDGETING FOR MEDICAL COSTS

A major reason for neglect of recognized disabilities is, of course, the impact of medical costs on the family budget. No one can anticipate whether he or his family will go through a year with little or no illness or will suffer an extended and expensive period of sickness. The large variations in the occurrence, duration, and severity of illness among individuals cause similarly large differences in their need for medical services and in the costs they have to meet.

The costs of medical care, unlike those for food, clothing, shelter and other necessities, are not budgetable by the individual family, because they do not occur in a fixed pattern and cannot be foreseen by the in-

dividual or the family. A particular family may go for years with below-average medical expenditures, but in one year's time it may find its entire savings exhausted by a long and expensive illness.

The medical care a family now receives is largely dependent upon its income. Despite all the public provisions for medical care, and care given through philanthropic organizations and free-of-charge by physicians, hospitals and others, low-income families receive, on the average, much less care than the well-to-do, though their needs are greater.

Families with low incomes not only receive less care, but they spend a greater proportion of their incomes on sickness costs than families in better financial circumstances.

#### BORROWING TO PAY FOR MEDICAL CARE

Although medical care expenses take only about 4 to 5 percent of the average American family's income in normal years, more people borrow money to pay for medical care than for any other single item in the budget. In a poll taken in 1944 by the Physician's Committee on Research, some 23 percent of those canvassed said they borrowed money in order to pay doctor or hospital bills. A number of studies of loans made by banks and other small-loan organizations indicate that 3 out of every 10 persons who borrow give the payment of "medical bills" as the purpose for which the money is to be spent. Many others, unable or unwilling to borrow from lending agencies, borrow from friends and relatives.

But not all families are able to borrow. As a consequence, many bills remain unpaid. Studies before the war showed that, on the average, doctors fail to collect a fifth to a third of the value of their bills each year.

#### ADEQUACY OF MEDICAL CARE, FACILITIES AND PERSONNEL

How adequate is the care which the American people receive? Some 15 years ago, a quantitative standard of adequate care, usually known as the Lee-Jones standard, was developed on the basis of the best available medical opinion of what was necessary for "good medical care" at that time. Today, these standards would need modernization, but so far as amount of care is concerned, they probably would be challenged mainly as being too low.

Comparison of the Lee-Jones standards with the services actually received indicates that even people in upper income brackets—those with annual incomes of \$10,000 or more—fail to receive all the service which professional judgment considers desirable. But low-income families suffer more illness than the well-to-do and receive less care. The gap between care received and care needed is much wider at the bottom or near the bottom of the income ladder than it is higher up.

The reason for this difference should be obvious. Medical care costs money and the poor have less money to pay for it. Various public opinion polls show that from 30 to over 40 percent of the American people have put off going to a doctor because of the cost. Individual doctors are not to be blamed for this. Financial barriers—not doctors—are the cause of the inadequate medical care which our people receive.

It is still commonly said that the poor and the rich get the best care. It's a nice generalization and here and there it is true, especially in some large cities. But taking the country over, it is not supported by facts. If adequate medical care is to be available to our people—according to their need for service and not according to their ability to pay—we must remove the financial barrier to adequate care.

Lack of health facilities and medical personnel further contributes to the present inadequacy of medical care in many areas. Even before the war, shortages in doctors, nurses, dentists, and other health personnel, and in hospitals and other facilities existed in many areas—especially in low-income and rural sections. There were large differences between States, and the spread was even greater within the States. Hospital facilities cluster in areas where there is sufficient income to assure their existence. Likewise, professional personnel tend to locate in areas where higher incomes prevail and where facilities in keeping with modern medical practice exist.

#### THE NEED FOR PROTECTION AGAINST SICKNESS COSTS

Sickness frequently throws a double burden on family resources. Aside from the unexpected and largely uncontrollable medical costs which sickness brings, prolonged illness of the breadwinner is likely to cut down or stop family income.

When family income stops or is interrupted because of illness of the breadwinner, when medical bills have exhausted family savings, when borrowing from loan organizations or friends and relatives is no longer possible, families are forced to turn to charitable or relief agencies for aid. Studies of the case loads of relief and other assistance organizations, dating back to 1890, indicate that on the average fully 30 percent, and in many instances as much as 50 percent, of dependency is caused by medical costs and loss of earnings resulting from sickness of the wage earner.

The lack of adequate measures to cope with sickness and with sickness costs constitutes the most serious gap in provisions for social security in the United States. This lack affects all areas in the country, all age groups, and nearly all income levels. Of course, we should strengthen our public health programs, in order to prevent all illness and disability that is preventable. But since most illness and most disability cannot yet be prevented, steps must be taken to make adequate medical care more accessible to all. The most practical method of working toward this goal is to distribute medical costs among large groups of people and over a period of time.

#### VOLUNTARY INSURANCE

The costs of sickness have been distributed for some people through voluntary insurance plans for many years. At present, benefits to which the insured are entitled under the many different types of voluntary plans vary in many ways. Only a few million persons, probably not more than 2 or 3 percent of the population, have what can be termed relatively complete protection against medical bills.

By far the largest enrollment in voluntary health insurance for service benefits is in Blue Cross hospital plans. Membership has grown tremendously within the past 10 or 15 years, but it still covers

less than 15 percent of the population of the United States. Protection against hospital costs is valuable, but the cost of hospitalization accounts for only about a fifth of medical costs paid by families, and voluntary hospitalization insurance does not protect against all of this.

Insurance of this type can, at best, serve only a fractional part of the national need. About 2,000,000 Blue Cross members are enrolled in medically sponsored prepayment programs for medical services which are coordinated with Blue Cross. Another 18,000,000 are eligible for hospital benefits only. Blue Cross membership is concentrated in medium-sized and large cities and their environs. Rural membership is very small. I believe only about 3 percent of the membership of the Blue Cross families are in rural areas.

The Blue Cross plans have demonstrated, on the one hand, the relative ease of insuring a substantial fraction of the middle-income group against hospital costs and, on the other hand, the great difficulty of insuring the low-income or rural groups through voluntary methods. Ordinarily, the plans have failed to insure those who most need this protection—the low-income groups and those in small cities and towns, in medium or small business establishments or self-employed.

The difficulties of enrolling the public in voluntary hospitalization plans are small compared to those of medical-care plans. There are in the United States at this time voluntary prepayment medical-care plans with an enrollment of between five and six million persons, whose members are entitled to service benefits. For a regular fee, usually payable monthly, members are guaranteed the receipt of specified services from physicians, and other types of medical care in case of illness. Many of these plans include hospitalization among the services.

The organizations differ greatly in the scope of services provided, and various limitations are placed on the amount of care furnished. Membership is frequently restricted to those below a specified age or income. Persons with preexisting disabilities may be excluded entirely or entitled to only limited service. Industrial plans, which in early 1945 included about 30 percent of the members of these prepayment plans, usually provide relatively complete care, but eligibility is in most cases restricted to employees of one organization and the scope of the plans is limited in many other ways.

In early 1945, about half of the persons who were members of the plans providing service benefits were members of plans sponsored by State and county medical societies. During the past few years, the number of medical society plans sponsored by State and county medical societies and the number of people enrolled have grown. The American Medical Association, which formerly opposed all forms of health insurance, has definitely gone on record as favoring voluntary health insurance plans of this type.

Senator DONNELL. Has the American Medical Association gone on record with respect to an involuntary insurance, that is to say compulsory insurance?

Mr. ALTMAYER. They are opposed to that.

Senator DONNELL. Have they passed resolutions to that effect?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. How recently have they done that?

Mr. **ALTMAYER**. As recently as last December at their Chicago meeting.

Senator **DONNELL**. All right.

Mr. **ALTMAYER**. With the exception of medical society plans in the States of Washington and Oregon, the scope of care provided by these plans is generally much restricted—primarily to obstetrical services and surgical care in the hospital. The Washington and Oregon plans have been in operation for many years and are not typical of the medical society plans as a whole or those being organized in other sections of the country.

The typical medical-society plan is limited in its benefits, is expensive, and often either limits the membership to those under a specified income (usually \$2,000 or \$2,500) or allows the doctor to make additional charges for those with incomes over a specified amount or those using a private room in the hospital. Thus, the families with incomes over the limit, do not really know what insurance protection they bought with their premiums.

During the past 10 years there has been a rapidly increasing growth in industrial group insurance through which employees are reimbursed in cash for all or a portion of their hospital and medical fees (principally surgical). Policies of this type formerly covered only employees, but recently the coverage in many instances has been extended to employees' dependents. At the end of 1944, approximately 7,000,000 to 8,000,000 persons were eligible for hospitalization indemnity payments. Of this number, about 6,000,000 were also eligible for surgical indemnities. Although this is a step in the right direction, insurance of this type is not a satisfactory substitute for a comprehensive health insurance program. Both the number of persons served and the benefits received are too limited. Comprehensive protection of this type would be more expensive than most persons could afford to pay.

This, in summary, is voluntary health insurance as it now exists in the United States. Membership is limited, services are incomplete, prices are high in comparison with services provided under some of the plans, and in many instances additional charges are made for the more expensive services. The plans themselves are unevenly distributed throughout the country. Each is individually planned and administered, and, with the exception of the Blue Cross hospitalization plans, there is practically no coordination among them.

The crucial test of a health insurance program is not its good intentions, but the population coverage it achieves and the scope of protection it furnishes. By these criteria, voluntary insurance against the costs of medical care has been tried and found wanting. This failure is not due to lack of effort, earnestness or skill on the part of individuals or organizations sponsoring these programs, nor is it the result of lack of interest on the part of the American people.

The rapid enrollment of Blue Cross and medical society plans indicates that even the limited protection offered by these plans is welcomed by the public. The failure of voluntary insurance is due to the fact that the task is too large and too difficult to be accomplished by organizations or associations representing only a portion—and in most instances a very small portion—of the public.

No type of voluntary plan, either here or abroad, has ever even approximated the goal of including all of the population in a region.

As a rule, those who are most in need of protection are not covered. Voluntary insurance is necessarily expensive, because it is constantly exposed to an adverse selection of risk among those who —

Senator ELLENDER. Mr. Altmeyer, suppose the pending measure should be adopted as written. What would become of all of these plans that you have been discussing just now, the Blue Cross plan and the other industrial insurance associations?

Mr. ALTMAYER. I think that they could be fitted into a comprehensive health insurance plan, either as service agencies or as representatives of the persons furnishing the service.

Senator ELLENDER. How would they maintain themselves?

Mr. ALTMAYER. They would maintain themselves by being reimbursed by the Federal Government for the service they rendered either directly or the service rendered by the persons that they represented.

Senator ELLENDER. The only portion of their facilities that could be used would be the hospitals if they have any.

Mr. ALTMAYER. Well, I mean some of these medical society plans. The doctors might prefer something along that line.

Senator ELLENDER. Let us take the Blue Cross plan which you say insures quite a few people and which has done good work. Would not the passage of this bill as written have the effect of putting the Blue Cross plan out of business?

Mr. ALTMAYER. Well, it might. I do not know.

Senator ELLENDER. Do you not know it would?

Mr. ALTMAYER. No, I do not know it would. The Blue Cross people will have to speak for themselves on that.

Senator ELLENDER. As I understand, they collect a certain amount per month from their membership for which they render certain services. Now, if you forced all of the people of the country—I think that we said yesterday 85 percent of them would come under the plan as envisioned by the pending bill—do you think that those paying compulsory insurance would also take membership in the Blue Cross?

Mr. ALTMAYER. No; but that is not the whole story. Some of these Blue Cross plans would want to furnish additional services by way of semiprivate or private rooms, for example, and people who like to pay through voluntary organizations for that additional service would do so since that would not be provided under this bill.

So far as the basic service under this bill is concerned, the hospitals (which really organized these Blue Cross plans which are producers' organizations and not consumers' organizations) might prefer to continue to be represented through Blue Cross plans, submit their bills to the Blue Cross organization, and let the Blue Cross organization handle all of the relations with the Government. That could easily be done.

Senator ELLENDER. How would they maintain themselves?

Mr. ALTMAYER. By being reimbursed by the Government first for the services rendered by the hospitals and secondly by the Government paying them the administrative expense that the Government would be saved by their handling the job for the hospitals.

Senator ELLENDER. Could that be attained under this bill?

Mr. ALTMAYER. Yes, sir.

Senator ELLENDER. Do you mean the administrative expenses?

Mr. ALTMAYER. Yes, sir. To the extent that they save the Government money, the Government could reimburse them for their administrative expenses.

Senator ELLENDER. All they would receive would be the actual expenses; it would then not be in the nature of a paying concern?

Mr. ALTMAYER. It would not be in the nature of a profit, but they are all nonprofit organizations now. They do not propose to earn a profit for themselves. They are all nonprofit.

Senator ELLENDER. You concede, however, that as to those organizations that have hospitals and facilities, that that would be most likely the services that would be paid for and contracted for by the Government, through the Administrator?

Mr. ALTMAYER. I do not think that I got that.

Senator ELLENDER. You have said that most of these plans, the Blue Cross and a lot of industrial groups, put up hospitals or had contracts for hospital services?

Mr. ALTMAYER. That is right.

Senator ELLENDER. That would be the only part of their facilities that would be really used through this forced plan?

Mr. ALTMAYER. For the Blue Cross?

Senator ELLENDER. No; I mean the Government.

Mr. ALTMAYER. Oh, no.

Senator ELLENDER. Well, why should the Government, or how could the Government; afford not to administer the compulsory plan if it was shown by handling it itself it would be less expensive?

Mr. ALTMAYER. That is the question. Take the medical society plans. If the doctors in the locality prefer to handle their relations with the Government through a medical society, there is no reason why the Government might not deal with the medical society plan officials, and let those officials deal with the individual practitioners.

Senator ELLENDER. But these societies would then have to abide by and be under certain rules and regulations, as would be made by Washington?

Mr. ALTMAYER. That is right.

Senator ELLENDER. They could not handle their affairs as they are now permitted to do?

#### METHOD OF REMUNERATION

Mr. ALTMAYER. Well, not completely free of any control over arrangements, but the bill provides, they could determine for themselves what method of remuneration the practitioners should receive. They would be completely free on that score.

Senator ELLENDER. That would be under the jurisdiction, though, of the Administrator here in Washington?

Mr. ALTMAYER. But the bill provides if a majority of the physicians in the community elect a certain method of remuneration, that method of remuneration prevails.

Senator ELLENDER. Irrespective of what it amounts to?

Mr. ALTMAYER. Oh, no, I was referring to the method of remuneration. There would have to be a lump sum allocation, based upon certain objective factors, but that could be written into the legislation by the Congress, and would not be subject to the whim of the Administrator.

Senator ELLENDER. Well, they would not be their own free agents. Whatever plans they would foster would have to in a measure receive the okay of the Administrator in Washington?

Mr. ALTMAYER. Subject to the general standards. But on this matter of how they distribute the lump sum that is assigned, they have that same problem under their own plans. Many medical society plans have to write down the bills that are submitted by the doctors, because the amount of money collected is not sufficient to cover the bills; so that is a problem that is common to either voluntary or compulsory health insurance.

#### SELECTION OF PHYSICIANS

Senator ELLENDER. Well, now about the selection of physicians of one's own choice. Do you expect to touch on that later?

Mr. ALTMAYER. It is perfectly clear that a person may select his own physician.

Senator ELLENDER. That is only in the case that the physicians of a certain community agree to abide by whatever rules and regulations come from Washington.

Mr. ALTMAYER. Well, if the doctor did not want to treat the patient the patients could not select them.

Senator ELLENDER. Let us assume a community where there are 100 physicians and surgeons, and let us further assume that of that number 60 percent of them would be willing to abide by common consent to whatever rules and regulations Washington agreed with, and suppose further that a patient desired a doctor who is not one of the 60 percent. What procedure would that patient have to go through in order to obtain the services of a doctor who happens to be in the 40 percent group, that is, those doctors of that community who do not choose to join the plan?

Mr. ALTMAYER. Well, if the doctor did not want to treat the patient and be reimbursed—

Senator ELLENDER. I am not putting it that way, Mr. Altmeyer. You say there is freedom in this bill of a patient selecting a doctor of his own choice.

Mr. ALTMAYER. That is right.

Senator ELLENDER. When you say that, you mean the doctor must abide by the rules and regulations of the administrator, and any doctor in the community who is left out could not be called in by that patient and be compensated out of the common fund.

Mr. ALTMAYER. He could be called in, but the patient would have to pay for it.

Senator ELLENDER. That is what you call freedom of selection?

Mr. ALTMAYER. Yes, of course.

Senator ELLENDER. In other words, you would force every physician in the country to belong to some association or to some group that would in turn deal with Washington.

Mr. ALTMAYER. Many physicians would probably elect—

Senator ELLENDER. But I say, is that correct?

Mr. ALTMAYER. No, because many physicians as in Great Britain would elect not to practice under the system.

Senator ELLENDER. But what I mean is in order to be paid out of these funds, is that right?

Mr. ALTMAYER. That is right.

Senator ELLENDER. That is what I had in mind.

#### EFFECT OF BILL ON VOLUNTARY PLANS

Senator DONNELL. Mr. Altmeyer, referring to Senator Ellender's queries in regard to the effect on the Blue Cross, as I understood your testimony you do not think that the average individual over the country is getting the service or who is entitled to the service under the bill, would duplicate the expense by both allowing his percentage to be taken by the Government, and at the same time also buying other service of the same type from the Blue Cross?

Mr. ALTMAYER. No, I would not think so.

Senator DONNELL. So the only place that the Blue Cross would be able to sell its services direct to the individuals thereafter would be in supplemental services of such type as you mentioned, special rooms?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. And as to the maintenance of hospitals, then the Blue Cross would have to depend upon only two sources of income, would it not, if it is to continue in existence? That would be first the income if any which it might derive from the Government by contracting to furnish the Government the services which the Government will furnish under the insurance plans; and secondly, by securing from the individuals the payment for these supplemental services. That is correct, is it not?

Mr. ALTMAYER. That is correct.

Senator DONNELL. Now, Mr. Altmeyer, it seems reasonable to believe, does it not, that the great bulk of such income, if any, as would be received by the Blue Cross, under that plan, if it were to work out that way, would be the income received for the normal services, namely, that that it would get from the Government?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. As to those services, those would be conducted under the regulations of the Government, as the Government might prescribe. That is correct, is it not?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. Have you made any study to estimate what would probably be the volume of these supplemental services that individuals would buy, over and above what the Government would provide? Have you made any studies designed to give us any estimate on that?

Mr. ALTMAYER. No, sir.

Senator DONNELL. So that it would look pretty clear, would it not, that unless these supplemental services are going to amount to a very considerable volume, that Senator Ellender's point is good, that the Blue Cross would virtually be forced out of business?

Mr. ALTMAYER. No. I do not think that that necessarily follows, because they are really essentially producers' organizations, representing the hospitals. There are very few that have any representation of the subscribers on them. The hospitals apparently find them of advantage to them, and the hospitals might very well consider them of advantage in dealing with the Government.

Senator DONNELL. At any rate the great bulk of the services which the Blue Cross, if it were to continue in existence at all, would normally perform would be those for the Government. That is correct, is it not?

Mr. ALTMAYER. That is right, on behalf of their hospital members.

#### FREEDOM OF CHOICE UNDER THE BILL

Senator DONNELL. Now, Mr. Altmeyer, referring to the second point that Senator Ellender made, namely, the question as to the freedom of choice by individual persons of physicians, as I understand it, and if I am wrong I wish that you would check me on this—as I understand it, if an individual has this compulsory insurance and wants to get a doctor who has not complied with the regulations of the Federal Government, the individual would only have the freedom of choice of going out and getting that doctor at his own expense?

Mr. ALTMAYER. That is right.

Senator DONNELL. In other words, he has no freedom of choice whatsoever as to employing that doctor to perform the services for which the Government would pay. That is correct, is it not?

Mr. ALTMAYER. That is right.

Senator DONNELL. So the only freedom of choice is just to spend his own money?

Mr. ALTMAYER. He has freedom of choice to select, but he would have to pay for that service.

Senator DONNELL. That is no freedom of choice under the bill. That is just the freedom of choice that any individual has to go out and get any doctor that he wants?

Mr. ALTMAYER. Yes, sir.

Senator ELLENDER. So that he would have to pay twice.

Senator DONNELL. He would be paying to the Government, and if he did not like the Government's doctor, or the man the Government approved, then if he wants to get another doctor he would have to contribute not only the amount to the Government but also pay separately out of his own pocket, independently of his governmental contributions, is that right?

Mr. ALTMAYER. That is right.

Senator AIKEN. May I ask a question. I would like to ask Mr. Altmeyer, is there any doubt in his mind that the Federal Government would approve any doctor who complied with the standards established by the State in which he was practicing?

Mr. ALTMAYER. It is specifically provided in the bill that any doctor licensed to practice shall have the right to participate.

Senator AIKEN. That is what I wanted to bring out, that you could not deny the doctor his right to participate.

Senator DONNELL. Where is that in the bill, if you have it. I am not familiar with it.

Mr. ALTMAYER. That is section 205, on page 45 of the bill.

SEC. 205. (a) Any physician, dentist, or nurse legally qualified by a State to furnish any services included as personal health service benefits under this title shall be qualified to furnish such services as benefits under this title (except as otherwise provided in subsection (c) of this section or in subsection (f) of section 214), and this provision shall extend to any group of physicians, dentists, or nurses or combinations thereof whose members are similarly qualified.

Now, subsection (c) refers to specialists or consultant services; and (f) of section 214 refers to nurses, because most States do not have registration or standards for practical nurses.

Senator DONNELL. If an individual wanted to get a specialist in a heart treatment, for illustration, is such a person under the exception set forth in subdivision (c), or subsection (c) of section 205?

Mr. ALTMAYER. The reason that is put in there is because no State has licensing of the various kinds of specialists. Somebody has to decide whether a person who says he is a specialist is really a qualified specialist.

Now I am getting into professional questions which I am not competent really to testify about, but in my understanding the Surgeon General as Administrator would consult with and probably be largely guided wherever there is a professional organization that has issued any certification of specialty.

Senator DONNELL. You think, as I understand it, and if I am wrong please check me, that the term "specialist" as used in subsection (c) of section 205, would include a heart specialist, for illustration?

Mr. ALTMAYER. I really do not know.

Senator DONNELL. You think that that would be something that the Surgeon General would be better qualified to testify on?

Mr. ALTMAYER. That is right.

Senator ELLENDER. I may be giving you an extreme case, but suppose in a community where there are, say, 10 doctors, and none of them agree to abide by the rules and regulations from Washington, how would the patients in that locality who contribute to this fund be able to obtain medical services?

Mr. ALTMAYER. Well, I imagine the Surgeon General would undertake to induce other physicians to come into that community who would be willing.

Senator ELLENDER. He would have to go outside for help?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. That would have the effect of putting out of business those physicians and surgeons to whom Senator Ellender referred?

Mr. ALTMAYER. That is an assumption contrary to fact, I think, for this reason, that this bill provides not only that the majority of physicians of the community elect the method remuneration, but any individual in the minority who wants a different method can make arrangements for it.

Senator ELLENDER. The point is that you force them to join the plan "or else," is that true?

Mr. ALTMAYER. You force them to charge the Government rather than charge the patient, if that is what you mean. I do not see why there would be any objection to charging the Government.

Senator ELLENDER. I do not know whether the Government pays it or the patient, but I was trying to demonstrate this freedom that we are speaking about.

Mr. ALTMAYER. That is freedom between the patient and the physician, each one to select the other, but as you point out the factor of payment affects the choice that is made.

Senator ELLENDER. Of course, I presume that as time went on, rather than starve, a lot of doctors would see themselves forced to join or else give up their profession, is that not true?

Mr. **ALTMAYER**. I do not think any doctors would give up their profession.

Senator **ELLENDER**. That could happen under this bill, however.

Mr. **ALTMAYER**. It has never happened under any other health insurance plans put into effect in other countries.

Senator **AIKEN**. We have an insurance plan in this country, I believe by the Farm Security Administration. Do you know of any instances where the local doctors have refused to participate in this insurance plan which is set up by the Farm Security? It simply means that they participate and they get their money, and if they do not, they either do not visit the person who is ill at all, or if they do visit them they take a chance on not getting their money. Therefore, they all have participated.

I come from the State which has Farm Security health insurance on a State-wide scale. I think that it has worked out very well there, and I think that all of the doctors in the State participate if they have a patient in that class. I do not think that there has been any trouble on that, when it is a question of getting part of their pay, or getting none of it.

Senator **ELLENDER**. But all of that has been through voluntary agreements entered into by the profession, which I think would be the case.

Senator **AIKEN**. They entered into an agreement with the cooperative set up by the Farm Security. It has worked out very well. I do not want anyone to think that just because I am asking questions that I am going to favor a system of Government doctors, but I want to make sure that this bill does not set up a system of Government controlled doctors.

Senator **ELLENDER**. Speaking for myself, I do not want to be judged as to what I am going to do about this bill by the questions I am asking. All I am trying to do is obtain from all witnesses what the bills means, where it will lead to, and that is all.

Senator **AIKEN**. That is my position exactly.

#### HEALTH INSURANCE IN OTHER COUNTRIES

Senator **DONNELL**. May I ask one further question. Mr. Altmeyer, you referred to the other countries in which there is health insurance. Would you mind telling us which are the major countries in which health insurance of a compulsory nature has prevailed?

Mr. **ALTMAYER**. There are about 35 countries that have compulsory health insurance, including nearly all of the industrialized countries. Great Britain is one, and France and Germany, Norway, and Spain, New Zealand, Denmark, Holland and Belgium, most of the South American countries; and in fact, off-hand I cannot think of the ones that do not have it.

Senator **AIKEN**. Are those plans financed in a manner similar to that proposed in this bill?

Mr. **ALTMAYER**. They rely upon the health insurance approach. The outstanding exception is Russia, which has a system of state medicine, and salaried physicians.

Senator **AIKEN**. This bill as I understand it, simply sets forth that money must be provided, and it does not provide the means of getting that money, does it?

Mr. ALTMAYER. It does not provide the means of getting that money, no.

Senator AIKEN. That would have to be provided by different committees than this one?

Mr. ALTMAYER. That is right.

Senator AIKEN. And probably would originate in the House if it was in the nature of a special tax or assessment?

Mr. ALTMAYER. That is right.

Senator DONNELL. Mr. Altmeyer, has it not been planned that the financing of this S. 1606 would be along the lines contemplated by S. 1050, the other Wagner-Murray-Dingell bill?

Mr. ALTMAYER. I think so. Of course, it is conceivable that you might finance it through an earmarked income tax instead of a pay roll tax.

Senator ELLENDER. Mr. Altmeyer, have you or any of your staff made any study of these countries that you have just referred to as to this involuntary method?

Mr. ALTMAYER. Yes.

Senator ELLENDER. What has been the tendency there with respect to physicians being put on a salary basis? Has it increased from the time the laws in the respective countries became effective or just what is the situation there in that respect?

Mr. ALTMAYER. No; I do not think that there has been any marked tendency that way. As you know, right now in Britain there is a proposal before the Parliament to extend very much the coverage and benefits provided under their health insurance system, and to turn it into a health service plan, covering the entire population. Under that plan it is proposed that the doctors be paid a part salary, a part basic salary, and a per capita fee in addition. That is proposed and it is not in effect at the present time. I am not clear whether the British medical association is opposed to that change, and I do not know what the outcome will be.

Senator ELLENDER. Do you not?

Mr. ALTMAYER. No.

Senator ELLENDER. I can imagine what is going to happen.

Mr. ALTMAYER. I might say in some countries, the doctors themselves have preferred to be paid on a salary basis and give part of their time to clinics, a certain number of hours a day or week. In South America and Mexico that is the typical way of the doctors rendering service. They are private practitioners, but they come into a clinic for a certain part of their time and are paid accordingly.

Senator ELLENDER. Under the terms of the bill as I understand it, doctors may elect to give their services for a regular monthly or yearly stipend.

Mr. ALTMAYER. Yes, sir.

Senator ELLENDER. Is that correct?

Mr. ALTMAYER. That is right.

Senator ELLENDER. Well, what would be the method of carrying that out? Let us assume in a community where there are 50 doctors, 5 of them elect to give their service on a monthly basis and the rest do not.

Mr. ALTMAYER. There would have to be a division of the amount, the total amount of money allotted to that community on the basis of the doctors who elected to accept their remuneration in one form

and the doctors who elected to receive it in another form. It would have to be upon the basis of the case load, so to speak, of the patients served.

Senator ELLENDER. Well, would the fees be so limited, I mean limited in the same manner?

Mr. ALTMAYER. Are you talking about the salaried doctor?

Senator ELLENDER. As I understand you, the salary would be based on the amount of funds allotted to that community.

Mr. ALTMAYER. Well, I thought that you posed the question, if some doctors in that community elected to get their money one way and other doctors another way.

Senator ELLENDER. I did not intend to go into that phase of it, but I am wondering how it would be operated as between those doctors that elect to receive pay on a monthly basis for their services, and the others who wanted to join the plan and who elect to do theirs on a fee basis for each person treated.

Mr. ALTMAYER. There would first have to be a determination of the reasonable cost of the services to be rendered the people in that community. Then there would have to be discussion with the local practitioners of the reasonable division between the doctors who want to be paid on this basis and the doctors who want to be paid on that basis.

Senator ELLENDER. In other words, the money would be divided up, shall we put it that way, as among those who choose to do the work on a fee basis, and those on a salary basis.

Now, how often would that have to be done, that is the allocation?

Mr. ALTMAYER. Well, you would reach a basic agreement that I would think would extend at least for a year. In the light of experience that might very well be adjusted from time to time. It might be a continuing agreement subject to adjustment.

Senator ELLENDER. So that if in a year, the amount of money that is allocated to a community should be less than the amount allotted in a prior year, those doctors receiving fees and those receiving salaries would be reduced accordingly, is that right, assuming there would be a reduction?

Mr. ALTMAYER. If there would be a reduction, but I do not know why there would be a reduction.

Senator ELLENDER. I do not know. There might be more sickness. You might have an epidemic in some community. How would you take care of such a situation?

Mr. ALTMAYER. Then you would want to provide, if you had anything like that, a free fund to put into that community.

Senator ELLENDER. All of those contingencies can be met by that?

#### FINANCING THE PLAN

Mr. ALTMAYER. I would envisage an allocation by States, with a small free fund so that in case of epidemic or unusual circumstances, in a State, you could make some funds available as between the States. Then from the State level you would have to break it down into communities.

Senator ELLENDER. I did not intend to go into the allocation feature of the bill, but since you have raised the question, the allocation is made in proportion to what—the population or the money collected, or the need, or just what?

Mr. ALTMAYER. It is not spelled out in the bill at all. I think the fundamental criterion ought to be the need.

Senator AIKEN. I am asking rather elementary questions, but what would the effect of this bill be upon those people who have no earning power whatsoever, who are now served when they are sick, if they are sick at all, or treated by government doctors, and I mean doctors hired by the local government? That is some hired by the year, and some hired in industry, I suppose that you would call it by piece work, or by the visit. They would be receiving medical care under the terms of this bill and thereby relieve the local community of the expense which is now considerable.

Mr. ALTMAYER. That is provided in this bill under title I, part C, whereby a community may pay a premium into this insurance system if it elects or it can furnish the service directly. The State would receive a grant-in-aid from the Federal Government on a variable grant basis—the poorer the State the greater the proportion of the Federal grant—to help it pay its premium or to pay for the service if it rendered the service directly through salaried doctors, fees to private practitioners, or some other arrangement.

Senator AIKEN. Then the community or the county or State would pay this premium in lieu of a pay roll tax which the earning patient would naturally pay?

Mr. ALTMAYER. Yes, sir.

Senator ELLENDER. To pursue the question of allocation that we were talking about before the Senator from Vermont asked you a question, do you not think it would be advisable for the committee to spell out into the bill the yardstick by which these funds should be allocated to the States?

Mr. ALTMAYER. I think it would be very fine.

Senator ELLENDER. And your view is that emphasis should be put on need.

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. Mr. Altmeyer, in section 201, if I may question the witness further, it is provided in subdivision (a) that every individual who is currently insured and has been determined by the board to be eligible for benefits, under this title in the current benefit years shall be entitled to receive personal health service benefits. I would like to ask you who is it that the bill contemplates shall be currently insured. Is that defined in the bill?

Mr. ALTMAYER. It is defined later on roughly this way: A person can qualify—

Senator DONNELL. In what section, please.

Mr. ALTMAYER. On page 70, section 215. I can summarize that to save you time.

Senator DONNELL. That is section 215. If you will be kind enough to summarize it, Mr. Altmeyer.

Mr. ALTMAYER. There are two ways in which a person can become eligible under the general provisions outlined in section 215.

Senator DONNELL. That is by which he may be insured?

Mr. ALTMAYER. Yes, sir. Either if he has earned \$150 in the last year or if he has been insured and has earned \$50 or more in half of the calendar quarters during the last 3 years. That is what this amounts to in substance. There is a so-called two quarters lag period

to give the Government the opportunity to post to the individual accounts, but the two criteria are earnings of \$150 in the last calendar year or employment in half of the calendar quarters during the last 3 years, and employment being defined as wages of \$50 or more in a quarter.

Senator DONNELL. Is there any age qualification?

Mr. ALTMAYER. No, sir.

Senator DONNELL. That is, any person who comes within these qualifications that you have mentioned regardless of age, youth, or old age, would be currently insured?

Mr. ALTMAYER. Yes, sir; and in addition the persons that Senator Aiken mentioned, on whose behalf premiums have been paid in, who are not able to work and have not therefore developed this automatic eligibility status, and the beneficiaries under the Federal Old Age and Survivors Insurance System are covered by a premium paid on their behalf.

Senator DONNELL. Has any estimate been made as to how many individuals in the United States would be currently insured under the terms of this bill?

Mr. ALTMAYER. Yes; it is estimated that between 105 and 112 million persons, counting both workers and their dependents.

Senator DONNELL. Has there been any estimate made as to the total annual expense of providing the personal health service benefits under this bill for these 105 to 112 million persons?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. What is the estimate of that?

Mr. ALTMAYER. The estimate is \$3,000,000,000 in an early year of the system which would work out—

Senator DONNELL. That is per year?

Mr. ALTMAYER. Yes, sir; which would work out to be equivalent to about 3½ percent of pay rolls in an average year. That is the total over-all cost. What I wanted to say is that 3½ percent of pay rolls is large enough in an early year to include the costs paid for the beneficiaries under Old Age and Survivors Insurance, and some special payments that would be made out of the Treasury for dental and home nursing care. The pay-roll tax implied in the bill would be 3 percent and not 3½ percent. The equivalent of a half percent would be met by general revenues.

Senator DONNELL. I am not quite clear on that. Do you mean it is contemplated that there shall be an employers' and an employees' tax on pay rolls?

Mr. ALTMAYER. This bill, of course, is entirely silent on that point.

Senator DONNELL. I understand, that is S. 1050; is it contemplated that there shall be employers' pay-roll tax and employees' pay-roll tax?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. In what percentage?

Mr. ALTMAYER. One and a half percent each.

Senator DONNELL. Now suppose, or has it been estimated, Mr. Altmeyer, whether or not that aggregate of 1½ percent from the employers and 1½ percent from the employees will meet this annual expenditure of \$3,000,000,000?

Mr. ALTMAYER. It will meet most of it.

Senator DONNELL. It will do that?

Mr. ALTMAYER. A pay-roll tax of 3 percent would raise about two and a half billion dollars, or a little more. In addition, there would be roughly half a billion dollars of general revenues.

Senator DONNELL. Two and a half billion through pay rolls, so that there would have to be \$500,000,000 per year raised from governmental sources, from one place or the other; is that right?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. Now, I understood you to say earlier that there are two possible plans of financing this matter, either the plan under S. 1050, which I understand is the pay-roll tax from employer or employee, or an ear-marked income tax; is that right?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. Would that ear-marked income tax be paid by every income-tax payer, or would it be confined solely to the persons who derive these benefits, this 105 to 112 million persons?

Mr. ALTMAYER. It would be paid by everybody, probably subject to a minimum exemption. All those people would then automatically acquire eligibility through their income-tax payments.

Senator DONNELL. Has there been given consideration as to which of these two financing plans is preferable, namely, the one under S. 1050, the pay-roll tax from employer and employee, supplemented by governmental payment, or, on the other hand, the ear-marked income tax?

Mr. ALTMAYER. Yes, sir; there has been a lot of consideration given to that. Over in the House Ways and Means Committee at the present time, for example, there are hearings going on to extend the Federal Old Age and Survivors Insurance System. As you know, there are about 20 million persons not covered at the present time. There is discussion going on as to ways and means of covering them.

My testimony over there was to the effect that as far as the employed persons who work for others, the simplest way is to collect as a pay-roll tax. For the self-employed persons not on anybody's pay roll, what amounts to an earmarked income tax would be the best way to collect it.

Senator DONNELL. Do you favor a combination of the two plans, a pay-roll tax and an earmarked income tax?

Mr. ALTMAYER. Yes, sir; I think that that would be the most practical way to start. We have, as you know, already set up in Baltimore records covering about 83 million individuals, and we have all of the methods worked out for reporting by employers. Those reports could be used as a basis for determining eligibility under this health insurance bill that is proposed, without any major additional expense.

Senator DONNELL. So, as I understand, you would favor imposing both a pay-roll tax upon the employers and employees and an ear-marked income tax?

Mr. ALTMAYER. For those you could not reach through the pay-roll tax.

Senator DONNELL. I see. Has there been any document or publication that has been prepared for study by the members of Congress as to the relative merits of the two plans of financing, Mr. Altmeyer?

Mr. ALTMAYER. We are just finishing a report at the request of the chairman which will touch on that feature.

Senator AIKEN. I have a couple more questions. As I understand it, if a patient that is insured under this plan is in a hospital and desires better facilities and better care than would ordinarily be furnished under the plan of insurance, that he can get those better facilities and care by paying additional charge for the hospital; is that correct?

Mr. ALTMAYER. That is correct.

Senator AIKEN. Now, suppose that an insured person sends for the doctor, and ordinarily so many visits a day would be required, but he likes the doctor's company pretty well and he wants him to come more, then for those additional visits the doctor can charge whatever he sees fit?

Mr. ALTMAYER. No; I mean the doctor would have to decide what visits are reasonable and refuse to come just to hold his hand.

Senator AIKEN. Or tell him some new stories. We all know that a doctor's stories and conversation probably has more effect on more patients than medicine.

Mr. ALTMAYER. If the doctor felt that was so, it would be reasonable for him to call.

Senator AIKEN. If the patient wants a certain doctor and is willing to pay him more than the fee allowed by this, can he do so?

Mr. ALTMAYER. No.

Senator AIKEN. Not if he has to come under the plan?

Mr. ALTMAYER. If the doctor elects to come under this, and is serving the patient as an insured person he cannot charge an extra amount to the patient.

Senator AIKEN. But he could have him come an unnecessary number of visits if he wanted to pay the entire cost of those visits himself?

Mr. ALTMAYER. You mean if the doctor had elected a fee for service? I do not think so, because the doctor would have to agree to submit all of his bills to the insurance institution. That is a very important feature of any insurance system, that it does provide certain protection. If it does not provide certain protection, why then everybody is up in the air as to just how much he will have to pay if he gets sick.

Senator AIKEN. He can pay for better hospital services?

Mr. ALTMAYER. Yes; because that is an objective thing that can be readily determined. He is guaranteed certain minimum hospital service, and if he wants luxury service, that is something very clear.

Senator AIKEN. If the insurance guarantees him \$7 a day, and he wants a room that costs \$10 a day, he can take that other room and pay the \$3 additional out of his own pocket?

Mr. ALTMAYER. Yes, sir.

Senator ELLENDER. As I understand it, Mr. Altmeyer, it is left entirely to the physician to determine whether or not an extra visit is necessary?

Mr. ALTMAYER. That is right.

Senator DONNELL. The term "Board" as used in section 201, namely in the language, "Every individual who is currently insured and has been determined by the Board to be eligible," is that the Social Security Board?

Mr. ALTMAYER. That is the Social Security Board. That eligibility refers not to whether he should have this doctor's service or not, but whether he is insured under the bill.

Senator DONNELL. To take the language of the bill, "Every individual who is currently insured and has been determined by the Board to be eligible for benefits under this title in the current benefit year," and that is the Social Security Board?

Mr. ALTMAYER. That is right.

Senator DONNELL. Now, let me ask you a question or two, but as I understand it, the Social Security Board, United States Public Health Service, which is administered by the Surgeon General, and the Office of Education are three branches, all under the Federal Security Agency; am I correct in that understanding?

Mr. ALTMAYER. Yes, sir; and the Food and Drug Administration, the Office of Vocational Rehabilitation, and some other agencies.

Senator DONNELL. Is there a close coordination and cooperation between those various branches of the Federal Security Agency?

Mr. ALTMAYER. That is right.

Senator DONNELL. Thank you.

Senator ELLENDER. There is one question that I would like to clear up. Under the plan to finance S. 1606, that you have discussed with Senator Donnell a moment ago, am I to understand that there is a limitation under which a person can become a member without paying the fee? If he is earning \$150 a year, is he entitled to services without pay?

Mr. ALTMAYER. If he earned \$150 or more, he automatically becomes eligible, or if he had been employed half of the time in the last 3 years, earning \$50 a calendar quarter in at least half of the quarters, he would be automatically eligible.

Senator ELLENDER. But the limitation is \$150 per year?

Mr. ALTMAYER. In the one case.

Senator ELLENDER. And as to a person in that category, he would automatically become a member without having to pay anything?

Mr. ALTMAYER. It is assumed that there would be a pay-roll tax of 1½ percent, that he would have to pay.

Senator ELLENDER. On whatever he earns, be it \$150 or less?

Mr. ALTMAYER. That is right.

Senator ELLENDER. What is the limitation as to the maximum?

Mr. ALTMAYER. \$3,600 a year.

Senator ELLENDER. So that any person receiving above \$3,600 would not pay anything on that amount but only on what he receives under \$3,600?

Mr. ALTMAYER. Yes, sir.

Senator AIKEN. Mr. Altmeyer, I would like to ask this question: Could a physician or surgeon participate in this plan 5 days a week and reserve the rest of the week for his wealthy clientele?

Mr. ALTMAYER. Yes, sir; he could.

The CHAIRMAN. So that under those circumstances, he could really increase his earnings?

Mr. ALTMAYER. Well, our cost estimates include higher average remuneration for physicians than they have ever earned in peacetime, so that even if he did not elect to serve patients outside of the system, he would, under this, earn on the average more than he had been in the habit of earning.

Senator AIKEN. In those circumstances, with more people getting medical care, many more people getting medical care, he would not

have time to put in his additional visits which he might otherwise give to a wealthy patient.

Mr. ALTMAYER. He could limit himself, of course.

Senator AIKEN. Are there doctors enough in the country to meet the needs provided everybody had medical care?

Mr. ALTMAYER. If they are properly distributed, there are just about enough doctors to meet the need. The trouble is that they are not properly distributed.

Senator AIKEN. There must be some doctors then that are not making a living, because we know that they are not properly distributed.

Mr. ALTMAYER. There are many doctors that are not making a decent living today.

The CHAIRMAN. Under this bill then, if it was put in operation, the income of the medical profession as a whole would be greatly increased?

Mr. ALTMAYER. Yes, sir.

The CHAIRMAN. That is because those who are now giving services are not being paid for them and would be able to collect?

Mr. ALTMAYER. There are two reasons. About one-quarter to one-third of the bills are not paid, and the other reason is that a great proportion of the doctors are not fully occupied, and under this bill they would be guaranteed payment and they would be fully occupied.

#### ATTITUDES OF MEDICAL ASSOCIATIONS

Senator DONNELL. How large an organization is the American Medical Association?

Mr. ALTMAYER. I think at least 100,000 members.

Senator DONNELL. Composed of physicians and surgeons?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. Do you know what proportion that is of the physicians and surgeons?

Mr. ALTMAYER. I think there are about 170,000 doctors licensed or somewhat more, and about 150,000 are active practitioners. Is that about right, Dr. Perrot?

Senator DONNELL. So that number of the members of the American Medical Association is about what percentage of the active practitioners or what proportion of the members of the American Medical Association are active practitioners?

Mr. ALTMAYER. That is just the reverse of your first question.

Senator DONNELL. I withdrew the other question. I would like to know whether substantially all of the members of the American Medical Association are active practitioners?

Mr. ALTMAYER. I imagine practically all of them, about 100,000 or somewhat more, as I recall.

Senator DONNELL. Then there are approximately how many active practitioners altogether?

Mr. ALTMAYER. Dr. Perrot said about 160,000.

Senator DONNELL. So that there is somewhere in the neighborhood of 60 percent of the actual active practitioners who are members of the American Medical Association?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. Now, doctor, if this bill is going to prove of financial benefit to the practitioners, what is the basis, if you know,

of the American Medical Association's opposition to compulsory health insurance?

Mr. ALTMAYER. I would rather that they speak for themselves, Senator.

Senator AIKEN. One other question. You said maybe 110,000,000 people would be insured under this plan. What groups comprise the other 30,000,000 people?

Mr. ALTMAYER. Mainly people not attached to pay rolls. I have a break-down here.

Senator AIKEN. You mean people living on fixed incomes, living on an annuity?

Mr. ALTMAYER. There are about 15,000,000 to 20,000,000 people who still would not be covered, even though this bill were amended to cover certain other groups that I mention later, and those consist of the following classes of persons: Marginal workers, unpaid family workers, and persons newly entering the labor market who just miss qualifying automatically; persons aged 18 and over and still in school; persons in institutions, of course; disabled individuals and their wives and children; next, widows not eligible under Federal Old Age and Survivors Insurance; and next, the aged persons who are not dependents of insured workers and who are not old-age beneficiaries; and finally single women not in paid employment.

Senator AIKEN. How would they be cared for?

Mr. ALTMAYER. You remember I said that they could be brought into the system by the State paying in a premium on their behalf.

Senator AIKEN. What about 15,000,000 or 20,000,000 ex-service-men and women that have the facilities of the veterans' hospitals at their command?

Mr. ALTMAYER. Well, there is no distinction made in this bill. Those who are in gainful employment would be covered, but they would be covered for everything provided under the bill. As you know, the veterans' benefits apply to service-connected disability and to nonservice connected if there is place for them and if the person can establish need, but they are not covered for out-patient care in nonservice connected cases, and their dependents are not taken care of under veterans' legislation.

Senator DONNELL. Is there any national organization of practicing physicians or surgeons which has expressed itself in favor of compulsory health insurance?

Mr. ALTMAYER. Yes, sir; there are several.

Senator DONNELL. Would you mind telling us which those are, if you recall?

Mr. ALTMAYER. There is one called the Physicians Forum, and the other one is the Committee for the Improvement of Medical Care. I presume they have asked to testify.

Senator DONNELL. Are those the only two that you know of that have so expressed themselves of the national organizations?

Mr. ALTMAYER. That is all that I know of.

Senator DONNELL. I appreciate that they can testify themselves, but I am asking you if you know as a fact approximately the membership of the Physicians Forum?

Mr. ALTMAYER. It is very small compared with the A. M. A.

Senator DONNELL. Do you know about what it is?

Mr. ALTMAYER. No; I do not know.

Senator DONNELL. And this committee, what is the name of that?

Mr. ALTMAYER. The Committee for the Improvement of Medical Care.

Senator DONNELL. How large an organization is that?

Mr. ALTMAYER. That is still smaller.

Senator DONNELL. Do you know what the actual membership is?

Mr. ALTMAYER. I do not know.

Senator DONNELL. Smaller than the Physicians Forum?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. Those are the only two organizations of physicians that you know of that favor the compulsory health insurance?

Mr. ALTMAYER. That is right.

Senator AIKEN. However, there are 50,000 or more that do not belong to any organization?

Mr. ALTMAYER. Yes.

Senator AIKEN. Are they peculiar to any particular region of the country?

Mr. ALTMAYER. No; I think that they are scattered.

Senator AIKEN. We have always been told that the A. M. A. was a closed-shop arrangement, and when you say 50,000 doctors in the country that do not belong, you naturally question the report that we have always had that the A. M. A. ruled every doctor, old and young, with an iron hand. But if there are 50,000 that do not belong, that makes me feel like asking more questions. I am wondering if we do have such a closed union as they are reported to have had.

Senator DONNELL. Are there any medical or surgical journals that you know of that have expressed themselves favorably to compulsory health insurance in this country?

Mr. ALTMAYER. Not that I know of.

Senator DONNELL. Have a number of them expressed themselves in opposition to it?

Mr. ALTMAYER. I think they have. There may be some that say a kind word.

Senator DONNELL. Do you mind telling us, Mr. Altmeyer, who is the actual author of S. 1606, I mean to say who actually prepared it, if you know?

Mr. ALTMAYER. I think it is a product of many minds that were put to work at the request of the authors of the bill.

Senator DONNELL. Was Mr. Falk, Isadore Falk, one of the gentlemen who participated in it?

Mr. ALTMAYER. Yes, sir; he is Director of our Bureau of Research and Statistics.

Senator DONNELL. Did he do the bulk of the work in the preparation of S. 1606?

Mr. ALTMAYER. I would not say he did the bulk of the work, he did a major or considerable part of it in cooperation with the United States Public Health Service and others.

The CHAIRMAN. Mr. Altmeyer, it has been a matter of evolution, has it not? It has been going on for a number of years. The bill was introduced by Senator Wagner some years back and hearings were held on that, and as a result of those hearings, additional ideas were developed and new provisions were suggested, and the thing has been growing over a period of years.

Mr. ALTMAYER. Yes, sir; I have myself participated actively since 1933 in the development of a national health plan. As the Senator points out, in 1939 there was a national health bill introduced, and over the course of the years there have been many people consulted in the development of a national health plan, including the representatives of the American Medical Association.

The CHAIRMAN. And suggestions have been made by members of the medical profession; letters have been sent in. I have had a great many letters from doctors in various parts of the country in which they suggest different provisions and proposals in connection with the national health program, and is it not true that in nearly every community in the country, there are some medical men who, even though they belong to the American Medical Association, feel there is a great need for an insurance system of this kind?

Mr. ALTMAYER. Yes, sir. I feel that if the medical practitioners of this country could sit around this table as we are sitting around it today, we would get a majority vote in favor of this bill.

The CHAIRMAN. At the commencement of the discussion of the proposed health legislation, the medical profession took a very decided position against it and did not attempt to assist in working out a program but merely abused it and criticized it and took no part in it, and they organized a program of carrying on propaganda against it; is that not true?

Mr. ALTMAYER. I am afraid it is.

Senator DONNELL. Has there been any poll taken among the practitioners as to how they feel on the subject of compulsory health insurance, Mr. Altmeyer?

Mr. ALTMAYER. Yes; I think that there was one taken. I do not recall when and what it showed.

Senator DONNELL. Do you remember who took it?

Mr. ALTMAYER. I do not remember that, I just have a vague recollection that there was a poll taken, and I do not remember whether the question was formulated so that you got a clear-cut reaction or not. It makes a great deal of difference if you put in some negative words in the question. Then you are sure to get an unfavorable response.

Senator DONNELL. In reference to Mr. Falk, he is not a physician, is he?

Mr. ALTMAYER. No, sir; he is a biologist and an economist.

Senator DONNELL. I think he holds a doctor's degree, doctor of philosophy, but he is not a physician.

Mr. ALTMAYER. No, sir.

Senator DONNELL. Or surgeon?

Mr. ALTMAYER. That is right, and neither am I.

Senator DONNELL. I see.

Mr. ALTMAYER. At the bottom of page 5 there was something missing, and I would like to read that sentence.

Voluntary insurance is necessarily expensive, because it is constantly exposed to an adverse selection of risk among those who enroll or stay enrolled.

Comprehensive insurance requires the united effort of the entire public. Experience the world over has shown that only through Government action can large-scale or complete coverage be achieved.

Senator DONNELL. Do you mind telling us just briefly what your own professional background is, and your educational background, so that we can have it here for the record?

Mr. **ALTMAYER**. Well, I studied economics at the University of Wisconsin and graduated in 1914. I was a school teacher for 4 years, and I returned to the university to take graduate work. In the midst of my graduate work, I became statistician for the Wisconsin Tax Commission, later senior accountant, and later chief statistician for the Wisconsin Industrial Commission, and still later secretary of the Wisconsin Industrial Commission. In 1933, I came down here representing the State in its relations with the Federal Government because our commission, besides administering all of the labor laws of the State of Wisconsin, also administered relief, general relief during the depression.

I stayed on down here as an official of the NRA in charge of labor law compliance, became Assistant Secretary of Labor in 1934, and was chairman of the Technical Committee which advised the Cabinet Committee on its recommendations which form the basis of the present Social Security Act, which was enacted in 1935.

In 1935, when the Social Security Board was appointed, I became a member, the Chairman, Governor Winant, resigned the early part of 1937, and I then became Chairman. I have been Chairman since then.

Senator **DONNELL**. Thank you.

Senator **AIKEN**. I think that you might add, Mr. Altmeyer, that some of the great discoveries and inventions have been made by those who were outside the industry which they were intended to benefit. I think that you have had demonstrations during the recent war. Some of the small boat builders never built any boats before. They got very high commendation from the Navy. They never built a boat before, and therefore were not orthodox and cut a lot of corners which the orthodox boat builder always kept in his practices. There happened to be a little concern in my own State, and they got very high commendation from the Navy.

So I do not think it is necessary that a man should be a doctor or connected with the medical practice in order to have some good ideas in regard to improving public health. On the other hand, I would not say that his ideas would always be sound and warranted of application.

Senator **DONNELL**. The Senator would say that the views of physicians and surgeons would be worthy of consideration and should be considered.

Senator **AIKEN**. If a man is sick and believes in the use of medicine, he would go to a doctor.

Senator **DONNELL**. I assume that we all think that, with all due deference to Mr. Altmeyer, and we are glad to have his views and appreciate them, but nevertheless, it is likewise proper to consider the views of gentlemen who are engaged in the profession of medicine and surgery.

Senator **AIKEN**. Perhaps we should not bring up so many matters here, but it is sure to come up sooner or later. What would you do, Mr. Altmeyer, about the conscientious objector who does not believe in the use of medicine, but would be required to pay his share of the costs?

Mr. **ALTMAYER**. That is a policy question, that this committee would have to decide. It is not an economic question, and it is not a professional question. It is a matter of religious conviction. We had

the same problem under state workmen's compensation laws. Some religious sects felt that they should not carry workmen's compensation, but so far as I know, the State laws required them to carry workmen's compensation insurance for the protection of their workers. But that question is of high policy.

Senator DONNELL. One further question, if I may ask. Mr. Altmeyer, is there any book that you know of in which the results of the compulsory health insurance in these various countries that you have referred to are described, and give that in some detail so that any of us who might desire to obtain by some ready reference manual, information along that line might be able to do it without too much scattering into different books.

Mr. ALTMAYER. Yes, there are several. Of course during the war it has been very difficult to study the functioning of these foreign systems, but I will be glad to go over the literature.

Senator DONNELL. Would you mind filing with the committee such memorandum as you think appropriate, giving us a short bibliography or as long as you deem proper along those lines.

Mr. ALTMAYER. May I point out in connection with the attitude of the medical profession that the British Medical Association, of course, favors compulsory health insurance and has spearheaded the movement to extend the coverage of the British health insurance system, to include dependents as well as the insured workers themselves and to cover services not now covered under the system.

Likewise, the Canadian Medical Association has come out in favor of compulsory health insurance.

So I do not think that we should draw the conclusion that it is necessarily inimical to the profession or that the profession as such, all over the world, is opposed to the idea of compulsory health insurance.

Senator DONNELL. I do not want to leave the implication by the question that I think the American Medical Association should be influenced, either primarily or solely, by their own financial position either under or outside of the compulsory health insurance. I thought, however, that the point that the chairman had suggested, that the doctors would really receive larger financial returns under the compulsory insurance, that it would be of interest to know, which I have no doubt we will later learn from them, what is their basis of opposition to this proposed insurance.

The CHAIRMAN. I am sure that we will have that during the course of the hearings, and I suppose that we will have representatives of the American Medical Association here, and they have already indicated their intention to be here and the representatives from several of the State organizations will be here.

Mr. ALTMAYER. I would like to say this as a nonmedical man, that I would not accuse or even think that the opposition of the American Medical Association is wholly economic. I think a large part of it is actuated by a genuine concern as to the effect on medical practice. I think they are unnecessarily alarmed, but I would not want to go further into that.

The CHAIRMAN. It is the experience that all institutions are adverse to any radical departure from the usual practice. Innovations have to come only after long periods of agitation and discussion, and there

has been considerable change in the minds of physicians in this country as a result of the discussions that have taken place here during the past few years in connection with this problem. We have received letters from them indicating their changed ideas.

Mr. **ALTMAYER**. If you are interested in the historical attitude of the American Medical Association, according to my recollection back in 1916, when I was studying the social insurance movement in this country, which started way back there—a committee of the American Medical Association studying the subject issued a statement favorable to compulsory health insurance in 1916, 1917, and 1919. But in 1920 the house of delegates of the A. M. A. came out in opposition to compulsory health insurance.

In 1932 there was a report on the cost of medical care by a committee under the chairmanship of Dr. Ray Lyman Wilbur, who was Secretary of the Interior in the Hoover administration. The majority report came out in favor of a plan for financing the cost of medical care either through taxation or through insurance.

The minority, which was composed, as I recall, rather largely of representatives of the American Medical Association, opposed the majority report, but said that if they had to choose between voluntary health insurance and compulsory health insurance, they would choose compulsory health insurance, their opinion being based on the experience of the two types of insurance in this country and abroad.

Senator **DONNELL**. That was the minority of the committee?

Mr. **ALTMAYER**. Which was composed largely of the representatives of the American Medical Association, in 1932, and which said that if they had to choose between voluntary health insurance and compulsory health insurance they would choose compulsory health insurance, as the lesser of the two evils. The American Medical Association formally approved that minority report.

Senator **DONNELL**. The house of delegates of the American Medical Association is the governing body of that association, is it not?

Mr. **ALTMAYER**. Yes, sir.

Senator **DONNELL**. And at no time has the American Medical Association, through its house of delegates, expressed approval of compulsory health insurance?

Mr. **ALTMAYER**. No, sir.

The **CHAIRMAN**. But the organization itself in its convention did adopt a resolution favoring compulsory health insurance at one time?

Mr. **ALTMAYER**. It was this committee of the American Medical Association that issued the statement that I have in mind, back in 1916 or thereabouts.

The **CHAIRMAN**. What committee is that?

Mr. **ALTMAYER**. I can furnish the exact title. It was the committee on social insurance of the council on health and public instruction (1919).

Senator **DONNELL**. That committee report was not adopted by the association, is that correct?

Mr. **ALTMAYER**. I do not believe that the association ever gave any affirmative approval to compulsory health insurance.

Senator **DONNELL**. In fact, the association took the view contrary to that recommendation?

Mr. **ALTMAYER**. My recollection is that in 1920 the house of delegates voted in opposition to compulsory health insurance.

The **CHAIRMAN**. You may continue.

#### COMPULSORY INSURANCE

Mr. **ALTMAYER**. The greatest value of voluntary health insurance has been the experience gained in learning how to operate compulsory prepayment plans. By a study of the accomplishments of voluntary insurance and the difficulties it has encountered, a program can be worked out which can succeed where voluntary plans have failed.

The principal reason why voluntary programs have not succeeded, and cannot succeed, is economic. Unless adequate funds are available, no program can adequately extend either its membership or the scope of its services.

A comprehensive health insurance program must rest on a method of financing which makes it possible for the family to budget the costs without having to deny itself the essentials of everyday living. The costs must also be distributed among a membership that is large enough to keep the premium low and in accordance with ability to pay. To accomplish these ends, compulsory insurance is necessary.

Compulsion is not a word that is accepted lightly by the American people, and the opponents of compulsory health insurance have made much of this natural antipathy.

#### VOLUNTARY PLANS ARE NOT DEMOCRATIC

The American Medical Association and other organizations favoring the present inadequate voluntary plans or sponsoring new voluntary insurance programs have implied that a compulsory system of health insurance would result in regimentation and a form of totalitarianism which is not in keeping with the principles expressed in our Constitution and in the Bill of Rights. However, it might be pointed out that voluntary insurance, as advocated by the American Medical Association, is anything but democratic. The A. M. A. recommends a series of voluntary plans, to be run by the medical societies. No mention is made of other associations or of public participation in the organization of these plans, in the control of the funds which the public will have to pay, in the formulation of the standards the plans will observe, or in their administration. The association violates the first principle of democracy—the right of the public to participate—to say nothing of the right of the public to control public enterprise essential to the welfare of the public.

#### PUBLIC OPINION POLLS ON HEALTH INSURANCE

In contrast, under compulsory health insurance, financing and administration would be determined by representatives of the public—using the advice and the skills of professional groups on professional matters. That may be why the public attitude toward health insurance as a part of a system of social insurance is so favorable, as evidenced by many polls of public opinion. The Gallup Poll of 1943 showed 59 percent of the persons canvassed in favor of a compulsory

health insurance plan. A public poll was taken a few months ago for and at the expense of the National Physicians' Committee, the spearhead organization attacking the bill we are discussing; that poll showed that 64 percent of the people prefer a prepayment method for meeting medical costs and that 55 percent think a Federal plan would be a "good thing for the nation as a whole."

Senator DONNELL. Is the Federal plan to which you refer in that sentence a compulsory plan?

Mr. ALTMAYER. I am just taking the words of the poll. That is what they use. They used the expression, "Federal plan."

Senator DONNELL. Did the poll mention "compulsory insurance"? I should say, did the question submitted in the poll specifically mention "compulsory health insurance"?

Mr. ALTMAYER. I have it here some place.

Do you think the Federal Government plan would be a good thing or a bad thing for the Nation as a whole?

Fifty-five percent said a "good thing"; 24 percent said a "bad thing"; 8 percent qualified their answers; and 15 percent had no opinion.

Senator DONNELL. Do you know how wide the participation was in that poll?

Mr. ALTMAYER. No; I don't know. It was conducted by a public relations organization at the request of this National Physicians' Committee, which is opposing this bill.

Senator DONNELL. So the wording, "compulsory health insurance," does not appear in this proposition; but your thought is, I take it, by common knowledge the expression "Federal plan" would be generally understood to apply to it.

Mr. ALTMAYER. Along with other questions they posed that as contrasted with a doctor organization plan.

Senator DONNELL. Would you mind putting into the record what the other plans are mentioned in the question submitted by the poll?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. You will file that with the committee?

Mr. ALTMAYER. Yes, sir.

Senator DONNELL. Thank you.

Mr. ALTMAYER. In January of this year, a poll taken throughout New York State by the New York State Commission on Medical Care, showed that 86 percent of those questioned favor an insurance system and 52 percent favor a compulsory governmental system.

Senator DONNELL. That is 34 percent more, I take it, who favor an insurance system, than favored a compulsory governmental system? Or, I will put it this way: Out of every hundred persons who voted on this matter, 86 favored an insurance system but only 52 favored compulsory governmental system?

Mr. ALTMAYER. That is correct.

In the District of Columbia, according to a survey made a few months ago by the Washington Post, an overwhelming majority—70 percent—of the residents favor President Truman's compulsory health insurance plan.

The increasingly strong public support for compulsory health insurance is based in large measure, I believe, on a recognition of the respon-

sibility of a democratic government to assure that the health of the people is safeguarded and improved to the utmost extent that medical science and our resources make possible.

Government already carries large responsibilities for health and medical services. In 1944 governmental expenditures—Federal, State, and local—exclusive of medical care for the armed forces, totaled nearly a billion dollars, or one-fifth of all the expenditures for health and medical care in the United States.

It should also be noted that we already have in effect in this country a system of compulsory health insurance covering the cost of medical care for work-connected disabilities—namely, workmen's compensation.

Senator DONNELL. I don't understand that last statement :

In 1944, governmental expenditures—Federal, State, and local—exclusive of medical care for the armed forces, totaled nearly a billion dollars.

Upon whom were those expenses incurred ?

Mr. ALTMAYER. Federal, State, and local ?

Senator DONNELL. I beg your pardon ?

Mr. ALTMAYER. Public health services, maintenance of TB hospitals, and mental hospitals, and care of the indigent, probably covered the major portion of those expenditures.

Senator DONNELL. And do you know what proportion of the nearly billion dollars was expended for those purposes, and any other purposes, by the Federal Government ?

Mr. ALTMAYER. I can give you those figures. I do not have them available.

Senator DONNELL. Would you mind filing those ?

Mr. ALTMAYER. Yes, sir ; I shall do so.

Senator ELLENDER. Would this bill absorb that expenditure ?

Mr. ALTMAYER. This bill would help relieve the Government of a considerable part of that expenditure. It would depend on how extensive you made the coverage, and depend on what you did so far as Title I is concerned, in making Federal grants to the States.

Senator DONNELL. Mr. Altmeyer, outside of medical care for the armed forces what are the major items of Federal expenditure under the present law ?

Mr. ALTMAYER. What I am not clear about, Senator, is whether that billion dollars includes veterans' hospitals.

Mr. SANDERS. It does.

Mr. ALTMAYER. It does. Can you answer the question as to the Senator's question as to the break-down of the Federal costs for medical care ?

Mr. SANDERS. I would rather that we submit the data later.

Mr. ALTMAYER. We will give you a complete break-down.

Senator DONNELL. I think that would be better, Mr. Chairman, if they would be kind enough to furnish this break-down.

(The matter referred to is as follows :)

Governmental expenditures for medical care, exclusive of medical service furnished to the armed forces, amounted to \$1,056 million in the fiscal year 1943-44. Of this amount, \$307.6 million, or 29 percent, was provided by the Federal Government and \$748.5 million or 71 percent, by State and local governments. Health and medical care expenditures by Government were distributed among various programs, as follows :

*Governmental Health and Medical Service expenditures for the fiscal year  
1943-44*

[In millions]

Program	Total	Fed- eral	State and local	Percent of total provided by—		
				Total	Fed- eral funds	State and local funds
Total.....	\$1,056.0	\$307.6	\$748.5	100	29	71
Public health services.....	198.3	46.5	151.8	100	23	77
Hospital care and construction (including medical and hospital care for veterans).....	555.6	105.6	450.0	100	19	81
Maternal and child health services.....	10.0	6.2	3.9	100	61	39
Services for crippled children.....	6.7	3.9	2.8	100	58	42
Emergency wartime health and medical service.....	126.6	126.6	-----	100	100	-----
Other health and medical services.....	158.8	18.8	140.0	100	12	88

The CHAIRMAN. Yes.

Mr. ALTMAYER. General health insurance merely extends the principle to include disability not arising out of employment.

Thus it is apparent that the question before us is not whether the government should assume responsibility for protecting and promoting the health of the people, but rather how much further the government should go in meeting that responsibility.

In order to be adequate and successful, health insurance must make it possible for everybody to have ready access to adequate medical care, both preventive and curative. If this cannot be achieved from the outset, the program that is adopted should lend itself to growth, with national coverage as the goal. To the greatest extent practicable, care should be provided for the dependents of insured workers on the same basis as for the worker. As far as practicable, the insurance program should be extended by supplementary agreements or otherwise to cover all noninsured groups who are in need of protection. All existing medical personnel and facilities meeting reasonable standards that wish to participate should be utilized to the maximum degree, and the remuneration for services should be adequate. The quality of service must not be sacrificed to economy. Both physician and patient should be assured freedom of choice. Professional groups, as well as the public, should participate in determining policies. Adequate provisions should also be made to stimulate professional education, research, and prevention of disease and disability.

A program of this scope will require sufficient medical personnel and facilities to provide comprehensive services, and these must be located throughout the country in a manner which will make services available to everyone. The program will have to encourage the training of needed personnel and the construction of needed facilities. The cost of such a program must be broadly distributed over groups in the population. The system must be so designed as to provide benefits to the insured regardless of his individual ability to pay and where he is residing at the time he is in need of services.

These, I think, are the main criteria by which an American plan for prepayment of medical costs should be judged.

## ADVANTAGES OF A NATIONAL SYSTEM

To achieve the goals, a national health insurance system has many advantages over 51 State and Territorial systems; such as may result from State-by-State action. A national system would encourage better distribution of professional personnel among the States as well as within States, and the construction of needed facilities. It would avoid the problems that result from the grossly unequal economic resources of the States for the support of health services, so that at least a minimum standard of adequacy can be achieved within a reasonable period of time in all States and in all communities. It would assume maintenance of continuity of insurance protection and ready access to services despite the mobility of population across State lines. It would achieve the administrative economy that results from avoiding the need to maintain and identify separate State-by-State records for such persons. It would be freely able to use natural medical and hospital service areas, regardless of State lines. It would escape the competitive disadvantages for States that establish social insurance systems as against States that do not.

Every State that has considered the establishment of a social insurance system has shown itself reluctant to act by itself.

Senator DONNELL. Mr. Altmeyer, has any State in the United States as yet imposed a compulsory health insurance program upon the people of its own jurisdiction?

Mr. ALTMAYER. No, sir; that is what I am pointing out. There is genuine reluctance there for competitive reasons. There are now two States with temporary disability plans; that is, pay for part of the wage loss.

Senator DONNELL. Which are those two States?

Mr. ALTMAYER. Rhode Island has had one in effect for several years; and California, at its recent special session of the legislature, enacted such a law.

The Congress faced this problem in 1935 when it was first considering the original Social Security Act; and it concluded at that time that Federal action was needed to set up a national system of social insurance and to make State action possible for the establishment of State systems.

The logical, the efficient, and the economical way to have a national system of compulsory health insurance is to establish a truly national system.

May I now turn to a more specific discussion of those parts of the bill under which the Social Security Board would have some administrative responsibility.

## TITLE I OF S. 1606

Title I deals with three groups of programs involving Federal grants-in-aid to the States for health services. Part A deals with public health services; part B with maternal and child-health services; and part C with the medical care of needy persons.

I strongly endorse the provision of variable grants-in-aid in all three parts of this title. I believe it is sound and necessary that the Federal grants should be proportionately larger to the poorer States. Also, since I believe that the variable proportions of such grants should be determined by a formula specified in the law, and that the

matching proportion required for each State should be the same for all of these related programs, I believe the variable grant provisions of the bill follow a sound pattern. If this uniformity were not retained, financial competitive situations would result in the States as between one program and another, and this would have unsound and undesirable effects.

The Public Health Service has already testified with respect to parts A and B of title I. I should like to comment on part C.

Sickness causes suffering and economic loss among all people, but it affects certain groups of people more than others. Among low-income families and people on the assistance rolls, illness comes oftener and lasts longer, on the average, than among others. Medical care is especially important to these persons not only to prevent or cure sickness but also to reduce dependency.

The three groups of needy persons covered by assistance programs under the Social Security Act are likely to have especially heavy medical needs since they are old or blind or are children in dependent families. Larger-than-average medical needs likewise exist among the group served by general assistance, which is financed wholly by the State or locality or both, without Federal financial participation. In many communities, in fact, only handicapped persons are eligible for general assistance. The bill wisely provides for including medical care for all these groups.

The provisions of the assistance titles of the present Social Security Act make it difficult to provide needed medical services effectively at the present time.

The Federal Government does not share at all in medical expenses or other aid to recipients of general assistance. It may share in medical expenses of the needy aged, blind, and dependent children only when these costs are included in determining the mount of the monthly cash payment to the needy person or family. The Federal matching is also conditioned on the requirement that these assistance payments, to the recipient or his legal guardian, are without restriction or control by the agency as to the way in which the money is used.

Medical bills are usually in the form of fees for services and are large for the individuals who have long, serious, or frequent illnesses. States cannot receive full Federal reimbursement of large payments because of the ceilings on Federal matching.

Thus the present Social Security Act not only limits the matching of funds for medical expenses but also does not permit a flexible method of paying for medical care.

The bill provides for several ways of financing the costs of medical care for needy persons. The State public assistance agency may provide for medical care of needy persons through (a) money payments; (b) payments to persons or institutions furnishing care; (c) direct provision of care; (d) agreements with State or local agencies, such as health departments to provide services; (e) contracts with the Surgeon General of the Public Health Service to cover the needy under the insurance system through equitable premium payments on their behalf; or a combination of these methods. This flexibility is probably desirable since until the insurance system is fully in operation, it is likely that many public assistance agencies would want to continue the various methods of payment now in effect.

## TITLE II OF S. 1606

The general pattern of the system of medical care insurance which would be established by title II seems to me thoroughly sound and workable. By building upon our existing national social insurance system, the bill assures both important economies in operation and a desirable link with the other parts of a comprehensive social security program.

## COVERAGE

Title II proposes to cover most workers and their dependents directly. It would also make eligible for personal health service benefits individuals who are entitled to monthly old-age or survivor's insurance benefits under the Social Security Act. And it provides that other groups may be covered if public agencies voluntarily enter into agreements with the social insurance administration to pay premiums on their behalf.

Three large groups of workers, and their dependents, are excluded from the direct compulsory coverage of S. 1606. These are employees of railroads, Federal Government and State and local governments. These workers and their families are as much in need as other workers of the protection against the costs of medical care which S. 1606 would provide. The Social Security Board recommends that the first two of these groups brought under the coverage of title II through deletion of the exclusions in paragraphs (3) and (6) of section 217 (b). In view of the questions which might be raised as to the compulsory coverage of States and local government employees under a national contributory social insurance system, we would recommend that coverage of this group be extended through voluntary agreements.

Your committee may be interested in rough estimates we have made of the number of workers and their dependents who could be expected to qualify for personal health service benefits under title II. Under this title, between 75 and 80 percent of the population, depending on employment and earnings levels, would probably qualify for benefits. With our present population, this would mean some 105,000,000 to 112,000,000 persons.

In addition, some 1 or 1.5 million beneficiaries under the Federal old-age and survivor's insurance system not already entitled to health benefits as workers or as dependents of workers, would be eligible for benefits in the first year of the program, and an increasingly larger number later as the number of beneficiaries grows.

If the Board's recommendations for inclusion of railroad and Federal Government workers were accepted, and if all State and local employees were covered through voluntary agreements—some 12,000,000 or 13,000,000 persons today—an additional 8 or 9 percent of the population would probably qualify as workers or dependents.

It is, of course, uncertain how many additional persons would become beneficiaries through supplementary agreements, authorized in the bill, to be made between the insurance system and public agencies that pay equitable premiums for special noncovered groups. In the course of time, the supplementary coverage could bring the total coverage to 90 or 95 percent of the total population. Thus nearly total coverage of the population could be achieved under this bill, while preserving the essential contributory insurance nature of the system.

## SCOPE OF THE BENEFITS PROVIDED

The goal of health insurance should be to assure ready access to all essential preventive and curative medical services to insured persons and their families. The scope of the services available as health service benefits should, therefore, be comprehensive and complete, including not only general practitioner services, but also specialist and consultant services, necessary laboratory services, dental care, expensive medicines and appliances, hospitalization, and home nursing.

Title II provides for all of these types of services, but places limitations on the amounts of hospitalization, dental, and home-nursing care and laboratory services that may be furnished as benefits, especially at the outset. Our studies have convinced us that such limitations are probably unavoidable at the start of the program. Health insurance has no magic way of creating facilities and personnel overnight, though it can result in a more effective use of available doctors, dentists, nurses, hospitals, and laboratories. Existing method of paying for services have limited the effective demand for medical care. As a result, we do not now have the personnel or the facilities to provide adequately all the care that is needed and that may be demanded once the financial barriers were removed.

The deficiencies are greater with respect to some types of service than others. They are much greater in some parts of the Nation than in others. A national social insurance system which assures adequate payments for services in all areas, and particularly in the smaller communities and rural areas, can be expected within a relatively short time to result in increased and improved services where these have been lacking or insufficient.

On a national basis, we have today enough or nearly enough doctors to provide essential services; the number of dentists in practice today is certainly less than half the number needed to provide essential dental services. In spite of large wartime increases in nursing personnel, it would appear that the number of nurses likely to remain in active practice is also fewer than we shall need. I am convinced, therefore, that the provisions of title II which call for a gradual introduction of the dental and home-nursing benefits are wise and necessary. We should plan, however, to move toward a comprehensive program as rapidly as possible.

Your Committee has already recognized the need for additional hospital and clinic facilities by passage of S. 191.

Additional hospitals and public health centers, particularly in rural and low-income areas, are needed to assure throughout the country hospital benefits proposed by title II, and to encourage the location of doctors in such areas. If expanded hospital facilities are to be utilized, once they are built, they must be staffed, and people in the communities must be financially able to pay for the services. A national medical-care insurance program provides the guarantee that needed hospital facilities will be maintained and used.

The limitation, proposed in title II, on the number of days of hospitalization available as benefit, and the exclusion of tuberculosis and mental-disease institutions, are probably necessary at the outset. The provision in the bill for further study of that subject is sound. The bill is also sound, I believe, in providing for a service-benefit which would guarantee to the insured person all essential hospital

services. Nevertheless, it probably it well to leave open the alternative, as is done in the bill, of cash payments to the patients where a service benefit arrangement is not feasible or not acceptable to a particular hospital.

The benefits do not include ordinary and inexpensive medicines. This is wise, since large amounts of money are involved; it is doubtful whether people need insurance protection for these commodities; and experience should first be accumulated with the more limited provision of unusually expensive items only.

#### COSTS AND FINANCING

The precise costs of the several types of health benefits proposed by S. 1606 would vary somewhat, of course, depending upon the coverage, specific characteristics of benefits, and upon a number of other specifications finally laid down in the act. The tentative figures I present here are, as much as possible, in terms of the coverage and benefit structure suggested by the bill. At various points we have had to make assumptions regarding details that depend on prospective administrative agreements and decisions. The cost estimates summarized here are based on a wide variety of data regarding numbers of physicians and other professional personnel who would furnish services under the program, their customary average incomes, average number of days of hospitalization, average rates of payment per day of hospitalization, and on assumptions as to how much could be done in providing dental, home-nursing, and laboratory benefits.

Our studies indicate that if the plan proposed by title II had been in an early year of operation in 1941—that is, the last prewar year—all of the benefits proposed in S. 1606 would have cost about \$19 per capita, inclusive of administrative expenses. This figure assures that hospital benefits under the bill would be provided in part as service benefits, covering the cost of essential services, and in part as cash benefits of specified (minimum) amounts. If only service benefits are provided, the per capita costs would be slightly higher, and if only cash hospitalization benefits are provided, the costs would be slightly lower than this average figure.

The 1941 figure needs to be adjusted upward to effect appropriate recognition of the general rise in price and income levels which has taken place between 1941 and the present; such adjustment results in a figure of about \$27 per capita. Approximately one-half of this would represent the cost of physician's services; around one-fourth the cost of hospital services; about one-tenth the cost of dental care; somewhat more than another tenth the cost of laboratory and related benefits; and about 2 percent the cost of home-nursing services. Grants for research and professional education would involve less than 1 percent of the total.

The over-all per capita cost figure cited might be reached within 2 or 3 years after the system is established, costs in the very first or second year falling somewhat short of this figure because of lags in the system's becoming fully operative. Later, as the number of hospitals and professional persons—particularly dentists and nurses—available to provide services rises to a more nearly adequate level, further growth in per capita costs is to be anticipated; such growth

would probably not exceed one-third, however, and would occur only gradually over a period of 5, 10, or 15 years or more. Future changes in price and income levels in the Nation generally could, of course, result in further changes in the per capita costs, because of the need to adjust the income of those providing services under the program and the prices paid for facilities and commodities.

I would like to emphasize that in developing these estimates of per capita cost, we have recognized the importance of adequate incomes for doctors, dentists, nurses, and others who furnish services, and adequate payments to hospitals. The amounts allowed in our estimates would result in average incomes for doctors higher than they have ever received in peacetime. They also allow for variations from the average; individual doctors, it is assumed, would continue to receive varying incomes, depending on their skill, experience, ability to attract and hold patients, and perhaps the part of the country in which they lived.

Because all services to insured persons would be paid for, and because the demand for service would increase—particularly among low-income families—it is probable that no doctors who wanted to practice full time would receive annual incomes as low as many doctors earned before the war. The same applies to dentists and nurses. Similarly, the estimated payments to hospitals are fully adequate in relation to the income customarily available to hospitals in peacetime and in relation to anticipated costs of providing a greatly expanded amount of hospital service.

An indication as to the total dollar costs of the prepayment plan proposed by the bill can be obtained by multiplying the per capita cost by the prospective number of persons who might be eligible for benefits under the provisions of the bill. This number would vary, of course, with the specific coverage and eligibility provisions which may finally be adopted, and it would also be affected by the amount of employment and unemployment. On the basis of my preceding discussion concerning coverage, I use a round figure of 110,000,000 persons to illustrate costs which might eventuate under title II.

This figure is intended to represent an approximation of the number of workers and their dependents who might, on the average, be covered under the compulsory coverage provisions of the bill. It implies a continuing relatively high level of employment and earnings. It does not include those who might come in under the voluntary contractual arrangements with public agencies authorized in section 209, nor does it include persons eligible for benefits as retired or survivor beneficiaries, in accordance with section 202.

The total dollar cost of the system for the compulsory-coverage group, if per capita costs are around \$27 and if 110,000,000 persons on the average are eligible, thus would be about \$3,000,000,000 annually, in the early years of the system.

Section 212 of the bill authorizes the appropriation to a special account of such sums as may be required to finance the program. It also provides for several types of specific credits to this account. In the first place, the account is to be credited quarterly with amounts equivalent to 3 percent of the earnings of workers in covered employment, as defined in section 217, exclusive of that part of individual earnings in excess of \$3,600 per year. In introducing the bill, Senator

Wagner and the chairman of your committee pointed out that no particular method by which the sums authorized to be appropriated was specified in the bill, since revenue-raising legislation must originate in the House of Representatives. Their reference to another pending bill they have introduced (S. 1050) which provides for the raising of revenue for health service benefits through social insurance contributions, together with the President's recommendation for a compulsory social insurance approach to the prepayment of medical costs in his message to Congress regarding a national health program on November 19, suggests that the proposed credit equivalent to 3 percent of earnings should be financed by means of special insurance premiums levied and segregated for health service benefits.

I endorse the use of insurance premiums as a method of financing the cost of the benefits proposed in title II of the bill. The Social Security Board has recommended on a number of occasions that provision against the costs of medical care should be met through social insurance as part of a unified and comprehensive social insurance system. I also endorse the principle of a contribution from general revenues to an insurance system of broad or national coverage.

Section 212 of the bill also provides that there should be a specific credit to the account to cover the costs of dental and home-nursing benefits for all recipients. It also provides for a credit with respect to certain costs incurred for old-age and survivor's beneficiaries under the Social Security Act. Still another source of income to the account would be the equitable reimbursements paid by public agencies on behalf of groups of persons covered under the insurance system through supplementary agreements with such agencies.

In appraising the cost figures for title II which I have summarized, it should be kept in mind that to a very large extent these costs would replace expenditures already being made for the same services without social insurance. Expenditures for civilian health and medical services, including hospital construction, in the past have totaled about \$4,000,000,000 to \$5,000,000,000 in an ordinary year. One-fifth of the total has consisted of public outlays and most of the remaining four-fifths, or about \$22 to \$26 per capita of the entire population, has represented private expenditures. Families ordinarily spend about 4 percent of their incomes, on the average, in private payments for medical, hospital, and dental care, medicines, and related items. Low-income families average more than 4 percent and higher income families less. Thus, the system of health benefits proposed in the bill would not represent, in the main, a new cost burden for the population as a whole, but a new method of paying medical costs.

#### ADMINISTERING A HEALTH INSURANCE PROGRAM

Our tentative cost estimates include the costs of administering the system. There has been considerable loose talk to the effect that medical care insurance would be weighted down by tremendously high administrative costs and by a bureaucratic machinery out of all reasonable proportion to the services provided.

The Social Security Board has now had more than 10 years' experience in administering a social insurance program which was also questioned at the beginning on the grounds of administrative expense. Today, we are operating the old-age and survivor's insurance system

at an administrative cost of about 2 percent of contributions collected or about 10 percent of benefit payments. As the benefit rolls increase, the cost of administration will decline to less than 5 percent of benefit payments. The costs of administering a service benefit program are somewhat higher than for a cash benefit program. However, foreign experience and the experience of voluntary prepayment plans in this country suggest that the administrative cost need not be more than 5 to 7½ percent of total expenditures. In fact, since part of the costs—for collecting contributions and keeping wage records—are already being met under existing social insurance, the additional costs may well be less than 5 percent.

We have given considerable thought to the procedures which the Board might follow in carrying out the administrative responsibilities which it would be assigned under S. 1606. Title II places on the Board the responsibility for determining eligibility for the personal health service benefits. The basic records of earnings needed for this purpose are already available for employments now covered by old-age and survivors' insurance and would be available for all employments if our recommendations with regard to the extension of coverage of old-age and survivors' insurance are adopted.

The use of an insurance system for payment of medical bills does not involve burdensome or restrictive arrangements for those in need of service or for those furnishing services. Nor would the insurance system interpose a "third party" or "red tape" between the patient and his doctor or hospital. Nor would there be any reason why the insurance system should interfere with the doctor in his professional relations with patients, or with the hospital in the management of its own affairs. On the contrary, an insurance system would relieve doctors and hospital administrators of their onerous duties as bill collectors, in which role they are obliged to assess ability to pay, thus acting in a sense as property appraisers and income tax experts.

I have already indicated my support of the principles followed in title II, of freedom of choice of doctor and patient, and the guaranty to all licensed physicians, dentists and nurses of the right to participate in insurance practice. I would add that it seems to me the bill is sound in requiring the Surgeon General to utilize the services of voluntary agencies. Those which can furnish services as benefits should have the same right to participate as individual practitioners. Those which can be helpful in administration—by representing doctors, dentists, hospitals, nurses, et cetera—should be used if they contribute to economy and efficiency.

A national health insurance system with national benefit provisions can still be highly decentralized in actual operation. People will ordinarily receive care in the communities where they live; doctors will ordinarily find it most convenient to submit their bills to a local health insurance office. Provision should be made—and under the bill, can be made—for the maximum possible adaptation to local practices and methods of obtaining service, within the over-all standards of the national program.

I heartily endorse the provisions of S. 1606 with respect to the use of advisory councils at every level of administration. The National Advisory Medical Policy Council would include representatives of the medical professions and of the public. It is sound to call upon the

medical profession for advice on policy matters relating to the administration of the program. Representatives of the persons receiving services and representatives of the public also have an essential role in the administration of a public program. The duties and responsibilities of the National Advisory Council and of the State and local councils, as set forth in the bill, seem to me soundly conceived. The final responsibility for national administrative decisions is left with the Administrator, but there are adequate safeguards to assure that he will consult with the Council on all important problems, and that the advice given by the Council and the opinions and recommendations of the Council will be periodically made known to the Congress.

The CHAIRMAN. Do some members of the committee desire to ask particular questions?

Senator DONNELL. Mr. Chairman, may I enquire: personally, I have not yet studied this bill, and I am wondering if Mr. Altmeyer would, if the committee requests his attendance, be willing to give us the benefit of his advice at some future time.

Mr. ALTMAYER. Delighted.

The CHAIRMAN. Yes, he certainly will; and I assume that when the hearings are concluded the testimony will be briefed, and then in executive sessions we could have Mr. Altmeyer sit in with us to answer particular questions that Senators might desire to understand.

Senator DONNELL. Very fine.

Mr. ALTMAYER. Thank you very much.

The CHAIRMAN. Thank you very much for your statement.

The hearing will now go over until tomorrow morning, at which time Robert Kenny, president of the National Lawyers' Guild, attorney general of the State of California, will testify; and also William Logan Martin, of the American Bar Association.

Senator DONNELL. Ten o'clock tomorrow morning?

The CHAIRMAN. Ten o'clock tomorrow morning.

(Whereupon, at 11:45 a. m., April 4, 1946, the committee adjourned, to reconvene at 10 a. m., Friday, April 5, 1946.)

# NATIONAL HEALTH PROGRAM

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FRIDAY, APRIL 5, 1946

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

The committee met at 10 a. m., pursuant to adjournment, the Honorable James E. Murray (chairman) presiding.

Present: Senators Murray, Ellender, Aiken, and Donnell.

The CHAIRMAN. The hearing will come to order.

The first witness this morning is Mr. William Logan Martin, of the American Bar Association. Do you have a prepared statement?

Mr. MARTIN. No; I have not, Mr. Chairman.

The CHAIRMAN. You are prepared to discuss the general principles involved?

STATEMENTS OF WILLIAM LOGAN MARTIN, REPRESENTING THE AMERICAN BAR ASSOCIATION; AND WALTER M. BASTIAN, TREASURER OF THE AMERICAN BAR ASSOCIATION

AMERICAN BAR ASSOCIATION REPORT ON S. 1161

Mr. MARTIN. I am in this situation: The invitation was received by the American Bar Association from your committee, but the association has not taken a position with respect to the pending bill. Therefore, I am not authorized to speak for it. But it has taken a position with respect to the predecessor bill, that is, S. 1161, which is quite like this one, and I should like to leave with the committee a copy of the report of the association on S. 1161.

The CHAIRMAN. Very well. Of course, many changes have taken place in the bill.

Senator AIKEN. Are you appearing for the association?

Mr. MARTIN. Yes, sir.

The CHAIRMAN. But you are taking no position on the present bill?

Mr. MARTIN. I am not authorized to do so, sir.

The CHAIRMAN. This is the report of the special committee to study and report as to parts of Wagner-Murray bill (S. 1161) relating to Federal control and regulation of medical practice and hospitalization.

Senator AIKEN. This report is on the legal effect of various parts of it. Is the report on the objective of the bill as a whole?

Mr. MARTIN. Yes, sir.

The CHAIRMAN. This report from the American Bar Association will be filed with the committee.

Senator DONNELL. I am not quite clear as to what the question was that was asked by Senator Aiken. May I ask Mr. Martin, does this report to which you have referred and which you have handed to the chairman, relate solely to the legal phases, or does it cover the entire field as it appeared and appealed to the American Bar Association?

The CHAIRMAN. That is the prior bill?

Senator DONNELL. That is S. 1161.

The CHAIRMAN. Yes.

Senator AIKEN. I asked him if they had reported their position on the over-all objective of the bill also.

Senator DONNELL. I did not understand whether you inquired whether this report related solely to the legal phases or the over-all picture.

Mr. MARTIN. My answer to the Senator was "Yes," on all of the phases of the bill.

Senator DONNELL. May I ask the witness a question. Mr. Martin, would you be kind enough to state for the record your place of residence and your connection with the American Bar Association?

Mr. MARTIN. Yes, Senator. My residence is Birmingham, Ala., and I am a practicing lawyer.

Senator DONNELL. For how long have you practiced?

Mr. MARTIN. Thirty-eight years.

Senator DONNELL. In Alabama?

Mr. MARTIN. Yes, sir.

Senator DONNELL. And you have been a member of the American Bar Association for quite a number of years?

Mr. MARTIN. For 32 years.

Senator DONNELL. Do you know what the approximate membership of the American Bar Association is?

Mr. MARTIN. It is 35,000.

Senator DONNELL. That is the largest in the history of the association?

Mr. MARTIN. That is correct, Senator.

Senator DONNELL. Mr. Martin, the document which you have offered here this morning was a report or is a report presented to the American Bar Association by a committee of which Mr. W. E. Stanley, of Kansas is chairman, and you and Mr. Clement F. Robinson are the other members?

Mr. MARTIN. That is correct.

Senator DONNELL. Relating to the general subject of Federal control of medical practice; is that correct?

Mr. MARTIN. That is correct.

Senator DONNELL. And is so entitled at the top of the various pages of the report?

Mr. MARTIN. Yes, sir.

Senator DONNELL. Now, Mr. Martin, did the house of delegates of the American Bar Association at the session held in Chicago on August 23 to 26, 1943, act upon this report?

Mr. MARTIN. It did, Senator.

Senator DONNELL. Is their action set forth in this pamphlet that you have given here?

Mr. MARTIN. Yes, Senator, on page 5.

Senator DONNELL. That, Mr. Martin, is the resolution authorizing the appointment of the committee, is it not, rather than the action of the house of delegates on the report?

Mr. MARTIN. Yes, Senator, that is correct.

Senator DONNELL. I call to your attention, Mr. Martin, at page 493 of the reports of the American Bar Association, being volume 69 for the year 1944, the following, and ask you to state whether or not this is the action taken by the house of delegates of the American Bar Association with respect to the report, and I quote:

*Resolved*, That the report of the special committee to study and report on United States Senate bill 1161, relating to Federal control and regulation of medical practice and hospitalization, and the action of the board of governors thereon, is hereby adopted and approved,

and may I also ask, Mr. Martin, before you answer the question, whether or not the recommendation of the board of governors in transmitting the report was as follows:

Under directive of the resolution adopted by the house at the 1943 annual meeting, the board of governors considered and adopted the report of this committee and directed that copies be sent to each bar association represented in the house of delegates, to Members of the Congress of the United States, and that the report be released for general publication.

I call your attention to that page from which I read and ask you to state whether that is the official action which it purports to be and which I have stated.

Mr. MARTIN. That is correct, Senator, but the resolution was not carried out to the extent of sending the copies as indicated in the resolution, for the reason as I recall that there was no further action indicated on Senate 1161, and it was not necessary to send copies to Members of Congress.

Senator DONNELL. Now, Mr. Martin, you have been a member of the American Bar Association as indicated for many years, and very active; have you not?

Mr. MARTIN. To some extent; yes.

Senator DONNELL. The American Bar Association was reorganized some 15 years ago; was it not?

Mr. MARTIN. Ten years ago.

Senator DONNELL. And in the course of the reorganization there was created a house of delegates which is the governing body of the association; that is correct; is it not?

Mr. MARTIN. That is correct.

Senator DONNELL. And the body which adopted the resolution which reads, referring to this report which you have submitted:

*Resolved*, That the report of the special committee to study and report on United States Senate bill 1161 relating to Federal control and regulation of medical practice and hospitalization, and the action of the board of governors thereon is hereby adopted and approved,

I say the body which acted upon that and passed that resolution is the house of delegates of the American Bar Association?

Mr. MARTIN. That is correct.

Senator DONNELL. That is the highest authority in the Bar Association which consists of some 35,000 members; is that correct?

Mr. MARTIN. That is the sole authority when in session.

Senator DONNELL. There is interim authority in the board of governors?

Mr. MARTIN. Yes, sir.

Senator DONNELL. But this action as indicated approves the action of the board of governors which was the interim body and expresses affirmatively the views of the house of delegates as the body which has the sole authority during the session of the association at Chicago. That is correct; is it not?

Dr. MARTIN. That is correct.

Senator AIKEN. I have got to leave for another important committee in 10 minutes, and I wonder if I could ask some questions before I go. I do not know much about the American Bar Association and its policies, but do I understand that the American Bar Association makes a study of important pending legislation and reports to the house of delegates which takes action?

Mr. MARTIN. Only in rare instances, Senator. It does not as a rule make studies of pending bills.

Senator AIKEN. Well, for instance, did the association take any action on the Social Security Act in 1935?

Mr. MARTIN. It did not.

Senator AIKEN. Or the Minimum Wage Act of 1938?

Mr. MARTIN. No.

Senator AIKEN. And you have never taken any action on the old-age assistance programs?

Mr. MARTIN. We have not.

Senator AIKEN. Or unemployment compensation?

Mr. MARTIN. No.

Senator AIKEN. How did you happen to take up this national health matter? Is that considered more important than the others or more likely to lead to drastic change in democratic processes or undemocratic processes as maybe you call them?

Mr. MARTIN. The origin of the resolution was this: Mr. Lloyd Wright, a lawyer of Los Angeles, introduced a resolution in the house of delegates.

Senator AIKEN. He is a lawyer, is he?

Mr. MARTIN. Yes, and a member of the house of delegates, from California. He called upon the board of governors to appoint a committee for the purpose of studying this bill, S. 1161. The house adopted that resolution. The committee was appointed and it made the study, and reported back to the board of governors. The board of governors had no authority except to report to the house of delegates, and did so. At the succeeding meeting in 1943, I believe, the house of delegates adopted the report recommended by the board of governors.

Senator DONNELL. Was it not 1944?

Mr. MARTIN. I think so, I am wrong, it was 1944.

Senator AIKEN. You and Mr. Stanley and Mr. Robinson were the committee that made the study?

Mr. MARTIN. Yes, sir.

Senator AIKEN. And this is the outcome of the motion of this attorney, Mr. Wright, from Los Angeles?

Mr. MARTIN. That is correct.

Senator AIKEN. That is all. I just wanted to find out whether it was customary for the Bar Association to do this. I do not claim

it to be wrong if you did make a study of all important proposed national legislation.

Senator DONNELL. The resolution of Mr. Wright was considered and acted upon in 1943 as indicated on page 5 of the report which you have filed here; was it not?

Mr. MARTIN. That is correct, Senator.

Senator DONNELL. And those two resolutions which are there stated to have been adopted read as follows; do they not:

*Resolved*, That the board of governors be requested to immediately appoint a special committee to study and analyze and investigate Senate bill 1161, and that the board of governors give publicity to the recommendations and findings of such special committee and the action of the board of governors thereon; be it further

*Resolved*, That the house of delegates is opposed to any legislation, decree, or mandate that subjects the practice of medicine to Federal control and regulation beyond that presently imposed under the American system of free enterprise.

Those resolutions were the ones that were adopted pursuant to the motion made by Mr. Wright; is that correct?

Mr. MARTIN. That is correct.

Senator DONNELL. Was the adoption of those resolutions after a debate, or do you recall?

Mr. MARTIN. I do not recall the debate in 1943.

Senator DONNELL. Was there a debate in 1944 when your report came in?

Mr. MARTIN. Yes, sir.

Senator DONNELL. Would you tell us, briefly, not the contents of it, but whether or not it was in your judgment as a lawyer, a thorough and comprehensive debate upon the subject?

Mr. MARTIN. It was. May I say this: It was proposed by the chairman of the committee, Mr. Stanley, who explained the report, and it was opposed by Mr. Charles M. Hay, of St. Louis, who at the time was counsel, as I recall, for the National Labor Relations Board, I think, or the War Manpower Commission, Mr. Bastian corrects me. He debated the question quite vigorously and very ably.

Senator DONNELL. May I interrupt to say this and to ask Mr. Martin this question, because it flows from a personal friendship and acquaintance with Mr. Hay over many years. He has passed on recently. Mr. Hay was one of the most able debaters generally so considered in the American Bar Association, is that correct?

Mr. MARTIN. That is correct.

Senator DONNELL. And he presented the side favorable to the idea of S. 1161?

Mr. MARTIN. Yes, sir.

Senator DONNELL. And the debate ensued and others participated on the other side?

Mr. MARTIN. That is correct.

Senator DONNELL. And as a result of that debate, the resolutions which I have read from page 493 of the report, Volume 69, 1944, were adopted?

Mr. MARTIN. Yes, sir.

Senator DONNELL. Would you be kind enough to state in the record how large a body this house of delegates is?

Mr. MARTIN. It is over 200 members.

Senator DONNELL. Generally speaking, how is it created? I mean how are the members of it selected?

Mr. MARTIN. In the house there is one member called the State delegate who is elected by each State. He is elected by the members of the American Bar Association in his State. There are also representatives of the State bar associations. Each State bar association selects according to its own practice its representative in the house of delegates. In addition, each local bar association which has in excess of 500 members is entitled to a representative. Then, there are various governmental officers who are members of the house of delegates, such as the Attorney General, the Solicitor General.

Senator DONNELL. You mean the Attorney General of the United States and the Solicitor General of the United States?

Mr. MARTIN. Yes, sir; and the president of the Association of Attorneys General, and many others; also the president of the American Law Institute.

Senator DONNELL. The American Law Institute is the body which undertook some years ago, beginning here in Washington, the restatement of the law in a monumental work which has proved of great importance to the profession, is that correct?

Mr. MARTIN. That is correct. It has tended to simplify important principles of law.

Senator DONNELL. Mr. Martin, would you state generally the type of investigation that your committee, consisting of yourself, Mr. Robinson, and as chairman, Mr. Stanley, of Kansas, undertook and performed in the preparation of this report which you have offered before the committee this morning?

Mr. MARTIN. Each member of the committee made a study separately, they being separated by great distances in the country.

Senator DONNELL. Where did Mr. Robinson live?

Mr. MARTIN. In Maine, and Mr. Stanley in Kansas. At a meeting of the board of governors, I think in January of 1944, the committee met in advance of the meeting of the board for the purpose of discussing this report. That was for some two days. We discussed it at length and agreed on our report to the board of governors. We had done considerable work. I had done considerable work in undertaking to analyze the bill from a factual standpoint to try to ascertain what it meant, if that were possible.

Then, we made investigations as to the extent of Blue Cross plans in this country, and we made surveys of medical literature to undertake to secure some facts or background on which we could base a report, because, naturally, as lawyers we were not so familiar with the medical profession nor the extent of medical service in this country. And after these investigations, we met and adopted a report which we recommended.

Senator DONNELL. In response to a question from Senator Aiken as to whether or not it is customary for the American Bar Association to investigate matters of general public interest, I believe you mentioned or responded that it is the exception or is unusual for them to do so.

Mr. MARTIN. It is unusual.

Senator DONNELL. Only in matters reflecting great public interest and of great outstanding public importance, is that correct?

Mr. MARTIN. Yes; and I may add that the philosophy of this undertaking, this scheme appeared to us to be so foreign to our form of

government that it attracted our attention and impressed us with the view that we owed a duty to undertake to explore it and report on it.

Senator DONNELL. Mr. Martin, I would like to read to you, if I may, a portion or rather the conclusion as set forth in this report, and ask you whether or not it now represents your present opinion of the matter. [Reading:]

The American Bar Association is limited to an expression of opinion and judgment with respect to those fields which relate to the administration of justice and which directly affect the safeguards and protection of the rights and liberties of the citizens of this country. Under normal circumstances, therefore, it is not the function of this association to attempt to influence substantive legislation by the Congress of the United States. But when, under the pretext of the general welfare, legislation is proposed in Congress which either inadvertently or with deliberate subtlety constitutes a direct attack on the rights and liberties of the citizens of this country it becomes the duty of this association actively to voice its objections, a summary of which is as follows:

(1) Local self-government must be preserved in our Federal system. State governments directly responsible to the will of the people are best adapted to exercise such supervisory control as may be instituted over the health and medical care of our citizens.

(2) S. 1161 seeks to invest in the Surgeon General, who is not an elected servant of the people and who is not amenable to their will, the power arbitrarily to make rules and regulations having the force and effect of law which directly affect every home.

(3) The measure furnishes the instrumentality by which physicians for their practice, hospitals for their continued existence, and citizens for their health and that of their families can be made to serve the purposes of a Federal agency.

(4) The bill fails to safeguard the rights of patients, citizens, hospitals, or doctors with respect to disputes arising or rights denied through the arbitrary or capricious action of one man.

(5) The bill fails to provide for any appeal to any court from the action of the Surgeon General.

(6) The vicious system whereby administrative officials judge without court review the actions of their subordinates in carrying out orders issued to them is extended in this bill to a point foreign to our system of government and incompatible with the adequate protection of the liberties of the people.

The Constitution of the United States is designed to protect the citizens of this republic in the exercise of the rights of free men. The provisions of that instrument can be rendered important, when our citizens, for the sake of an apparent immediate benefit, surrender to their government such direct control over their lives that government, by imposing a constant fear upon them of having those benefits withheld or withdrawn, can compel from them obedience and subservience to its dictates.

I ask you to state whether those conclusions represent your present views as to S. 1161, the measure which was under consideration by your committee?

Mr. MARTIN. They do, Senator.

Senator DONNELL. Now, you have not examined S. 1606, the pending measure?

Mr. MARTIN. I have, Senator.

Senator DONNELL. You have examined it?

Mr. MARTIN. Yes, sir.

#### APPRAISAL OF S. 1606

Senator DONNELL. Would you tell us, please, what your opinion is generally of S. 1606 and the reasons therefor?

Mr. MARTIN. I think it is more extensive than S. 1161. The substantial differences which I found in comparing the two bills, I will indicate in short: The Surgeon General, under the new bill, performs his duties

under the supervision of the Federal Security Administrator, whereas formerly he was supreme in the performance of his duties. Second, the Surgeon General may delegate to any Federal or State official any of his duties, except that of prescribing rules and regulations. He may appoint local area committees selected from panels of names submitted by local individuals or agencies.

The fiscal foundation is different in the later bill. A sum is appropriated sufficient to defray the expenses of the enterprise, while at the same time there is to be credited to that appropriation 3 percent of the wages paid and on which, my recollection is, social-security taxes are now based. Authority is authorized for the appointment of sufficient personnel under civil service to carry out the scheme. The Surgeon General is required to make a full report to Congress.

He may make payment by any other method than that agreed on by a majority of the doctors who are on a panel to the doctors who do not elect the method adopted by the majority. Payments are to be adequate, based on customary annual income of the doctors employed. The Surgeon General is to exercise no supervision or control over participating hospitals, and no agreement entered into by participating hospitals with the Surgeon General shall prescribe its administration, personnel, or operation.

The scheme is more extensive in that it includes dental and nursing benefits, whereas these were not included in the former bill.

The definition of wages is somewhat different in that it adopts a plan by which it lists the wages on which the tax is to be imposed, excluding a number of classes of wage earners, whereas heretofore it simply referred to a certain section of the Social Security Act which contained the listing of deductions or exemptions from the tax.

Those, in short, are the differences, some of them minor to some extent, which I found between the two bills.

Senator DONNELL. Now, Mr. Martin, would you be kind enough to state as to the fundamental principles which you find embodied in S. 1606, whether or not your observations would differ materially from those set forth in the conclusions with respect to S. 1161 contained in the report which has already been presented by you this morning.

Mr. MARTIN. Of course, I have to speak personally. I cannot speak for the association.

Senator DONNELL. I understand.

Mr. MARTIN. My view would not differ at all.

Senator DONNELL. And were you to have before you personally—I understand that you cannot speak for the association—but were you to have before you personally, S. 1606 at this time just as you had as a member of the committee, S. 1161 in 1943 and 1944, what would be your net conclusion and advice to our committee as to your opinion respecting S. 1606, whether it is wise or unwise legislation, and the reason for your conclusion?

Mr. MARTIN. Well, I think the judgment of the Bar Association would be the same. I think its conclusion would be the same.

Senator DONNELL. As prevailed with respect to S. 1161?

Mr. MARTIN. That is correct, if it had S. 1606 before it.

Senator DONNELL. What is your own personal conclusion, if you do not mind telling it to us, Mr. Martin?

Mr. MARTIN. My personal conclusion, Senator, is that it is probably the most extensive undertaking made by Congress beyond the limits of the Constitution of this country.

I cannot conceive that a bill which goes so far as this into the intimate details of the lives of American citizens can be justified under the Constitution of the United States.

Senator DONNELL. Do you mind telling us, briefly, those principles or express provisions of the Constitution to which you refer?

Mr. MARTIN. The tenth amendment particularly.

Senator DONNELL. Which reserves to the States and to the people the powers not expressly or impliedly conveyed to the Federal Government.

Mr. MARTIN. That is correct. If a State government, for instance, wanted to adopt a scheme of this kind, it has a perfect right to do so, and the people have a right to do so in the States; but, as I see the Government of this country, it never would have been formed if the founders had ever had the faintest idea that Congress would ever undertake such an enterprise as this.

Senator DONNELL. Mr. Martin, is there anything further that you would desire to state upon the general question that I have asked you?

Mr. MARTIN. Well, in studying this matter the last few days, since I was notified I would be selected to appear here, there came to my mind a paragraph in Washington's Farewell Address, and I was impressed that it applied to the situation today, and it was just as apt today as it was when he delivered it 140 years ago, and I would like to put that in the record.

Senator DONNELL. We would be glad to have you do so.

Mr. MARTIN. He said:

Toward the preservation of your Government, and the permanency of your present happy state, it is requisite, not only that you steadily discountenance irregular oppositions to its acknowledged authority, but also that you resist with care the spirit of innovation upon its principles, however specious the pretexts. One method of assault may be to effect, in the forms of the Constitution, alterations which will impair the energy of the system, and thus to undermine what cannot be directly overthrown. In all the changes to which you may be invited, remember that time and habit are at least as necessary to fix the true character of Governments, as of other human institutions; that experience is the surest standard, by which to test the real tendency of the existing Constitution of a country; that facility in changes upon the credit of mere hypothesis and opinion exposes to perpetual change, from the endless variety of hypothesis and opinion \* \* \*

Now, I do not think anyone has ever questioned Washington's leadership, patriotism, wisdom, courage, and love of country, and that is a very impressive thing to me.

Now, for the last decade in this country we have seen irregular oppositions to the acknowledged authority of the Government. The Constitution has been said to be "outmoded," and that we need a new government, but the Constitution provides its method of amendment. There has grown up a spirit of innovation upon the principles of the Constitution, upon many specious pretexts. Here, by Senate bill 1606, the Federal Government proposes to take over the mental and physical illness of all the people and interpose its activity between the intimate relationship of the doctor and the patient, all in direct

conflict with the tenth amendment to the Constitution, which reserves to the States and to the people thereof all power and authority not expressly or impliedly delegated to Congress.

Thus, Congress would undermine what could not be directly overthrown.

We had thought that time and habit and experience had fixed the true character of our Government, but here an extraordinary change in our governmental structure is proposed, based on hypothesis and opinion.

The hypothesis is that a certain sector of the people do not receive sufficient medical care and it is the opinion of the proponents of Senate 1606 that Congress can remedy the situation by setting up a gigantic scheme under the control of one man by which the Government would take over all medical care, supervising doctors, dentists, nurses, and hospitals.

Such an undertaking on such a basis, to quote Washington's phrase "exposes to perpetual change, from the endless variety of hypothesis and opinion."

Senator DONNELL. Mr. Martin, the Farewell Address likewise contains the express mention of the fact that, if the people desire in any respect to change the Constitution, let it be done by the processes provided in the Constitution, rather than by usurpation.

Mr. MARTIN. That is correct.

Senator DONNELL. Mr. Martin, is there anything further that you would think of at this moment to suggest to the committee bearing upon S. 1606?

Mr. MARTIN. I believe not, Senator.

Senator DONNELL. May I ask you one question, and I hope you will not be too modest in your response, and that is as to your own professional practice and experience. You told us of practicing the number of years that you have, but I would like, if you would be kind enough, for you to tell us of the nature of your professional experience.

I have no doubt Mr. Bastian would answer it more fully.

Mr. MARTIN. I have held public office.

Senator DONNELL. Would you tell us what public office?

Mr. MARTIN. I held the office of assistant persecuting attorney of Montgomery, Ala., for 2 years. For 4 years I was assistant attorney general of Alabama. For 3 years I was attorney general of Alabama. I resigned to enter the service in 1917, being a graduate of West Point.

Senator DONNELL. You participated in the World War?

Mr. MARTIN. Yes, sir.

Senator DONNELL. In what capacity?

Mr. MARTIN. I was commissioned in the aviation section of the air service, in which I served for some 6 months, and then transferred voluntarily to the Field Artillery, where I served to the end of the war. I was then appointed judge of the circuit court of Montgomery County, Ala., which I held for 2 years, and then went to Birmingham, and I have been in private practice of law ever since.

Senator DONNELL. Have you appeared in the Supreme Court of the United States?

Mr. MARTIN. Yes, sir; in the case of Steward Machine Co. against Davis, I believe, involving the constitutionality of the Social Security Act, and in other cases in that court.

Senator DONNELL. That is one of the very outstanding cases in the history of the Supreme Court of the United States?

Mr. MARTIN. That is correct.

Senator DONNELL. Have you been a member of the house of delegates of the American Bar Association?

Mr. MARTIN. Since it was organized.

Senator DONNELL. And for how many years, approximately, have you had membership in the house of delegates?

Mr. MARTIN. Ten years.

Senator DONNELL. And were you chosen as a State delegate or as a local delegate?

Mr. MARTIN. State delegate.

Senator DONNELL. That is to say, the members of the American Bar Association in the State of Alabama selected you for ten consecutive years as one of the members of the house of delegates of the American Bar Association?

Mr. MARTIN. That is correct.

Senator DONNELL. And the State, I mean to say the members of the American Bar Association in Alabama had the power of appointment of only one individual to serve in that capacity; is that correct?

Senator DONNELL. You are well acquainted with the American Bar Association and known of its influence among the lawyers of the country?

Mr. BASTIAN. I have been a member of the house of delegates, also, as long as the judge has. I represented, until December, the bar association of the District of Columbia there. I was not a State delegate, and I am a member of the house of delegates by virtue of my position as treasurer, to which I was elected at the meeting in Cincinnati last December.

Senator DONNELL. Among the gentlemen who have occupied the office of president of the American Bar Association are David A. Simmons, of Houston, Tex.; Joseph W. Henderson, of Philadelphia, Pa.; George Maurice Morris, of Washington, D. C.; Walter Armstrong, of Memphis, Tenn.; J. M. Lashly, of St. Louis; Charles A. Beardsley, of Oakland, Calif.; Frank J. Hogan, of Washington, D. C.; Arthur T. Vanderbilt, of Newark, N. J.; Frederick H. Stinchfield, of Minneapolis; William L. Ransom, of New York; Scott M. Loftin, of Jacksonville; Earle W. Evans, of Wichita; Clarence E. Martin, of Martinsburg, W. Va.; C. A. Thompson, of St. Louis; Charles A. Boston, of New York; Joseph Marvel, the father of it, Wilmington, Del.; Henry Upson Sims, Birmingham, Ala.; G. E. Newlin, of Los Angeles; Silas H. Strawn, of Chicago; Charles S. Whitman, New York; Chester I. Long, Wichita; Charles E. Hughes, former Chief Justice of the Supreme Court, New York; John W. Davis, New York; R. E. L. Saner, Dallas, Tex.; Cordenio A. Severance, St. Paul; William A. Blount, Pensacola; Hampton L. Carson, Philadelphia; George T. Page, Peoria, Ill.; and a host of others that might be mentioned and including, I am proud to say, a number of gentlemen from the city of St. Louis, Mo.

Mr. BASTIAN. That is correct.

## POLITICAL ATTITUDE OF THE AMERICAN BAR ASSOCIATION

The CHAIRMAN. Mr. Martin, the house of delegates that you referred to here, authorized this study that you have told us about?

Mr. MARTIN. Yes, Mr. Chairman.

The CHAIRMAN. The house of delegates is regarded as a conservative body, is it not?

Mr. MARTIN. I would think so; yes.

The CHAIRMAN. The American Bar Association is also recognized in the country as a very conservative organization?

Mr. MARTIN. I could not say that; I think the American Bar Association, if you divide bodies of lawyers into two sectors, and if you call the Lawyers Guild the radical element, then the American Bar is its conservative element.

The CHAIRMAN. At any rate, the American Bar, I assume, elects the members of the house of delegates, do they not?

Mr. MARTIN. No.

The CHAIRMAN. How are the members of the house of delegates selected, who selects them?

Mr. MARTIN. The State delegates, one from each State, are selected by the members of the American Bar Association within individual States. There are 52 delegates, including the Territories. The other members are selected by the local bar associations whether or not they are members of the American Bar Association.

The CHAIRMAN. Where the local body has 500 members; is that right?

Mr. MARTIN. That is right, local lawyers; they do not have to be members of the American Bar Association to select their own delegate.

The CHAIRMAN. Well, those bar associations that have as many as 500 members, would usually be located in big cities?

Mr. MARTIN. That is correct; yes.

The CHAIRMAN. And the delegates that would come from those bodies would be, usually, conservative lawyers?

Mr. MARTIN. From big cities?

The CHAIRMAN. Yes, sir.

Mr. MARTIN. Well, the political trends have not so indicated in the last decade, sir.

The CHAIRMAN. Well, the political trend in the house of delegates has not changed very much, has it?

Mr. MARTIN. No; it has not.

The CHAIRMAN. They are still conservative?

Mr. MARTIN. Yes.

The CHAIRMAN. Not very many radical lawyers in the house of delegates, are there?

Mr. MARTIN. I would not think so; no. However, the American Bar Association does not determine that. For instance, the Association of the Bar of the City of New York selects its own delegates, and the American Bar Association has nothing to do with the personnel of their selection. Of course, the individual they select must be a member of the American Bar Association.

The CHAIRMAN. You say that it is only in cases of unusual legislation, legislation of the character vitally affecting the people, that your organization undertakes an investigation or study?

Mr. MARTIN. Yes; I may say one other study that we have made is the administrative law bill, and we have devoted considerable time to that.

The CHAIRMAN. What other important, vital legislation did you study? Did you study the national income-tax law?

Mr. MARTIN. No.

The CHAIRMAN. You never did?

Mr. MARTIN. I do not recall it.

The CHAIRMAN. Is it not true that the leaders of the American bar all very seriously opposed the enactment of the national income-tax law?

Mr. MARTIN. Oh, no; I would not think so.

The CHAIRMAN. You think that they were in favor of it?

Mr. MARTIN. You mean 40 years ago?

The CHAIRMAN. When it was first proposed.

Mr. MARTIN. In 1916?

The CHAIRMAN. When it was first broached in this country, was it not very bitterly debated, and was not the legal profession utterly opposed to a national income-tax law?

Mr. MARTIN. I cannot answer that question, Senator.

The CHAIRMAN. You have never given study to the history of the Bar Association in that regard?

Mr. MARTIN. I have not; no.

The CHAIRMAN. Now, you quoted the President of our country with a great deal of feeling. Have you also examined some of the quotations of Abraham Lincoln that come somewhat later than George Washington?

Mr. MARTIN. Yes.

The CHAIRMAN. In one of his statements he said:

The dogmas of the quiet past are inadequate to the stormy present; as our case is new, we must think anew and act anew.

Do you agree with that?

Mr. MARTIN. Within the framework of our Government and our Constitution, yes.

The CHAIRMAN. Well, of course, it always comes within the framework of our Constitution, many things are regarded as socialistic, but after they are debated and enacted into law, they become democratic principles; is that not true?

Mr. MARTIN. Well, I cannot say yes to that.

The CHAIRMAN. There was a great deal of opposition to appropriating funds in this country to feed the starving millions in the late depression and that was very bitterly opposed, the idea of appropriating Federal funds for the purpose of feeding the great mass of unemployed in this country at that time.

Mr. MARTIN. I do not think that there was any great opposition to that.

The CHAIRMAN. Were you giving attention to what was going on in Congress when the matter was first broached?

Mr. MARTIN. Yes.

The CHAIRMAN. And the bitter opposition to it, was there not opposition in the Congress?

Mr. MARTIN. I do not recall whether there was or not.

The CHAIRMAN. You say that you believe that everything that you said in reference to the original bill, 1161, applies to the present bill, 1606?

Mr. MARTIN. In general, yes.

The CHAIRMAN. In general?

Mr. MARTIN. Yes.

The CHAIRMAN. Have you gone into the provisions of 1606 that differ radically from the original 1161?

Mr. MARTIN. Yes.

The CHAIRMAN. You have?

Mr. MARTIN. Yes.

The CHAIRMAN. And you think, notwithstanding the fact that the present bill has been changed in very many respects, that still everything that you said with regard to 1161 applies now to 1606?

Mr. MARTIN. 1606 has not been substantially changed, I do not think, Mr. Chairman.

The CHAIRMAN. You do not consider the present changes in the bill as having any effect upon the reports that you made?

Mr. MARTIN. I do not.

The CHAIRMAN. That is all.

Senator DONNELL. Mr. Martin, some reference was made by the chairman to whether or not city lawyers are apt to be conservative. I ask you to state whether or not you know that the headquarters of Mr. Robert Walker Kenny, the president of the National Lawyers Guild, are in San Francisco, Calif.?

Mr. MARTIN. I am not familiar with that, Senator.

Senator DONNELL. I will ask you to state, also, whether or not the composition of the American Bar Association is confined to the larger cities of the country?

Mr. MARTIN. Oh, no.

Senator DONNELL. For instance, in the State of Montana, from which our distinguished chairman comes, I observe that Deer Lodge and Shelby each has a member in the American Bar Association or did in 1944, and I say, in fairness, three from Billings and one from Butte and one from Helena. Also, in your own State, do you know whether or not there are members of the American Bar Association from the smaller cities and towns?

Mr. MARTIN. Oh, yes; we have about 250 members from Alabama.

Senator DONNELL. How are they distributed generally?

Mr. MARTIN. Throughout the State generally.

Senator DONNELL. I presume that there are a number in the larger cities?

Mr. MARTIN. Yes, sir.

Senator DONNELL. Quite a number?

Mr. MARTIN. Yes, sir.

Senator DONNELL. Perhaps a predominant number?

Mr. MARTIN. Yes, sir. New York City has the greatest number of any city.

Senator DONNELL. But likewise, it is true that the smaller towns have members also?

Mr. MARTIN. Yes, sir.

Senator DONNELL. By the way, the list from which I was reading to you, Mr. Martin, I observe now was a supplementary list of mem-

bers and does not undertake, Mr. Chairman, to give all of the members from Montana, but was a supplementary list which is used now in the compilation as a matter of economy instead of giving the complete list each year.

Mr. BASTIAN. That is because of the difficulty of print paper situation.

Senator DONNELL. May I ask that there be inserted in the record at this point, Mr. Chairman, a copy of section 3, section 4, and sections 5, 6, and 7 of article V, the constitution of the American Bar Association, which sections relate to the composition and method of selection of members to the house of delegates, and I call attention in this connection, Mr. Chairman, to the fact that among others who are members are distinctly stated to be the chairman of the National Conference of Bar Examiners, the president of the National Conference of Commissioners on Uniform State Laws, the president of the Association of American Law Schools, the Attorney General of the United States, the director of the Administrative Office of the United States Courts. That is Mr. Henry Chandler.

Where does he live?

Mr. BASTIAN. In Washington, now.

Senator DONNELL. The president of the National Association of Attorneys General, the chairman, or in his absence the vice chairman, of each section of the association, the president, secretary, and treasurer of the association. Former presidents of the American Bar Association who register an attendance at any annual meeting of the association by 12 o'clock noon on the opening day thereof, members of the board of governors, and so forth. Also, that the particular provisions of section 7 of article V with respect to delegates from affiliated organizations, the American Law Institute, the American Judicature Society, and any other national organization in the legal profession having individual membership and having 25 percent of its members who are members of the American Bar Association, and which shall be approved by the house of delegates as an organization to be represented in the house of delegates through affiliation with the American Bar Association.

May I ask you what is the American Judicature Society?

Mr. MARTIN. Mr. Bastian is more familiar with that.

Mr. BASTIAN. I do not belong to that society.

Mr. MARTIN. It is a branch organization consisting of a number of lawyers who are interested especially in the administration of justice.

Senator DONNELL. Thank you.

Mr. BASTIAN. May I make one correction?

Senator ELLENDER. In reference to the citation just made, may I suggest that it be filed with the committee, and if it is important enough to put in the permanent record, the committee will do so.

Senator DONNELL. That is agreeable entirely with the amendment that the record shall show the pages which will be filed, so that anyone may readily read it.

Mr. BASTIAN. May I make this correction. I believe there may be a misapprehension. The State bar associations are not limited to 500 members, they could have 10,000,000 members if need be. It is only the local bar association which must have 500 members.

Every State bar association in the United States is represented.

The CHAIRMAN. Mr. Martin, in the course of your studies, in making up this report, did you go into the subject of the degree that the great masses of our people are denied access to modern medical care?

Mr. MARTIN. I did considerable reading, Mr. Chairman, along that line.

The CHAIRMAN. What was the result of your reading; were you convinced that there is a very great need?

#### BLUE CROSS PLANS

Mr. MARTIN. I was convinced that there is a segment of the people not indigent, because the indigent usually get the care they need, due to a tax-supported hospital service, but there is an upper class, probably of those employed with compensation of between \$2,000 and \$3,000 a year, which probably does not get the care it would like to have. But since the advent of the Blue Cross plans now covering 40,000,000 people in this country, such medical and surgical care is now within the reach of that group.

The CHAIRMAN. You consider people that earn from \$2,000 to \$3,000 a year form an upper class in this country?

Mr. MARTIN. I would say it is a middle class, certainly not in the indigent class.

The CHAIRMAN. Do you think that a family with an income of from \$2,000 to \$3,000 a year would be able to finance sickness in their family to the degree that they should be entitled to have, through medical care and hospitalization?

Mr. MARTIN. Under the Blue Cross plans, easily.

The CHAIRMAN. You think that they can?

Mr. MARTIN. Oh, yes.

The CHAIRMAN. You are familiar with the Blue Cross plans?

Mr. MARTIN. To some extent. For a maximum payment of \$49 a year, any size family from 2 to 20 can get the medical service it needs. That is \$4 a month.

The CHAIRMAN. That is limited service, a limited coverage that you get from the Blue Cross.

Mr. MARTIN. It includes medical care and doctor's care, and my State of Alabama in the last 2 years—

The CHAIRMAN. I think that you are mistaken. Have you made any careful study?

Mr. MARTIN. I would not say careful—I think that I have trustworthy sources—but I know my State in the past 2 years has provided for hospital organizations to include and provide for doctor's care, and now the hospital associations are putting doctors on their board of directors and adding that service to hospital care which they heretofore extended.

The CHAIRMAN. Well, the testimony which we have been receiving here is a little bit different from your ideas on that subject, and, of course, as you have not made a thorough study of it, we will have to rely on the testimony of others who have gone into it with great care.

Senator DONNELL. I think we are entitled to rely on Mr. Martin's judgment, also, and I am sure that we will give due weight to his testimony.

The CHAIRMAN. To the extent that his testimony and his study would justify giving any credit to his conclusions, of course, it would, but he says that he has not given any very careful study to the subject of the Blue Cross.

Mr. MARTIN. I know what the Blue Cross covers. It covers 40,000,000 people in this country, and I know in my own State what the cost is, and I know what it covers there. I do not know what it covers in other States, because I have not studied the plans in other States, but as a general rule, I think the plans are substantially the same.

The CHAIRMAN. Have you made any study of the problem of these families with an income of from \$2,000 to \$3,000 a year, with regard to their need of borrowing funds for the purpose and starting themselves in a downward spiral as a result of the indebtedness that they have taken on, frequently to pay medical care expenses?

Mr. MARTIN. I have made no such study, Mr. Chairman, but it would not be a great problem to borrow \$49 a year.

The CHAIRMAN. Have you observed any polls that have been taken in the country with reference to the desire of the people of the country to have a system of public-health insurance?

Mr. MARTIN. I have seen none, no.

The CHAIRMAN. You have taken no notice of that?

Mr. MARTIN. No.

The CHAIRMAN. That is all.

Senator DONNELL. Mr. Martin, pardon me, what did you mean by the statement that you had not made a careful study of the Blue Cross?

Mr. MARTIN. Well, I have not examined the details of every Blue Cross system in the United States. I do not know how many each covers, and I do not know the cost of each, but I know in a general way

Senator DONNELL. What affirmative study have you made of the number covered by the plans.

Blue Cross, so that we may know as to the extent of the coverage?

Mr. MARTIN. Well, in the preparation of this report, I secured a great deal of literature from different sources, and I analyzed it and digested it into a brief here of some 27 pages. I studied the literature of countries with some kind of health insurance, the plan of the Dominion of Canada, the system in Germany, in England, in Russia, and Europe, and I studied the expenditures in the United States for medical services, the progress of medicine in the United States compared with that of European countries, the hospitals in the United States, medical services in the United States, hospital insurance, Blue Cross hospital plans, health insurance, nonprofit and governmental hospitals, voluntary hospitals, indigent care and the cost thereof, and relationship between doctor and patient.

That is an index of the subjects which I compiled from my study of the literature on the subject.

Senator DONNELL. I gather that you have made some study, although you do not mean to state that it is an exhaustive complete study of the Blue Cross; is that correct?

Mr. MARTIN. That is correct. I had overlooked for the moment this study made 2 years ago or 3 years ago.

Senator DONNELL. And in your response to Chairman Murray in which you stated that you had not made a careful study, do you mean

to say that you made a study that was lacking in care, or that you simply had not made a comprehensive and complete study?

Mr. MARTIN. I have not made an exhaustive study.

Senator DONNELL. But you have made a study to which you referred and which you described?

Mr. MARTIN. Yes, sir.

Senator DONNELL. Did you put in any considerable quantity of time in making that study?

Mr. MARTIN. Yes, sir. I devoted more time to it than my law partners thought that I should.

Senator DONNELL. Do you have any idea about how much time, over all?

Mr. MARTIN. I devoted about a month to it.

Senator DONNELL. To the Blue Cross?

Mr. MARTIN. To the entire subject.

Senator DONNELL. How much time did you put in on the Blue Cross?

Mr. MARTIN. I do not know that; I could not say.

Senator DONNELL. You did put in the study that you have detailed here to the committee?

Mr. MARTIN. That is correct.

Senator DONNELL. Now in regard to the exact figures, for instance the 40,000,000 figure that I think that you mentioned, are you undertaking to state with accuracy the figures or are you giving your best recollection?

Mr. MARTIN. I had better break that figure down. There are 40,000,000 people in this country covered by the Blue Cross plans and the plans which are fostered by insurance companies; such is my information.

Senator DONNELL. You are using the Blue Cross as a generic term for voluntary insurance?

Mr. MARTIN. Where premiums are paid for the service.

Senator DONNELL. You are not confining the use of the Blue Cross to some organization that calls itself the Blue Cross?

Mr. MARTIN. No. I think there are 21,000,000 today under the Blue Cross plans and that number is increasing at the rate of 5,000,000 a year.

Senator DONNELL. And the figure of 40,000,000 as I understand it, you are using as applicable to Blue Cross in the generic sense, and not merely the technically Blue Cross organizations; am I correct?

Mr. MARTIN. That is correct.

Senator DONNELL. As to the coverage; it is not true that ordinarily the Blue Cross does cover only bed and board in the hospital and not surgeon's fees, or do you know?

Mr. MARTIN. I think that was the case originally, but it is greatly extended now, as in my own State, which I referred to, where it now covers medical service.

Senator DONNELL. And it is a fact that several millions, at any rate, of our citizens do have medical and surgical coverage under the Blue Cross?

Mr. MARTIN. Yes, sir.

Senator DONNELL. Now, in view of the courtesy of Mr. Bastian in coming, if I might ask him to tell us why Mr. Martin is here this

morning and what if any thing occurred in the way of polling the board of governors of the American Bar Association.

Mr. BASTIAN. We received an invitation from the distinguished chairman of this committee to be present, so our appearance is not a voluntary one but as a result of an invitation very generously extended. The president of our association and the chairman of the house of delegates—Mr. Willis Smith, of North Carolina, is president and Mr. Gregory, of Illinois, is chairman of the house of delegates—are now at Nuremberg at the invitation of the War Department observing the war crime trials. The administrative committee of the American Bar Association met in Chicago the early part of March and that committee consisted of the President and the chairman of the house who are absent, the Secretary, the chairman of the budget committee who comes from the same State as our distinguished chairman, the chairman of the committee on sections who come from Delaware, and myself, so that we had four out of the six members present.

We examine the invitation of the chairman of the committee and polled the board as to whether or not we would designate Mr. Martin to be present, because of the study which he had made to speak on the former proposed legislation. The bar association had not passed on S. 1606, but we thought it would be of interest to the committee to hear our views on the previous bill and hence the presence of Mr. Martin today.

I might say that the polls were unanimous in the authorization of Mr. Martin.

Senator DONNELL. Who is the chairman of the budget committee?

Mr. BASTIAN. Mr. William Jameson, of Billings, Mont.

Senator DONNELL. Is there anything further, Mr. Bastian?

Mr. BASTIAN. That is all.

The CHAIRMAN. I was going to ask Mr. Martin if he had made any study of the reports of the Selective Service System in connection with the examination of the young men of this country during the recent war.

Mr. MARTIN. No, I have not.

The CHAIRMAN. And you are not familiar with the fact that there had been a very large percentage of American youth rejected as defective due to the fact that their health had been neglected?

Mr. MARTIN. From general reading, yes, I was aware of that fact.

The CHAIRMAN. You know that, do you?

Mr. MARTIN. Yes.

The CHAIRMAN. And you know that that situation prevails in the country quite generally, that there are a great many people who because of their failure to get adequate medical care in time have greatly impaired their health?

Mr. MARTIN. I suppose so. My eyes are bad, and I perhaps did not have the care in my youth that I should have had, but I cannot have perfect eyes, and everybody cannot have perfect eyes, and everybody cannot have perfect health unless we are all going to be perfect. We are human beings.

The CHAIRMAN. But the health of the American people would be greatly improved if there was some way in which they could have ready access to modern medical advice and care?

Mr. MARTIN. I should think so.

The CHAIRMAN. It would greatly benefit American industry, and American business, too, would it not, if we had a system of health care in this country where people would not hesitate to go and consult their physicians and take care of their health in time before their health became seriously impaired?

Mr. MARTIN. I think that we should have a real Elysium if there were no ills at all. We would have a wonderful country if nobody ever got sick or nobody had an ailment.

The CHAIRMAN. Do you think that that is the aim of this bill, to have nobody ever get sick?

Mr. MARTIN. No, I do not think so. I do not think that that is possible.

The CHAIRMAN. Of course not. Why would you make that observation then? I do not think that that is called for in an answer to my question. It does not seem to me that anybody would ever expect to have any such a situation as that kind, but there could be a great improvement in the national health if we had some system whereby people would not hesitate, and where they would not feel as a result of the cost of medical care that they would be able to go and get it at the proper time.

Mr. MARTIN. Yes, and with an expenditure of four and a half billions of dollars, or three billions of dollars, or whatever it is, of course there is bound to be a favorable result from it.

The CHAIRMAN. We are spending over that or that much at the present time, are we not?

Mr. MARTIN. Individually in private enterprise under our system of private enterprise.

The CHAIRMAN. So that people who have the money are able to get very excellent care and others who have not the funds must go and borrow it and put themselves in a pretty bad situation when they go into debt to get the money necessary to pay medical bills?

Mr. MARTIN. Yes, but I do not think it is the philosophy of our Government for the Government to bail them out.

The CHAIRMAN. You do not think so?

Mr. MARTIN. It is the philosophy of the State government. It is up to the States to do that and to private industry and private enterprise, and I think it has been doing a great work along that line.

The CHAIRMAN. That was the same argument made in opposition to appropriations for the purpose of feeding the unemployed in the late depression?

Mr. MARTIN. Was private enterprise then undertaking to feed the unemployed? Private enterprise is now under the Blue Cross plans undertaking to provide medical care.

The CHAIRMAN. I say the argument that you just made, that it is not the function of the Government to do that—

Mr. MARTIN. The Federal Government, Senator.

The CHAIRMAN. That was an argument made in opposition to the Federal Government taking over the problem of unemployment and feeding the unemployed in the late depression, was it not? That was the argument opposed to it.

Mr. MARTIN. I do not recall.

The CHAIRMAN. And you are a lawyer and you are taking great interest in these public questions, one of the leaders in the American Bar Association, and you do not know that that was the situation in the late depression?

Mr. MARTIN. No.

The CHAIRMAN. Which was one of the most serious things that ever hit this country?

Mr. MARTIN. I know generally that the country was in a grave condition and it is not my impression that there was any great objection to the expenditure of Federal funds for the relief of the country and those that needed it.

The CHAIRMAN. You think that there was no objection to it?

Mr. MARTIN. No, that is my impression and my recollection. That was 13 years ago.

The CHAIRMAN. Of course, your recollection is not in accord with the facts.

Mr. MARTIN. That may be true.

Senator DONNELL. You mentioned or the chairman mentioned governmental participation. As I understood it, you were pointing out that as between the State governments and the Federal Government, you do not believe that this health insurance plan is a function of the Federal Government, that if the Government is to intervene in the matter, it is a problem and function of State governments as distinguished from the Federal Government?

Mr. MARTIN. Under our present form of government, that is correct.

Mr. DONNELL. Thank you very much.

The CHAIRMAN. The next witness will be Mr. Leo J. Linder, of the national committee on social legislation, National Lawyers' Guild.

#### STATEMENT OF LEO J. LINDER, NATIONAL LAWYERS' GUILD

Mr. LINDER. Mr. Chairman and members of the Senate committee, by name is Leo J. Linder. I am a lawyer admitted to practice in the courts of the State of New York, with offices at 74 Trinity Place, New York City. I have been admitted to practice in the State courts of New York since 1924. I am a member of the United States Supreme Court. I have practiced in other courts throughout the country.

Senator ELLENDER. Where were you born; in New York City?

Mr. LINDER. In New York City.

Senator ELLENDER. Where were you educated?

Mr. LINDER. In New York City.

Senator ELLENDER. What college?

Mr. LINDER. The City College and the Columbia Law School.

I appear here today on behalf of the National Lawyers' Guild, and pursuant to the authority of the national executive board of that body. I am chairman of the national committee on social legislation of the Lawyer's Guild, and I appear here to present to this body the report of that national committee on the National Health Act, which has been approved by the national executive board of the National Lawyers' Guild; and I ask permission to file that report—printed copies of which have been distributed, I believe—with my testimony here today.

The CHAIRMAN. It may be filed.

(The document referred to is as follows:)

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### THE NATIONAL HEALTH ACT

(A Report by the National Committee on Social Legislation, National Lawyers Guild)

There is no problem of more pressing importance before the American people than the problem of protecting the health of the American people by assuring adequate medical care for all Americans.

Millions of Americans cannot afford and do not receive adequate medical care. The majority of Americans, those with low or moderate incomes, are not able to meet the costs of serious illness. And for the millions of Americans who live in rural areas, there simply are not enough doctors or health facilities to provide basic health protection.

The urgent need for a national health program was recognized by President Truman in his message to Congress on November 19, 1945. In that message, the President urged the Congress to adopt a five-part national health program broadly covering (1) medical care insurance, (2) disability compensation, (3) hospital construction, (4) medical education and research, and (5) Federal-State public health services.

Simultaneously with the President's message, Senators Wagner and Murray and Congressman Dingell introduced the proposed National Health Act of 1945<sup>1</sup> which would enact into law three parts of the President's five-part program, dealing with (1) medical care insurance, (2) medical education and research, and (3) Federal-State public health services.<sup>2</sup> The other two parts of the President's health program, hospital construction and cash disability benefits, are, or will be, the subject of separate bills.

#### I. THE MEDICAL CARE AND EDUCATION PROGRAM

##### *The need for a national medical care program*

The compelling need for security against sickness has generally been recognized. Approximately 7 million persons in our country are disabled by illness on an average day.<sup>3</sup> About half of these, or 3½ million persons, would be working but for disability.<sup>3</sup> The balance includes children, housewives, aged persons, and others not in the labor force, but who are largely dependent upon those in the labor force. Workmen's compensation covers "less than one-tenth (perhaps nearer one-twentieth) of the disabling illnesses" affecting persons in the labor force.<sup>3</sup> Apart from the expense of illness, loss of earnings because of disability is estimated at between 3 and 4 billion dollars annually, and the loss of working time from 1.5 million to 3.3 million man-years.<sup>4</sup>

The economic burden of ill health falls most heavily on the largest segment of the working population which cannot afford adequate health service, and, at the same time, suffers the greatest amount of illness.<sup>5</sup> The poor and the low-

<sup>1</sup> S. 1606; H. R. 4730, 79th Cong., November 19, 1945.

<sup>2</sup> All five parts of the President's national health program are, in turn, a part of the overall social-security program proposed by the Wagner-Murray-Dingell social-security bill of 1945 (S. 1050; H. R. 3293, May 1945). The new National Health Act of 1945 constitutes a separation of three parts of the health program of the complete social-security bill for separate action by the Congress.

<sup>3</sup> Our committee's report on the comprehensive Wagner-Murray-Dingell social-security bill, heretofore published (Lawyers Guild Review, vol. V, No. 4, July-August 1945, pp. 221 ff.), also contains an analysis of those portions of that bill which are not duplicated in the new National Health Act of 1945.

<sup>4</sup> Social Security Board, Ninth Annual Report, 1944, pp. 23-25; Need for Medical-Care Insurance, Bureau Memorandum No. 57, Bureau of Research and Statistics, Social Security Board, Federal Security Agency, Washington, D. C., April 1944, p. 3: "An estimate of the prevalence of disability for the entire population indicates that, on an average day of the year, about seven million persons are disabled by sickness. Of these, about half have been disabled for less than 6 months; the remainder for longer periods.

<sup>5</sup> "Almost half of the 7,000,000 people disabled from illness on any day are in the labor force"; that is, when they are well, they are either employed or look for work."

<sup>6</sup> U. S. Medicine in Transition, Fortune Magazine, vol. 30, No. 6, December 1944, 156, 157; Social Security Board, Ninth Annual Report, pp. 23-24; National Resources Planning Board Report for 1943: Part 3, Security, Work and Relief Policies, 78th Cong., 1st sess., Doc. No. 128, hereafter cited as "N. R. P. B.," p. 153.

<sup>7</sup> Proceedings of the National Health Conference, 1938, Washington, D. C., pp. 56-57; The Costs of Medical Care, by I. S. Falk, C. Rufus Rorem, and Martha D. Ring, Chicago, 1933; Medical Care for the American People, final report of the committee on the costs of

paid wage earners suffer more sickness, are sick longer, and can afford less medical care, and, in fact, receive much less medical care than they need. The social wastes involved must be measured in terms of the loss of millions of man-hours and man-days of productive labor and in the avoidable deterioration of the human wealth of the nation.<sup>8</sup>

Our failure to provide adequate health insurance and medical care has resulted in the alarmingly large percentage of young men called for military service who have been rejected because of physical defects and ailments.<sup>7</sup>

The American Medical Association has published an analysis in which it declares that, aside from the indigent, families earning up to \$3,000 a year are unable to meet the costs of major sickness and need some measure of assistance.<sup>9</sup> This means that 92 percent of our population need assistance in meeting the costs of medical care.<sup>9</sup>

In an ordinary year, Americans pay about \$4,000,000,000 annually for all civilian health and medical services. Of this sum, four-fifths comes from private funds. The average cost is about \$30 a person annually. But some families pay much less than this, and many families pay very much more. The difficulty is that no family can anticipate or properly budget medical expenses because they are so unpredictable.<sup>10</sup>

Twenty-nine leading experts in the field of medical care, in a report recently published setting forth the Principles of a Nation-wide Health Program,<sup>11</sup> find: "When the costs of medical care are paid for by people as sickness occurs, according to the traditional system of fees to physicians and hospitals, these costs fall unevenly and unpredictably upon individual families. Such costs cannot be budgeted as can other items of expenditures, and they consequently bring financial distress and sometimes economic disaster to many families of all income groups except the well-to-do. Furthermore, the cost or the fear of cost often lowers the adequacy of service, or prevents the utilization of services at a time when they would do the most good. Appreciation of these facts has become common among the general public and among the professions, and it is now widely accepted that the costs of medical care should be distributed among groups of people and over a period of time."

medical care, Chicago, 1932; Factual Data on Medical Economics, American Medical Association, 1939, ch. XXIX, p. 66; Health in Handcuffs, by John A. Kingsbury, ch. IV; report of the technical committee on medical care, The Need for a National Health Program, published February 1938, and its report, A National Health Program—Report of the Technical Committee on Medical Care, transmitted to Congress by the President on January 23, 1939 (H. R., Doc. 120); Shall We Tax Ourselves To Pay the Doctor? Helen Weigel Brown, Liberty Magazine, August 19, 1944, pp. 15, 53; U. S. Medicine in Transition, Fortune Magazine, vol. 30, No. 6, December 1944, pp. 156, 184; Medical Care in a National Health Program, an official statement of the American Public Health Association, American Journal of Public Health, vol. 34, No. 12, December 1944; Principles of a Nation-Wide Health Program, report of the health program conference, committee on research in medical economics, New York, November 1944, Need for Medical-Care Insurance (*supra*, note 3), pp. 6-11.

<sup>8</sup>The cost of illness and premature death in this country amounts annually to about \$10,000,000,000, including in this total the combined costs of health services and medical care, loss of wages through unemployment resulting from disability, and the loss of potential future earnings through premature death. Every year 70,000,000 sick persons lose over a billion days from work or customary activities.

Summary by Dr. Kingsbury in Health in Handcuffs of findings of the technical committee on medical care. (See footnote 5.)

<sup>7</sup>Brigadier General Hershey, in an address before the National Nutrition Conference for Defense, on May 27, 1941, declared that of the first million men examined in the draft, 400,000 were found unfit for general military service, and that these physical examinations revealed that "we are physically in a condition of which nationally we should be thoroughly ashamed."—New York Times, May 28, 1941.

Of the first 3,000,000 registrants, more than one-half were rejected. (U. S. Selective Service System. Causes of Rejection and Incidence of Defects; An Analysis of Reports of Physical Examination From 21 Selected States. Washington, 1943. 41 pp. (Medical Statistics Bulletin 2.)) Soon after the start of the war certain of the physical standards were relaxed. Nevertheless, recent figures from Selective Service still show the appalling fact that 50 percent of the 14,000,000 young men examined (most of them under 30 were either completely unable to perform general military service or were made fit only after correction of defects. These figures were derived from data submitted by Col. Leonard G. Rowntree in: Senate Committee on Education and Labor. Wartime Health and Education; hearings before a subcommittee \* \* \* on S. 74. Washington: U. S. Government Printing Office, 1944. Pt. 5, pp. 1618, 1647; pt. 6, pp. 2034-2037; and Interim Report From Subcommittee on Wartime Health and Education to the Committee on Education and Labor Pursuant to S. Res. 74. Washington: U. S. Government Printing Office, January 1945. 22 pp. (Subcommittee Rept. No. 3.)

<sup>9</sup>Factual Data on Medical Economics, 1939, American Medical Association, Bureau of Medical Economics, p. 66.

<sup>10</sup>NRPB, pp. 22, 945.

<sup>11</sup>Social Security Board, Ninth Annual Report, p. 28.

<sup>12</sup>Report of the Health Program Conference (see footnote 5).

The answer to this problem is obviously to be found in the insurance principle of pooling costs and risks so that many persons may pay into a fund from which those who need care can receive it. The difficulty with voluntary private insurance is that it involves a small pool restricted to a limited group. To protect the solvency of the fund, these private voluntary plans are usually limited in protection to certain specified medical services, excluding others, and are usually so expensive that they can be afforded only by well-to-do or high-wage-earning persons. Voluntary private insurance is thus too restricted in benefits and too expensive in cost to be serviceable for more than a small minority of the American people.<sup>12</sup> Social insurance, which involves distributing the risks over virtually the entire Nation, is clearly the cheapest and the most effective means of dealing with the problem. There is no reason why the principles of social insurance, which have been a demonstrated success in insuring against the risk of unemployment or old age, should not be equally successfully applied in dealing with the risk of sickness.

Two problems are involved: First, the provision of medical care to those who need it, when and where they need it. Second, the insurance of income lost during unemployment by reason of disability or sickness.

The first requires a system of medical-care insurance which will distribute the costs of medical care among the entire population, and, by creating a fund contributed to by the entire working population, provide the means to pay for the costs of medical care for all who need it. The necessity for a national health fund is well stated by President Truman in his message to Congress on November 19, 1945, as follows:

"\* \* \* This health fund should be built up nationally in order to establish the broadest and most stable basis for spreading the costs of illness and to assure adequate financial support for doctors and hospitals everywhere. If we were to rely on State-by-State action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross State boundary lines."

The second requires a system of cash disability benefits. Such a system of cash disability benefits affecting all disability, whether of occupational origin or not, is, of course, nothing more than the extension of the familiar principle of workmen's compensation to the entire field of disability. Disability benefits for temporary sickness should be associated with benefits for temporary unemployment. This would involve merely the elimination of the unsound principle that a worker who is without income because he is without work should be paid a benefit so long as he is well, but not when he is sick. Plainly, he needs cash benefits even more when his temporary unemployment is due to sickness, since he must not only make up the income lost during unemployment, but must meet the additional expenses of his illness. Similarly, the disability benefit payments for permanent or chronic disability should be associated with old age retirement benefits on the principle that the income lost should be made up when a person is retired, irrespective of whether the retirement is by reason of old age or chronic illness. Legislation to provide cash disability benefits is to be the subject of a special recommendation by the President.

The bill would meet the first problem which may be restated as follows: How to assure to every person working for a living, and to his or her family, medical care when and where and as often as it is needed. The provision of medical care also, of course, requires the solution of the problem of fairly protecting the members of the medical profession who render the needed services.

#### 1. THE PROGRAM OF MEDICAL CARE

The bill meets the problem of providing needed medical care by giving to all insured persons and their families what the bill calls personal health service benefits. These services are to be rendered without payment of any fees by the insured persons. Thus, when a worker or self-employed person, or any of his family dependents, needs medical, dental, nursing, or hospital care, he or she

<sup>12</sup> Voluntary hospital-care plans cover about 16,000,000 persons, but the protection is partial, and families of low income cannot afford to pay the \$18 to \$25 per year for hospital-care insurance alone. Only 4,000,000 to 5,000,000 persons are covered by medical-care insurance. See C. E. A. Winslow, *Health Care for Americans*, Public Affairs Pamphlet No. 104, 1945, pp. 11-13; *Prepayment Medical Care Organizations*, by Margaret C. Klem; Bureau Memorandum No. 55, Bureau of Research and Statistics, Social Security Board, June 1944.

would receive such care, subject to the limitations hereinafter discussed, without being concerned about the cost of the services to be received. The services would, of course, be paid for, but they would be paid for out of the personal health service account in the United States Treasury established by the bill.

*Persons entitled to receive personal health service benefits*

These rights to personal health service benefits would be vested in substantially all employees in industry and commerce, agricultural and domestic workers, employees of nonprofit institutions and, in addition, all persons self-employed in business or a profession. The benefits would be available not only to the employees and self-employed persons, but would be available also to their wives or disabled husbands, their children under 18, or children of any age if disabled, and their dependent parents.

In addition, these benefits would also be available to all persons entitled to old-age and survivor benefits, under the Social Security Act, even if they do not qualify directly for personal health service benefits.<sup>13</sup> Furthermore, the indigent persons in our country, who are at present dependent upon local and State public assistance and relief (3½ million persons in 1944) could be covered for personal health service benefits under the bill if the public agencies responsible for their care arranged to make payment for their personal health service benefits.<sup>14</sup> Federal, State, and local government employees are excluded,<sup>15</sup> but Federal, State, and local public agencies may, by arrangement with the Surgeon General, secure health service benefits for their employees by making working arrangements for reasonable reimbursement<sup>16</sup> to the trust fund.

*Personal Health Service Benefits Provided*

These benefits include general medical benefits,<sup>17</sup> special medical benefits,<sup>18</sup> general dental benefits,<sup>19</sup> special dental benefits,<sup>20</sup> home nursing benefits,<sup>21</sup> laboratory benefits,<sup>22</sup> and hospitalization benefits.<sup>23</sup>

<sup>13</sup> Sec. 202, p. 35.

<sup>14</sup> Sec. 209 (a), pp. 55-56. Under the bill the Federal Government would contribute up to 75 percent to the States for medical care of needy persons (pt. C, secs. 131-137, pp. 26-34). However, this is not mandatory, and if the public agency concerned does not make the arrangements, the indigent under its jurisdiction will not be covered. The sick indigent need medical care often more acutely than others. The inadequacies of medical care sometimes provided by some of the public-assistance and welfare agencies is well established. (NRPB, pp. 89, 203, 460, 461, 520, 521.)

<sup>15</sup> Sec. 217 (b) (3) and (4), p. 74.

<sup>16</sup> Sec. 209, pp. 55-56. This provision does not assure health service benefits to Government employees. On principle, there is no reason why the health of Government employees should not receive, as a matter of right, the protection available to the rest of the working population.

<sup>17</sup> "The term 'general medical benefit' means services furnished by a legally qualified physician or by a group of such physicians, including all necessary services such as can be furnished by a physician engaged in the general or family practice of medicine, at the office, home, hospital, or elsewhere, including preventive, diagnostic, and therapeutic treatment and care, and periodic physical examination" (sec. 214 (b), p. 65).

<sup>18</sup> "The term 'special medical benefit' means necessary services, requiring special skill or experience, furnished at the office, home, hospital, or elsewhere by a legally qualified physician who is a specialist or consultant with respect to the class of service furnished, by a group of such physicians, or by a group of physicians including such specialists or consultants" (sec. 214 (c), pp. 65-66).

<sup>19</sup> "The term 'general dental benefit' means services furnished by a legally qualified dentist or by a group of such dentists, including all necessary dental services such as can be furnished by a dentist engaged in the general practice of dentistry, with or without the aid of an assistant or hygienist under his direction, and including preventive, diagnostic, and therapeutic treatment, care and advice, and periodic examination" (sec. 214 (d), p. 66).

<sup>20</sup> "The term 'special dental benefit' means necessary services, requiring special skill or experience, furnished at the office, hospital, or elsewhere by a legally qualified dentist (with or with the aid of an assistant, a hygienist, or an anesthetist under his direction) who is a specialist or consultant with respect to the class of service furnished, by a group of such dentists, or by a group of dentists, including such specialists or consultants" (sec. 214 (e), p. 66).

<sup>21</sup> "The term 'home-nursing benefit' means nursing care of the sick furnished in the home by (1) a registered professional nurse, or (2) a practical nurse" under special qualifications (sec. 214 (f), pp. 66-67).

<sup>22</sup> "The term 'laboratory benefit' means such necessary laboratory or related services, supplies, or commodities as the Surgeon General may determine, including chemical, bacteriological, pathological, diagnostic and therapeutic X-ray, and related laboratory services, refractions, and other ophthalmic services furnished by a legally qualified practitioner other than a physician, physiotherapy, special appliances prescribed by a physician, and eyeglasses prescribed by a physician or other legally qualified practitioner \* \* \*" (sec. 214 (g), p. 67).

<sup>23</sup> Sec. 214 (h), pp. 67-68. discussed in text below.

There is no limitation to medical benefits and they are to be provided to the extent to which they are necessary.<sup>24</sup> They are to be provided by general practitioners and specialists, practicing individually and as groups, and all legally qualified physicians would be listed as general practitioners. Patients would have free choice of selection from among the physicians listed, and in the same way as they do now, physicians may decide what patients they will treat.<sup>25</sup>

The hospitalization benefit, which is limited to 60 days (although this may be increased to 120 days in a year following the determination of the adequacy of the fund to permit such increase), is an amount not less than \$3 and not more than \$7 for each day of hospitalization for the first 30 days; not less than \$1.50 or more than \$4.50 for days of hospitalization exceeding 30; and not less than \$1.50 or more than \$3.50 for each day of care in an institution for the care of the chronic sick. Hospitalization benefits are not available for treatment in a hospital or other institution for mental or nervous diseases or tuberculosis, although hospitalization benefits may be granted for tuberculosis or psychosis for 30 days following diagnosis thereof.<sup>26</sup>

Persons entitled to medical, hospitalization, and related benefits under any workmen's compensation law are not entitled to personal health service benefits with respect to the same injury or disease.<sup>27</sup>

#### *Compensation of Physicians*

The bill provides that the professional personnel furnishing medical care is entitled to assurance of adequate compensation, "especially in terms of annual income or its equivalent and by reference to annual income customarily received among physicians, dentists or nurses having regard for age, specialization, and type of community; and payments shall be commensurate with skill, experience, and responsibility involved in furnishing service."<sup>28</sup> The Bill provides that the compensation of physicians would be paid to them out of the insurance fund on: (1) a fee basis, according to a fee schedule approved by the Surgeon General, or (2) a per capita basis, according to the number of individuals on a practitioner's list, or (3) a salary basis, for whole or part time service, or (4) a combination or modification of these, as the Surgeon General may approve, "according in each local area as the majority of the general medical and family practitioners or of the general dental practitioners, respectively, to be paid for such services shall elect," provided that the Surgeon General may also make payment by another of these methods to those doctors who do not elect the method of the majority, and the Surgeon General may negotiate arrangements with hospitals or groups.<sup>29</sup>

#### *Administration*

The responsibility for administering the medical and hospitalization benefits is vested in the Surgeon General of the United States Public Health Service, but he must perform his duties under the supervision and direction of the Federal Security Administrator, after consultation with the National Advisory Medical Policy Council as to questions of general policy and administration, and further in consultation with the Social Security Board as to the most effective methods

<sup>24</sup> Sec. 210 (a), p. 57, authorizes the Surgeon General to require payment of a fee for benefits, if necessary "to prevent or reduce abuses." With respect to dental and home-nursing benefits, it is provided that the Surgeon General may restrict the contents thereof, but after July 1, 1947, the restricted content of dental benefits shall include at least examination, including X-ray, diagnosis, prophylaxis, extraction of teeth that may be considered injurious to the individual's health, and treatment of acute diseases. The determination may fix an age above which the restriction of content shall apply. With respect to home nursing, restriction of content may be by providing part-time care on an hourly or visit basis, or by limitation of amount of maximum service per case (sec. 210 (b), p. 58).

<sup>25</sup> Sec. 205, pp. 45-51.

<sup>26</sup> Sec. 214 (h), pp. 67-68; sec. 210 (c), (d), p. 59. The question should be considered whether it would not be better to avoid limiting hospitalization benefits to specific maximum and minimum money benefits. It should be noted that the bill permits the Surgeon General (1) to enter into contracts with hospitals for the payment of the reasonable cost of hospital service, within the specified minimum and maximum rates, and (2) to contract for the inclusive services of a hospital and its attending staff (sec. 214 (h), pp. 67-68; sec. 205 (g), pp. 48-49; sec. 203, pp. 35 ff).

<sup>27</sup> However, a workmen's compensation agency may enter into contractual arrangements with the social-insurance system to have all medical benefits under the workmen's compensation law provided through the social-insurance system (sec. 209 (b), pp. 56-57).

<sup>28</sup> Sec. 205 (i), pp. 49-50.

<sup>29</sup> Sec. 205 (g), pp. 48-49.

of providing benefits and as to legislation and methods of administration policy.<sup>30</sup> Contracts for services and facilities made by the Surgeon General require approval of the Federal Security Administrator and consultation with the National Advisory Medical Policy Council.<sup>31</sup> This Council is established to advise the Surgeon General with respect to questions of general policy and administration, professional standards, methods and arrangements for furnishing the services, and the establishment of special advisory, technical, local or regional boards, committees, or commissions. The Council is to consist of members selected by the Surgeon General, with the approval of the Federal Security Administrator, from panels of names submitted by medical, professional and other organizations concerned with medical services and education, the operation of hospitals, and public representatives in such proportion as is likely to provide fair representation to the principal interested groups that furnish and receive benefits.<sup>32</sup> In his annual report the Surgeon General would be required to include a record of consultations with the Advisory Council and of its recommendations.<sup>33</sup>

The Surgeon General is required, insofar as practicable, to "give priority and preference to utilizing the facilities of State and local departments or agencies on the basis of mutual agreements with such departments and agencies."<sup>34</sup>

The bill declares explicitly in a section entitled "Methods and Policies for Administration," that the methods of administration, including the methods of making payments to practitioners, shall—

"(1) insure the prompt and efficient care of individuals entitled to personal health service benefits; (2) promote personal relationships between physician and patient; (3) provide professional and financial incentives for the professional advancement of practitioners and encourage high standards in the quality of services furnished as benefits under this title through the adequacy of payments to practitioners, assistance in their use of opportunities for post-graduate study, coordination among the services furnished by general or family practitioners, specialists and consultants, laboratory, and other auxiliary services, coordination among the services furnished by practitioners, hospitals, public-health centers, educational, research, and other institutions, and between preventive and curative services, and otherwise; (4) aid in the prevention of disease, disability, and premature death; and (5) insure the provision of adequate service with the greatest economy consistent with high standards of quality."<sup>35</sup>

## 2. MEDICAL EDUCATION AND RESEARCH

The Surgeon General is directed to administer grants-in-aid to nonprofit institutions engaged in medical research and professional education, providing for the education or training of persons to furnish medical, dental, nursing, hospital, laboratory and related benefits, "or to human knowledge with respect to the cost, prevention, mitigation or methods of diagnosis and treatment of disease and disability." During the first 5-year period, preference shall be given to projects to aid servicemen. For these purposes, there is to be available \$10,000,000 for the year 1946, \$15,000,000 for the year 1947, and for each year thereafter an amount equal to 2 percent of the amount expended for medical care benefits in the last preceding year.<sup>36</sup>

## 3. FINANCING

A "Personal Health Services Account" is established in the Treasury. Sums sufficient to finance the benefits provided are authorized to be appropriated to this account. From these appropriations, there is to be credited to the account amounts equal to 3 percent of wages or remuneration received by employed and self-employed persons up to \$3,600 per year in covered employment, the cost of dental and home nursing benefits, the amount expended for social security beneficiaries who become insured before the bill goes into effect, and, in addition, reimbursements to the account made on behalf of noninsured persons entitled to personal health service benefits, such as needy persons, specially provided for as hereinafter indicated.<sup>37</sup>

<sup>30</sup> Sec. 203 (a), pp. 35-36.

<sup>31</sup> Sec. 203 (c), pp. 36-37.

<sup>32</sup> Sec. 204 (a), (b), pp. 41-44.

<sup>33</sup> Sec. 203 (l), p. 41.

<sup>34</sup> Sec. 203 (e), pp. 37-38.

<sup>35</sup> Sec. 205 (f), pp. 47-48.

<sup>36</sup> Sec. 213, pp. 63-64.

<sup>37</sup> Sec. 212, pp. 61-63.

While no tax is imposed by this bill, it is probable that the bill's sponsors will later propose a 3 percent pay-roll tax on wages of employed persons up to \$3,600 per year (probably to be paid half by the employer and half by the employee) and a tax on self-employed persons of 3 percent of their earnings up to \$3,600 per year. The sponsors of the bill take the position that it is in the interest of the national health and welfare that a system of medical, dental, nursing and hospital care be made available to substantially the working population of the United States. How the money is to be raised can be determined later. This leaves for subsequent consideration the question of whether the moneys are to come out of general revenues, or out of ear-marked taxes; it leaves for later consideration the question as to whether financing should be on a pay-as-you-go basis, or whether reserves should be set up for future operations.

This is wholly sound. The Congress has, ever since the founding of our Nation, appropriated moneys urgently required in the public welfare without first determining upon the source of the funds. It would be unthinkable for the Congress to postpone appropriating moneys for military supplies for the waging of war or for meeting any urgent national need until the sources of the funds were first determined. In the same spirit, the Congress should meet its responsibility to create an urgently needed national system of health care.

## II. GRANTS TO STATES FOR HEALTH SERVICES AND FOR MEDICAL CARE FOR NEEDY PERSONS

### 1. HEALTH SERVICES

In addition to the provision of medical care, it is a matter of urgent public importance that Federal, State and local public health services be continued and largely expanded. It has been pointed out that there are still 40,000,000 people in this country who live in communities where there are either no local health services at all or where such services are provided only by inexperienced, part-time health officers. Most of these areas spend less than half of the \$1 a person a year that is needed to pay for such essentials as collecting vital statistics, providing public health laboratory services, controlling communicable diseases, securing decent sanitation, providing for the hygiene of mothers, infants, and school children, and carrying out a necessary program of health education. At least \$2 a person is needed for a really complete program, including necessary public health nursing service. We cannot rest satisfied until every one of our 3,070 counties has an adequate local health service.<sup>38</sup>

The bill proposes increased grants to the States for (a) public health services and (b) maternal and child health services.

(a) *Public health services.*—The bill proposes to reenact two special public health programs dealing with venereal diseases and tuberculosis. It also enlarges the general national public health program.

With respect to the special venereal diseases program, the bill would reenact existing legislation which appropriates a sum sufficient to enable the Surgeon General to assist the States and localities to establish and maintain adequate measures for the prevention, treatment and control of these diseases.<sup>39</sup> With respect to the special tuberculosis program, \$10,000,000 is appropriated for the first year and thereafter yearly a sum sufficient to enable the Surgeon General to assist the States and localities in establishing and maintaining adequate measures for dealing with this disease.<sup>40</sup> The appropriations for these programs are to be allotted among the several States on the basis of their respective populations, the size of their problems and their financial needs.<sup>41</sup>

With respect to the general national public health program, the present authorization of \$20,000,000 per year is replaced by authorization of an appropriation of a sum sufficient to extend and improve public health work, especially in rural communities, in economically depressed areas and in other communities where such services are below nationally accepted standards of adequate public health

<sup>38</sup> Winslow, *op. cit.*, p. 20.

<sup>39</sup> Sec. 314 (a), Public Health Service Act, as amended by sec. 101, p. 2.

<sup>40</sup> *Id.*, sec. 314 (b), pp. 2-3.

<sup>41</sup> *Id.*, sec. 314 (c), pp. 3-4. The 1930 Report of the Interdepartmental Committee to Coordinate Health and Welfare Activities urged that Federal grant-in-aid should be expanded for special programs dealing with pneumonia, cancer, malaria, mental hygiene, and industrial hygiene in the domain of public-health service work, in addition to special programs dealing with venereal diseases and tuberculosis. It is to be regretted that the bill limits special grants to the two fields of venereal diseases and tuberculosis.

services. In order to receive the Federal grants, States are required to develop their own plans in accordance with their own needs and to submit these plans for approval by the Surgeon General. The amounts of the grants range from 50 to 75 percent of the total public funds expended under approved State programs under a formula based upon the relationship of the per capita income of the State to the national per capita income, the States with lower relative per capita income receiving the larger grants.<sup>42</sup>

(b) *Maternal and child health services.*—Two programs are here involved: (1) maternal and child health services and (2) services for crippled or otherwise physically handicapped children. For each of the two services, State plans must be submitted to and approved by the Chief of the Children's Bureau. The State plans must provide that the services and facilities will be available to all mothers and children in the State or locality who elect to participate in the respective programs.<sup>43</sup> Federal grants for each of the programs are from 50 to 75 percent of the total public funds expended under the respective State programs. The formula for determining the amount of the grant is the same as for public health services, giving greater aid to the poor States.<sup>44</sup> For the maternal and child health services and for the crippled and handicapped children a sum sufficient is authorized to be appropriated each year, instead of present appropriations of \$5,820,000 annually for maternal and child health services and \$3,870,000 annually for crippled children's services.<sup>45</sup>

## 2. GRANTS TO STATES FOR MEDICAL CARE OF NEEDY PERSONS

The Wagner-Murray-Dingell Social Security bill proposed a new complete Federal-State comprehensive public assistance program by grants-in-aid to States of between 50 and 75 percent of the cost of State plans for public assistance.<sup>46</sup> It was intended that such State comprehensive public assistance plans should include medical care for needy persons. The proposed new National Health Act would adapt these public assistance provisions of the former bill to provisions for medical care for the needy by establishing grants-in-aid to States of 50 to 75 percent of the cost of State plans for medical care of needy persons.<sup>47</sup> Such medical care could be provided (1) by the State or local public assistance agency through money payments to individuals, payments to persons or institutions furnishing care or direct provision of such care, (2) by other agencies of the State, (3) through arrangements with the Surgeon-General to furnish services under the medical care system established by this bill, or (4) through a combination or modification of these methods.<sup>48</sup>

The need for providing medical care for needy persons who would not be covered by the medical care insurance provisions of the bill is as essential as the provision of such assistance to persons not protected by social insurance. The bill's proposals to provide such medical care would meet an urgent need for those who are altogether unable to meet its cost and whose medical needs are greatest.

## III. THE OBJECTIONS TO THE NATIONAL HEALTH PROGRAM ARE WITHOUT MERIT

The bill has been subjected to violent attack.<sup>49</sup> Generally, only the medical care portion of the health program of the bill has been the object of the attack. Those who have attacked the bill have generally ignored the beneficent and desperately needed health proposals of the bill other than its proposals for medical care.

In essence, the argument of the opponents is that these provisions would bring about a system of State medicine or socialized medicine and would destroy the private practice of medicine in the United States.<sup>50</sup> These contentions

<sup>42</sup> Id., sec. 314 (f), pp. 4-10.

<sup>43</sup> Secs. 122 (a) (8), 124 (a) (5), pp. 16, 18. The maternal and child-health services are to be administered by the State health agency.

<sup>44</sup> Sec. 125, pp. 19-21.

<sup>45</sup> Sec. 121 (a), pp. 13-14; cf. Social Security Act, as amended, secs. 501, 511. Under the present title V of the Social Security Act there is a 50-50 matching of State expenditures on services for crippled children (sec. 514) and on part of the funds for maternal and child-health services (sec. 504a, referring to sec. 502a).

<sup>46</sup> S. 1050, pp. 56-65.

<sup>47</sup> Pt. C, pp. 26-34.

<sup>48</sup> Sec. 136 (b), p. 34.

<sup>49</sup> See literature by John M. Pratt, published by the National Physicians' Committee for Extension of Medical Service, Chicago.

<sup>50</sup> Kingsbury, *Health in Handcuffs* (supra, note 5), p. 18; *Need for Medical-Care Insurance* (supra, note 3), p. 23.

are without foundation. The opponents of the bill who cry State medicine ignore the fact that 42 percent of expenditures for hospitals and doctors in 1942 were either tax supported or otherwise without cost to the patient. Nearly all hospitals for mental and nervous diseases and for those suffering from tuberculosis are public institutions. They account for more than one-half of all hospital beds in the United States and approximately 70 percent of our hospital services already administered by State medicine. We have public systems of medical care for veterans, for merchant seamen, for the indigent and others.

The system of medical care provided by the bill has no resemblance whatever to State medicine. It is merely an insurance system by which, on insurance principles, employed and self-employed persons would, it is contemplated, contribute to a fund from which payments are made for medical and hospital services for those within the insurance scheme and their families. There is nothing socialized about that. Indeed, the insurance system proposed is merely an extension of the familiar and accepted principles of workmen's compensation, which provide medical care and cash benefits in cases of industrial disability. And the suggestion that workmen's compensation is a system of socialized medicine would be regarded as patently preposterous.

The medical care provisions of the bill have been attacked on the ground that they are foreign to our system of government and also are incompatible with the adequate protection of the liberties of the people. There is nothing foreign to our system of government in the provision of medical care for the people of our country by an insurance system. It is no more foreign to our system of government than is the system of old-age security and unemployment insurance. In fact, one of the very first health insurance systems introduced in the modern world was established in the United States in 1798 when Congress enacted the health insurance system for merchant seamen. With some variation, this has existed for nearly 150 years.

Providing its citizens with the right to medical care, with the opportunity to enjoy health, with the ability to prevent suffering and destitution caused by illness and the inability to obtain medical treatment is not an attack on the rights and liberties of the citizens of this country. On the contrary, it establishes conditions of health and decency under which citizens of this country can enjoy their rights and liberties.

It has been asserted that the bill would subject to bureaucratic control and supervision the intimate and confidential relationship between doctor and patient; that the freedom of choice of doctors and patients will be impaired; and that it would seriously disturb existing intimate relationships between doctor and patient. On the contrary, the fact is that there will be no interference in the normal relationship and confidence between doctor and patient. Every person insured under the act will have the right, the absolute right within the framework of unavoidable practical limitations and subject to the right of the physician to refuse to accept a patient, to choose the doctor who may treat him; and since the bill gives every qualified physician the right to practice under the system, the choice will be no more limited than it is now. No doctor is compelled to render services and no doctor is compelled to accept any person as a patient whom he does not wish to treat and, of course, any physician who does not wish to treat patients under the insurance system may continue his private practice, and private practice may also be combined with practice under the system. These freedoms of choice remain unimpaired. When an insured person is refused by a physician he has the right to make another choice, and, of course, subject to routine regulations, will have the right to change physicians. Even today patients meet with obstacles in changing physicians during treatment.

The experience of physicians in countries which have had health insurance systems for years demonstrates the unsoundness of the arguments advanced by opponents of the bill. In Great Britain, health insurance has been in effect for over a quarter of a century, and the British Medical Association has repeatedly approved it. British physicians would regard as absurd the suggestion that health insurance has brought about a system of "state medicine."<sup>11</sup>

The opponents of health insurance ignore the fundamental problem which health insurance is designed to meet: how to distribute the costs of medical care so that those who need medical care will receive it. It is because sickness is unpredictable that it is impossible for a majority of the American people

<sup>11</sup> See statement of Dr. G. C. Anderson, medical secretary of British Medical Association, quoted by Kingsbury in *Health in Handcuffs* at p. 54.

effectively to budget to meet its costs. It is because catastrophic sickness most frequently falls upon those who can least afford to pay for its costs that a method for distributing the costs is necessary. It is because the whole Nation is concerned with the health of all the people that this problem must be solved on a national scale. The bill provides a sound and effective means of dealing with the problem.

The Social Security Board has stated:

"The much-advertised fears of 'socialized medicine,' 'regimentation' of doctors, hospitals, or patients, loss of the patient's freedom to choose his doctor, and deterioration of quality of care can be made wholly groundless. A system of medical care insurance can and should be so designed as to avoid these disadvantages. By making services readily available to those who need them, without fear of the costs, the quality and effectiveness of service may be improved, and the income of doctors and hospitals may be made better and more secure. If, at the same time, professional education, research, and the construction of needed facilities are financially aided, progress in medicine and improvement in national health can be greatly accelerated."<sup>52</sup>

The attacks upon this bill were launched as soon as the President's message was delivered and the bill introduced. We believe that these attacks were best answered by President Truman in his message to the Congress of the United States recommending the enactment of national health legislation. Speaking of provision for prepayment of medical costs, he said:

"None of this is really new. The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have misnamed it 'socialized medicine.'

"I repeat—what I am recommending is not socialized medicine. Socialized medicine means that all doctors work as employees of the Government. The American people want no such system. No such system is here proposed.

"Under the plan I suggest, our people would continue to get medical and hospital services just as they do now—on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all-important difference: Whether or not patients get the services they need would not depend on how much they can afford to pay at the time."

### Conclusion

Upon analysis, we conclude that the provisions of the bill are urgently needed for the protection of the health and welfare of the American people. Because the National Health Act would meet an urgent need of the people of this country, we approve it and urge its immediate enactment. As President Truman has so well said:

"We are a rich Nation and can afford many things. But ill health which can be prevented or cured is one thing we cannot afford.

"By preventing illness, by assuring access to needed community and personal health services by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic productivity. We shall increase the professional and economic opportunities of our physicians, dentists, and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people."

We find nothing in the bill which will diminish or impair the rights and liberties of the citizens of this country. On the contrary, its enactment would serve to make these rights and liberties real and effective. For the sick are not free, and only a healthy America can exercise its rights and enjoy its liberties.

NATIONAL COMMITTEE ON SOCIAL LEGISLATION,  
NATIONAL LAWYERS GUILD,  
LEO J. LINDNER, *Chairman*,  
MORRIS A. WAINGEE, *Secretary*.

Report prepared by:

LEO J. LINDNER and  
MORRIS A. WAINGEE.

Mr. LINDNER. The report of the national committee adopted by the National Lawyers' Guild strongly supports the National Health Act,

<sup>52</sup> Social Security Board, Ninth Annual Report, 1944, p. 31.

and regards the National Health Act as legislation of paramount importance and benefit to the American people.

Our committee has studied the subject of social insurance for many years, and has made exhaustive and detailed analyses of the predecessor bills which preceded the National Health Act, and I refer, of course, to the Wagner-Murray-Dingell social security bill, S. 1161, and to the revised Wagner-Murray-Dingell social security bill, S. 1050.

We observe that the present bill, the National Health Act, S. 1606, is substantially patterned upon the medical care and public health provisions of the social security bill, S. 1050.

#### THE NEED FOR NATIONAL HEALTH INSURANCE

Now, our report dealing with the National Health Act starts with a consideration of the need for medical care in this country, and we are persuaded that the findings made by many authoritative bodies indicate clearly that in an ordinary year one-third of the population of the United States receives no medical or dental care whatever; and the authority for that statement is the report of the Technical Committee on Medical Care transmitted to the Congress by President Roosevelt on January 23, 1939, House of Representatives Document 120.

We find that a distinguished group of experts in the field of medical economics has reported that at least "nine-tenths of our population need protection against the uneven and unpredictable costs of sickness."

We believe that the existing arrangements for providing medical care accordingly need much improvement, and we are satisfied that the insurance principle of pooling costs and risks so that persons can be paid out of a common fund when and where and as often as they need care should be applied.

We believe that the difficulty with voluntary private insurance is that it involves a small pool restricted to a limited group, and we observe that the necessity of protecting the solvency of the fund results in a limitation of protection of private voluntary plans to certain specified medical services, and also to large cost.

We thus conclude that voluntary private insurance is too restrictive in benefits, and, too expensive to be serviceable for more than a small minority of the American people.

We believe that social insurance, which involves distributing the risks over virtually the entire Nation is clearly the cheapest and most effective means of dealing with the problem; and we believe that national social insurance and a national health fund is enormously preferable to any State-wide compulsory social insurance systems, for the reasons excellently stated by President Truman in his message to Congress on November 19, 1945, where he said,

If we were to rely on State-by-State action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross State boundary lines.

Senator ELLENDER. How much smaller is the per capita cost under the pending measure than it is under the system of voluntary insurance?

Mr. LINDER. Much smaller, Senator.

Senator ELLENDER. I would like to know, why is that? I understand that these plans are voluntary and on a nonprofit basis.

Mr. LINDER. That is correct. The difficulty is that in order to protect the solvency of the fund, the private insurance systems are necessarily restricted in scope.

I am a member of the Blue Cross system in New York City, and I pay \$24 a year, but the only service I get under that Blue Cross policy that I have is a limited hospital service. I get no medical care at all for myself and for the members of my family.

Senator ELLENDER. Could you get more if you paid more?

Mr. LINDER. There are other systems. I also have a health and accident insurance policy which costs me \$60 a year, and gives me very limited coverage after a 30 day waiting period, and for a limited period. I also pay—27 times 4—a little over \$100 a year to another health and accident insurance company, that provides, also, very inadequate and limited coverage.

I can say without qualification at all that the benefits which would be provided under the Wagner-Murray-Dingell bill would be enormously greater than the benefits I get under all three systems of private protection which I have personally resorted to as a means of protecting myself and my family.

Senator ELLENDER. Do not some of those policies you have now protect you not only for medical care but give you a weekly or monthly stipend?

Mr. LINDER. That is correct.

Senator ELLENDER. That is what you are paying for.

Mr. LINDER. That is correct. I should have indicated that the \$60 a year policy does not give me any substantial cash benefits at all. That is a commercial traveler's policy.

Senator ELLENDER. Is it your view that the Blue Cross is limited to such an extent that it could not provide the necessary care for sick people?

Mr. LINDER. I have not the slightest doubt that Blue Cross could not, without going bankrupt, provide the medical care that is provided in the Wagner-Murray-Dingell bill unless the premiums were three to four times the present premiums.

I should like to say, Senator, that this part of my discussion is a discussion in which I think I am less expert than the portion of my testimony that I would like to now go into, which deals with legal matters. I can speak of my own personal knowledge with respect to personal experience with respect to Blue Cross, but I think your committee would be better served if you let experts in the field of public health and experts who have examined the data with respect to that talk to you.

With your permission, I would like now to devote the bulk of my testimony to what I think are the most appropriate subjects with which I should deal.

They are first the matter of the constitutionality, and second the matter of the criticism made of the bill, or of the predecessor bill, by the American Bar Association, to which most of this morning's session has been devoted.

## CONSTITUTIONALITY OF S. 1606

With respect to the matter of constitutionality, I notice that the report of the American Bar Association presented here this morning contains one sentence on constitutionality. It states:

S. 1161 is utterly beyond the powers of Congress.

This morning Mr. Martin expatiated on that subject a little more fully, and he said that he thought the proposed legislation contravened the tenth amendment to the Constitution.

Unfortunately, neither Mr. Martin nor the American Bar Association's report gives us any citation of authority to support the conclusion of unconstitutionality.

I would like to submit, gentlemen, that the matter of constitutionality of this legislation is decisively determined by the decisions of the United States Supreme Court dealing with the social security cases.

I note that in one of them, *Steward Machine Company v. Davis*, 301 U. S. 548, Mr. William Logan Martin, who appeared here this morning, was counsel for petitioner asserting the unconstitutionality of the unemployment compensation provisions of the Social Security Act; and while he is unquestionably entitled to his personal opinion, the United States Supreme Court did not adopt that opinion, and so he is still averring unconstitutionality in the face of the authoritative determination of our Highest Court.

*Helvering v. Davis*, 301 U. S. 619, is a decision of Mr. Justice Cardozo, and was handed down May 24, 1937. That decision clearly indicates that social insurance legislation of the type here involved is beyond the possibilities of doubt clearly constitutional.

Senator DONNELL. Does it mention "social insurance legislation"?

Mr. LINDER. Oh, yes.

Senator DONNELL. Would you mind reading the sentence or sentences that you think establish that?

Mr. LINDER. I will be glad to.

I should first state the context of the decision. *Helvering v. Davis* was a petition to review the reversal of a decree in which the petitioner sought to enjoin compliance with the tax requirements of title 8 of the Social Security Act. That was the title which imposed taxes for old-age security.

On page 640 of the decision Mr. Justice Cardozo says:

The scheme of benefits created by the provisions of title 2—  
which are the old age security benefits—

"is not in contravention of the limitation of the tenth amendment. Congress may spend money in aid of the general welfare.

And Mr. Justice Cardozo says that there have been greater statesmen who have had other views; but he goes on to indicate that the United States Supreme Court believe that the constitutional power to spend money in aid of the general welfare clearly includes the power to tax and to spend money by way of old-age security benefits to persons entitled under a legislation providing for it.

Mr. Justice Cardozo also deals directly with the problem of the so-called States' rights, which Mr. Martin presented. On page 644 of the

decision, Mr. Justice Cardozo says, and he was dealing there with the problem of old-age destitution and old-age insecurity:

The problem is plainly national in area.

He says, moreover, that the laws of the separate States cannot deal with it directly. Congress at least had a basis for that belief.

States and local governments are often lacking in the finances necessary to finance an adequate security.

And then there is a discussion of "whether wisdom or unwisdom resides in the scheme it is not for us to say."

And so I say, gentlemen, the American Bar Association may believe that this bill is unconstitutional, but the highest court of our land believes otherwise.

Senator DONNELL. Mr. Chairman, I submit that the highest court of our land did not have this bill before it. The matters before it were social security legislation now on the books. We should discuss that latter, however.

#### APPRAISAL OF AMERICAN BAR ASSOCIATION REPORT

Mr. LINDER. Very well. I should like to spend the balance of my time with the American Bar Association report which has been presented here.

The national committee on social legislation of the National Lawyers' Guild has made a careful analysis of the report which Mr. Martin presented here this morning.

That report was published under the title, "Medical Care Provisions of the Wagner-Murray-Dingell Social Security Bill," and I have a printed copy of the analysis of the A. B. A. report. I just have a few copies, and I would like to hand them to the Senators here present; and I should like to ask, Mr. Chairman, for permission to file this report with the minutes of this hearing as well. I should note that this report deals with the A. B. A. report which was concerned with S. 1161. But I agree with Mr. Martin that the philosophy and the general purport of the present bill, the National Health Act, are substantially the same as those of the S. 1161; and therefore that the criticism which the A. B. A. report makes is perhaps equally applicable to both bills, although I should note in passing that the new bill, the bill you have before you now, the National Health Act, is a substantial improvement over S. 1161, and in many respects is a better bill insofar as medical care provisions are concerned.

Now, before I submit it, I should also like, Mr. Chairman, to have permission to have the decision in *Helvering v. Davis*, 301 U. S. 619, dealing with old-age security, and the decision in 301 U. S. 548, the *Steward Machine Company v. Davis*, incorporated with my testimony as part of the record of this hearing.

The CHAIRMAN. It may be incorporated.

Senator ELLENDER. It will be filed for reference.

Mr. LINDER. Now, our analysis of the American Bar Association report leads us to the conclusion that that report, I regret to say, contains many errors of fact, many serious errors of interpretation, and abounds in conclusions which are unwarranted and totally unjustified; and I want to now deal with the chapter and verse in that regard.

I do not have the formal printed report which Mr. Martin presented this morning.

The CHAIRMAN. Here is one. [Handing document to witness.]

Mr. LINDER. I have, and my study has dealt with, the copy of that report which was published in the American Medical Association Journal of March 11, 1944, beginning at page 716. And with your permission I would like to refer to the A. M. A. Journal, because I have that annotated and marked.

Senator DONNELL. Would you be kind enough to give us such references as we may be able to follow in the report? I think it is quite proper that you should refer to the document that you have, but it would facilitate our following it along.

Mr. LINDER. On page 14 of your copy, Senator.

Senator DONNELL. Yes; thank you.

#### FREEDOMS UNDER THE BILL

Mr. LINDER. In the second column, item 2, quoting from the report:

Senator Wagner states: "There is complete freedom of choice of doctors by patient. This is incorrect. If either the patient or the doctor named on the panel by the Surgeon General declines to accept the other the patient is assigned to some other doctor."

Item 5 on page 15.

Senator ELLENDER. Are you going to comment on those?

Mr. LINDER. Yes. Yes; I just want to aggregate a few points.

Item 5, page 15:

Senator Wagner states: "There is freedom of types of remuneration for the doctor. This is misleading. The doctor is forced on a salary or on a fee basis, or on a combination of both, as determined by the Surgeon General, who approves the fee tables."

Item 8:

Senator Wagner states: "No doctor is forced on a salary basis. This is misleading. The doctor is forced on a salary or on a fee basis, or on a combination of both, as determined by the Surgeon General."

Now, gentlemen, I would like to refer to the bill and see whether the comments there are justified.

Senator DONNELL. Referring to S. 1161?

Mr. LINDER. No; I refer to S. 1606.

Senator DONNELL. Of course, S. 1161 was the one which the American Bar Association referred to.

Mr. LINDER. I am perfectly willing to refer to that, but I think the provisions are substantially the same.

Senator DONNELL. I do not have before me S. 1161 to make the comparison.

Mr. LINDER. I have a copy, and I will go through S. 1161 and compare it with the present bill. My criticism of the ABA report applies equally to both.

The CHAIRMAN. That was the position taken by Mr. Martin.

Mr. LINDER. Yes.

The CHAIRMAN. That he had examined both provisions, and that his report on S. 1161 applies to S. 1606.

Senator DONNELL. That is on the major over-all situation?

Mr. LINDER. That is right.

Senator DONNELL. He did point out certain changes in the two bills, differences between the two bills. I am not familiar whether these are applicable to these particular discussions or not.

Senator ELLENDER. Suppose you confine yourself to the bill that was considered by the American Bar Association.

Mr. LINDER. I will indicate the provisions of both bills at one time so that you can have the whole thing before you properly.

What the ABA had before it in this connection was section 905 (1) and (2). And the sense of section 905 (1) and (2) of S. 1161 is substantially the same as the sense of section 205 (a) and (b) of the present bill. I can read both to satisfy you that that is correct.

In 905 (1) of S. 1161, the bill provided:

Any physician legally qualified by a State to furnish any services included as benefits under this title shall be qualified to furnish such services as benefits under this title, except as otherwise provided in subparagraph 4—

which deals with specialists—

in accordance with such rules and regulations which may be prescribed.

And the counterpart of that in the present bill is section 205 (a):

Any physician—

and then the words "dentist, or nurse," because of the addition of dental and nursing—

legally qualified by a State to furnish any services included as personal health service benefits under this title shall be qualified to furnish such services as benefits under this title.

And then there is a provision extending this to any group of physicians, but the sense of both of these sections is the same. That is that every qualified doctor is entitled to furnish the services. That is the same in both of these bills.

905 (2), of S. 1161 says:

Every individual entitled to receive as a benefit services from a physician shall be permitted to select from among those designated in paragraph 1 of this section those from whom he shall receive such services, except specialist services, subject to the consent of the practitioner selected; and to change such selection in accordance with such rules and regulations as may be prescribed.

Now, the parallel section in the current bill is 205 (b), and the sense of it is, I submit, substantially the same. I read now from the current bill:

Every individual entitled to receive general medical or general dental benefit shall be permitted to select, from among those designated in subsection (a) of this section, those from whom he shall receive such benefit, subject to the consent of the practitioner or group of practitioners selected, and every such individual and every group of such individuals shall be permitted to make such selection through a representative of his or their own choosing, and to change such selection.

I submit that the sense of the sections which were criticized, which were under consideration by the ABA, is provided in the current subsection, but in order to consider the propriety or the soundness of the ABA criticism it is necessary to look further and to examine the provisions for payment or for compensation of physicians; and so I refer you to section 905 (7), (10), and (11) of S. 1161, which are substantially

duplicated in 205 (g), which is on page 48 of your bill, and (k) and (l). Now, in the old bill, S. 1161, this is what the provision was:

Payments from the trust fund to general medical practitioners for services under this title shall be made (a) on the basis of fees for services rendered to individuals entitled to benefits according to a fee schedule approved by the Surgeon General, or (b) on a per capita basis, the amount being according to the number of individuals entitled to benefits who are on the practitioner's list, or (c) on a salary basis, whole time or part time, or (d) on a combination or modification of these bases, as the Surgeon General may approve; according in each local area as the majority of the general medical practitioners to be paid for such services shall elect, subject to such necessary rules and regulations as may be prescribed.

That was in the old bill. That section was rewritten in the new bill, in 205 (g), and substantially improved. I will read now from 205 (g) on page 48:

Payments from the account to general medical and family practitioners or to general dental practitioners, for services under this part, shall be made (1) on the basis of fees for services rendered to individuals entitled to benefits, according to a fee schedule; (2) on a per capita basis, the amount being according to the number of individuals entitled to benefit who are on the practitioner's list; (3) on a salary basis, whole time or part time; or (4) on a combination or modification of these bases, as the Surgeon General may approve; according in each local area as the majority of the general medical and family practitioners or of the general dental practitioners, respectively, to be paid for such services shall elect:

And the new bill adds this proviso:

*Provided*, That (1) the Surgeon General may also make payments by another method (from among the methods listed in this subsection) to those general medical and family practitioners or to those general dental practitioners who do not elect the method of such majority, especially when in the judgment of the Surgeon General such alternative method of making payments contributes to carrying out the provisions of subsection (f) of this section—

And subsection (f) parallels subsection 6 of 905 in the old bill, and is a general provision that the methods of administration should be designed to insure the best quality care and provide professional incentive and aid in the prevention of disease, disability, and death, and insure adequate service with the greatest economy, consistent with high standards of quality.

Then you should also look at subsection (10) of the old 905 and subsection (11) of 905, which are again duplicated in substance in the new bill.

I am reading now from section 905, subdivision (10), S. 1161, on page 47:

The Surgeon General may prescribe maximum limits to the number of potential beneficiaries for whom a practitioner may undertake to furnish general medical benefits, and such limits may be nationally uniform or may be adapted to take account of relevant factors, as the Surgeon General may determine.

Senator DONNELL. Pardon me, Mr. Linder; would you mind telling us so that we may follow along what are the corresponding sections of S. 1606?

Mr. LINDER. Certainly. That is (j) of 205 on page 50. Shall I read it again?

Senator DONNELL. If you don't mind.

The CHAIRMAN. I might observe that it is very unfortunate that the American Bar Association did not come here prepared to discuss the bill that is now pending. It seems to me that it is going to give us a lot of work, as we are going to have to go back over the other bill

in order to understand his testimony and compare word for word the corresponding sections. We will have to do it, I suppose, but it is unfortunate.

Senator ELLENDER. I don't believe there is much difference in the language, as was pointed out by the witness.

The CHAIRMAN. Why do we not assume that, then, and let him go ahead and discuss the matter from the standpoint of the bill now before us, and not have to wade through all this.

Mr. LINDER. I am only doing this because I was asked to.

The CHAIRMAN. If you insist on it, I am perfectly willing that we stay here all day.

Senator DONNELL. Not at all. I think this is perfectly all right. We shall for the present purposes assume—and this is not a reflection against Mr. Linder, for he no doubt has made a study, but I think all lawyers may differ on what some other lawyer may say—we might assume that they are the same, substantially.

Senator ELLENDER. I understood he wanted to show where the ABA was wrong as to subsection 2 and 5 on pages 14 and 15, respectively, and that is what I would be interested in hearing.

Mr. LINDER. I am doing that now. I am sorry that the meticulous examination of these provisions is necessary, but there is no other way of doing it.

Senator DONNELL. Of course, Mr. Chairman, I think such a meticulous examination would be necessary in order to determine whether or not the criticism made by Mr. Linder is apt and appropriate, but I am perfectly willing to take Mr. Linder's assurance as to his judgment that the sections are substantially the same.

Mr. LINDER. I had no objection to making the analysis, because it gave me an opportunity as well to indicate the extent to which the new bill is an improvement over the old. As in this last subsection (g) of 205, you see what the draftsmen of the bill have done has been to add a very salutary proviso which was not in S. 1161. I think myself that the ABA criticism would be equally applicable to (g) as a whole as it was to the old section, if there was any basis for the criticism to begin with.

Senator DONNELL. But you do not consider that there was any basis for the criticism to begin with.

Mr. LINDER. That is right. That is right. Now, coming to a conclusion of this consideration of methods of payment, section 205 (j), dealing with the present bill, which is the analogue of 905 (10), of S. 1161:

In order to maintain high standards in the quality of services furnished as medical or dental benefit, the Surgeon General may prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish general medical or general dental benefit, and such limits may be nationally uniform or may be adapted to take account of relevant factors.

I think that is a good rewriting of 905 (10).

Next is subdivision (k) of 205.

Senator DONNELL. I want to state, Mr. Chairman, that at the appropriate time I want to ask Mr. Linder a few questions particularly with respect to subdivision (j), which he has been kind enough to read.

Mr. LINDER. Very well; I will be glad to answer them. This is (k) of 205:

In any local area where payment for the services of a general or family practitioner is only on a per capita basis, the Surgeon General shall make per capita payments (subject to limits prescribed in accordance with subsection (j) of this section) on a pro rata basis among the practitioners and groups of practitioners of the local area on the list established pursuant to subsection (e) of this section with respect to those individuals in the local area who, after due notice, have failed to select a general or family practitioner or who having made one or more successive selections have been refused by the practitioner or practitioners selected.

Now, gentlemen, I am sorry to have laboriously plowed through these sections, but there was no other way in which I could adequately deal with the criticism made by the ABA.

It seems to me that the sections that I have just read indicate clearly that there is free choice of physicians for patients, within those practical limits which common sense would necessarily impose.

Senator DONNELL. There are limits, however, are there not?

Mr. LINDER. Surely.

Senator DONNELL. For instance, if you do not mind my interruption, in subdivision (j), section 205, it is prescribed that the Surgeon General may prescribe maximum limits and the number of potential beneficiaries for whom a practitioner may undertake to furnish general medical or general dental benefits.

Mr. LINDER. Yes.

Senator DONNELL. May I complete the question? I would like to have your observation on it. For instance, if the Surgeon General stated, say, that Doctor Jones in Sedalia, Mo., is limited to 50 potential beneficiaries that he may treat, and I happen to live there, and I am No. 51, and I want Doctor Jones, who is my old family physician; but since I am No. 51 I cannot get him under that section of the bill. Am I correct on that or not?

Mr. LINDER. Senator, your assumption is an assumption which I cannot entertain. It is an assumption of so unreasonable a regulation that it would be nugatory and ineffective.

Senator DONNELL. You mean that 50 may be too low?

Mr. LINDER. It may be too low.

Senator DONNELL. Suppose it is 250 and I No. 251; I cannot get the services of Doctor Jones if I happen to be the one next man beyond the 250. Am I correct, or am I not?

Mr. LINDER. I must make an answer in two sections.

Senator DONNELL. Could you make it "yes" or "no" first?

Mr. LINDER. I do not think a "yes" or "no" answer would intelligently give you the information you desire.

Senator DONNELL. Very well.

Mr. LINDER. First of all, (j) only applies to the per capita compensation. It has no application where a per capita arrangement has not been adopted by the doctors. That is the first point that you must understand.

Now, if the majority of the doctors in Sedalia, Mo., decide that they do not want to be paid on a fee basis, that they do not want to be paid on a salary basis, that they want to be paid on a per capita basis; that is to say, that they want to be paid according to the num-

ber of patients they serve, and assuming that they have done so; and assuming, second, that there are 500 people in Sedalia, and that with 500 people to be served and with a limited number of doctors to serve them, and with the doctors having agreed upon by majority vote a per capita basis, then if a regulation is imposed the regulation would have to be reasonable, and if it was not reasonable the doctors or the patients could take it up on review; and if it were reasonable, Senator, where no doctor would take you, and you had been refused by every doctor, then it might be that a reasonable regulation might require you to be assigned to a doctor regardless of your preference or the doctor's preference; but you would have to get that extraordinarily remote situation. That situation would have to apply only in such an unusual case as that before you could have any possible dissatisfaction.

I want to make this complete answer, if I may, because if I make a complete answer I think that my whole point of view will be clearly apparent.

The scheme of this bill, as set forth in the sections which I have read, is that all the doctors in Sedalia, Mo., have a right to treat patients within the system if they want to. If they do not want to, they are not compelled to do so. If they prefer to treat only the wealthier people in the community who can pay them more substantial fees commensurate with what they regard to be the value of their services, they need not serve the people taken care of here. That is No. 1.

No. 2, every person in Sedalia, Mo., who is covered has a choice of going to any doctor on the list, and every doctor who wants to be and is qualified under the laws of the State of Missouri is entitled to be on the list.

How is the doctor to be paid? The doctor is to be paid according to the vote of the majority of the doctors in Sedalia. The majority can decide whether they want to be paid according to a fee schedule. They can decide that they want to be paid on a salary basis. They can decide that they want to be paid on a per capita basis. They can decide that they want to be paid on a combination of these.

It seems to me that our belief in democracy ought to extend to our belief in applying democratic principles to the doctors as well. If the doctors understand that the people in Sedalia, Mo., cannot get adequate medical care unless the costs of medical care are insured, then it would seem to me again that the doctors in Sedalia, Mo., ought to recommend this arrangement, because here for the first time the patients are sure of service and here for the first time the doctor is sure of his fee.

Now, the only difference in the relationship between the doctor and the patient provided here is that the doctor instead of saying to his patient after he has finished his ministrations, "My fee is so many dollars"; the doctor says, "I have noted the service given." And he then is paid by the Government.

Now, if I should break a leg and under my policy after my doctor has treated me I should ask my doctor to send his bill to the insurance company, I would not think he was being socialized, and most doctors would be entirely satisfied, too.

All that this bill does is that it insures everybody in the way that I am now insured when I personally buy private insurance, which I can afford to buy, but which many people cannot.

What is involved here is essentially an extension of the principles of workmen's compensation. It would be preposterous to suggest that workmen's compensation is socialized medicine or involves bureaucratic interference with the rights and privileges of freemen; because we all understand that workmen's compensation creates a situation that when a worker is injured he gets the attention he needs.

Senator ELLENDER. May I ask a question? I must leave in a few minutes. I tried to develop this point with Mr. Altmeyer yesterday, and if I understood him correctly, he agrees with the ABA in that there is not complete freedom of choice of doctors by patients as quoted here by you on page 14 and attributed to Senator Wagner. The reason being that in order for one to be able to get his or her family physician, the family physician must be on the accredited list of physicians as certified to by Washington.

Mr. LINDER. Not at all.

Senator ELLENDER. Yes, he must.

Mr. LINDER. Senator—

Senator ELLENDER. Wait a minute, now. On page 46 of the bill it is stated in subdivision (e) of section 205.

Mr. LINDER. I have it.

Senator ELLENDER (reading) :

The Surgeon General shall publish and otherwise make known in each local area to individuals entitled to benefit under this title the names of medical and dental practitioners and groups of practitioners who have agreed to furnish services as benefits under this title and to make such lists of names readily available to individuals entitled to benefits under this title.

Now, if in my community there are 25 doctors and only 10 comply with this section, what would happen to the remaining doctors? Could they service patients who pay into the fund?

Mr. LINDER. Only 10 legally qualified?

Senator ELLENDER. No, not legally qualified. I am assuming that the 25 are legally qualified to practice.

Mr. LINDER. But only 10 have agreed to serve?

Senator ELLENDER. Yes, only 10 have agreed to comply with subsection (e). As I understand it, those 10 would be put on a list and the rest of them, 15 in number, would be left out. If my family physician is among the 15, then I cannot call him?

Mr. LINDER. Sure you can.

Senator ELLENDER. Unless I pay for his services?

Mr. LINDER. That is right.

Senator ELLENDER. Surely. I would pay twice.

Mr. LINDER. You can still call him, can you not?

Senator ELLENDER. Yes; but I have got to pay for it separately; that is, in addition to the deductions made from my salary.

Senator DONNELL. In addition to the fact that he would have been charged the other taxation on the plan.

Mr. LINDER. What about a public-school system? If you do not want to send your child to a public school you do not have to, but you have to pay for it.

Senator ELLENDER. I understand.

Mr. LINDER. That is the same point.

Senator ELLENDER. No, it is not. You say that the ABA is wrong in its conclusion. I say that you are wrong. I wish I had time to stay and argue it out with you.

Mr. LINDER. I am sorry that you do not have the time.

Senator ELLENDER. I must leave.

Senator DONNELL. Mr. Chairman, without any criticism of Mr. Linder, because I can see his concern and his interest in this matter and his desire to elucidate his theories, the question I asked him could be answered "Yes" or "No" with an explanation; and I dare say that if Mr. Linder had a witness on the stand and he asked him that question he would insist on the question being answered "Yes" or "No."

Mr. LINDER. What is the question?

The CHAIRMAN. What is the question?

Senator DONNELL. The question was, as nearly as I recall, if I live in Sedalia, Mo., which I do not, but if I live in Sedalia, Mo.—and here I am going to change that so as to get the name of my home town in. If I live in Webster Groves, Mo., which is one of the charming and delightful suburbs of the city of St. Louis, if I live there and my doctor is Dr. Jones, under the present situation I have a right to request him to serve me, and if he is willing he has no restrictions in so doing. Is that correct?

Mr. LINDER. Right.

Senator DONNELL. Under the provisions of this subsection of section 205, S. 1606, as I understand it, and I am quoting:

The Surgeon General may prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish general medical or general dental benefit.

That is correct, is it not?

Mr. LINDER. That is right.

Senator DONNELL. We will assume, therefore, that the Surgeon General says that in Webster Groves, Mo., no doctor may take more than 250 patients.

Mr. LINDER. You are assuming now that the doctors have agreed on the per capita basis.

Senator DONNELL. Yes, sir. Assume they have agreed on that.

Mr. LINDER. All right.

Senator DONNELL. And after they have assumed it they have therefore come under the operation of the bill, which they can do or not do. Am I right?

Mr. LINDER. That is right.

Senator DONNELL. Say they do in Webster Groves, Mo.—because of what was pointed out here yesterday, the fact that this may increase their income, which is entirely proper for them to take into their minds—they do agree on accepting the terms of the bill; and there is a limitation placed so that Dr. Jones may take only 250 patients. My question, as nearly as I can recall it was, assuming all these facts, that in the city of Webster Groves the doctors by majority vote have decided Dr. Jones can have only 250 patients, and that majority vote is taken as part of the system of S. 1606, and Dr. Jones, who is my close and intimate friend and personal physician, finds himself limited to 250 patients; and I walk into his office with a high fever. I am therefore No. 251.

Mr. LINDER. Why are you 251. Why are you not in the 250?

Senator DONNELL. The 250 have been there before me.

Mr. LINDER. I see.

Senator DONNELL. There are 250 on the list before me, and I walk in as 251. Dr. Jones cannot, as I read this section, treat me regardless of the extremity under which I may be.

Mr. LINDER. I think that is a normal procedure.

Senator DONNELL. The question is, am I correct or not correct in my understanding? I think that the witness can answer that "Yes" or "No."

Mr. LINDER. The answer is "Yes."

Senator DONNELL. I am correct.

Mr. LINDER. Yes.

Senator DONNELL. What is your explanation?

Mr. LINDER. I say the answer is "Yes"; and I do not think that is any more terrible than if you went to your doctor and he were busy delivering a baby and he said, "I cannot take care of you; I am busy." The point is that common sense imposes reasonable restrictions. If it were reasonable that in Webster Groves there should only be 250 patients for 1 doctor, and if you had not diligently notified the doctor that you wanted to be one of his 250, that, as I understand it, is your misfortune, just one of the trifling incidents of operating a system of medical care. The thing I want to make clear, Senator, is that you must never forget subdivision (g) of section 203 of the act.

Senator DONNELL. Now, Mr. Chairman, it would be a little difficult for me to be carrying around this act with me all the time.

Mr. LINDER. You have to pass on it.

Senator DONNELL. Mr. Chairman, I doubt very much if I could prevent my fever from rising to a very high point if I did.

Mr. LINDER. Now, subdivision (g) of section 203—

Senator DONNELL. Wait a minute; subdivision (g) runs from line 9 down through line 25, and 17 more lines on 49.

Mr. LINDER. You have got the wrong (g).

Senator DONNELL. Oh, I have.

Mr. LINDER. Page 38.

Senator DONNELL. If I were, in a hurry and had a bad fever it might cause me a little difficulty to find (g).

Mr. LINDER. Page 38.

Senator DONNELL. That is only 15 lines. Go ahead.

Mr. LINDER. Subdivision (g) of section 203:

The Surgeon General, after consultation with the Board, and after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, shall prescribe and publish such rules and regulations and require such records and reports, not inconsistent with other provisions of this act, as may be necessary to the efficient administration of this title.

And then there is a proviso that is not pertinent to what I am going to say.

The sense of that section is that all regulations must be reasonable. All regulations must be designed within the spirit of the act. All regulations must be designed to carry into effect subdivision (f) of section 205, which says that the methods of administration shall insure the prompt and efficient care of individuals entitled to personal health service benefits, promote personal relationships between physi-

cian and patient, provide professional and financial incentives for the professional advancement of practitioners, and so on.

The point is that you must not assume an unreasonable regulation and then beat this legislation with the stick of that unreasonable assumption.

Senator DONNELL. In the first place, I do not think the regulation I assumed was unreasonable within the four corners of this bill. You have to have some figure provided under subdivision (j) of section 205. I have selected a figure.

Mr. LINDER. Which is unreasonable.

Senator DONNELL. If you think it is, tell me why it is.

The CHAIRMAN. Assuming that it is reasonable, would there be anything unreasonable in the Surgeon General's permitting him to take one more patient? Would that not be a reasonable thing to assume, if he insisted on having that doctor, that the Surgeon General would say, "All right; you may have that doctor."

Mr. LINDER. Of course.

Senator DONNELL. So far as I have observed the bill does not say that.

The CHAIRMAN. I know.

Senator DONNELL. May I state this: I do not want to have a prolonged argument, because we will have to settle all these things, but I would like to get Mr. Linder's ideas. This says that the Surgeon General may prescribe these maximum limits of potential beneficiaries, which is the maximum number of patients, which maximum limits may be nationally uniform or may be adapted to take account of relevant factors.

Mr. LINDER. That is right.

Senator DONNELL. The point I am making is that the Surgeon General has a right to make a limit beyond which Dr. Jones, after this majority vote of the doctors in Webster Groves, cannot go.

Mr. LINDER. May I interrupt a moment?

Senator DONNELL. If I may finish, please. Point No. 2: I realize what Mr. Linder has expressed as regards the reasonableness of regulations, and yet there is not a man, woman, or child, if there be any in this room this morning, that has not heard of unreasonable regulations in the administration of bureaucratic affairs in our Government.

Mr. LINDER. That is what the courts are for.

Senator DONNELL. I do not want to go to court.

Mr. LINDER. Why not?

Senator DONNELL. If I had a fever.

Mr. LINDER. What would you do if you had a fever and could not get a doctor?

Senator DONNELL. And I want to submit this, because we must stop, and I must not take more than my fair share of the time. I want to say two things; First, that to my mind there is an exceedingly unreasonable policy in allowing the majority of doctors in the city of Webster, Groves, Mo., to put it in the power of any individual board or combination of boards to say how many patients Dr. Jones on Gore Avenue can take; and I say there is strong reason and view that Dr. Jones should not be restricted in determining the persons whom he will serve. Nor should the patient, perhaps in extreme cases,

like emergencies, be required to rely on some regulation in Washington, perhaps even having to go to court to enforce his rights, as Mr. Linder indicates.

I do not want to go further or interfere with Mr. Linder's testimony at this point, though I do have quite a number of questions to ask him later.

Mr. LINDER. There are a whole series of answers to the point you have made.

Point No. 1 is that you cannot quarrel in our system with the necessity for regulation. You cannot quarrel with the necessity for reasonable regulation.

The CHAIRMAN. I was going to make that point.

Mr. LINDER. There must be a maximum limitation on the number of patients to be served by doctors, or otherwise you would have a situation where the doctors would be overburdened and the patients could not get decent service.

Senator DONNELL. Is there any such limitation now under the law of our country as to the number of patients the doctor may take? Is that not left to the good judgment of the doctor himself; and has not our spirit of American enterprise and personal adjustment found it necessary to leave that to Dr. Jones rather than somebody in Washington?

Mr. LINDER. First of all, the doctors and people in Webster Groves would for all practical purposes determine the situation. There are a whole series of specific provisions providing for local areas and their administration, so the suggestion that this is something that the Surgeon General will be soothing your fevered brow in Webster Groves is fantastic, with all due respect, Senator. Only the doctor in Webster Groves could take care of you. And it makes sense also that in Webster Groves reasonable limitations should be placed upon the number of patients any one doctor should take care of.

#### FINANCIAL NEED FOR MEDICAL CARE

It seems to me, Senator, that you must approach the whole question from this standpoint. I do not know anything about Webster Groves, but assuming that it is a community in which there are poor people and people of small income; the fact is that the majority of the people of small income and medium-sized income in the United States are not in a position to meet the costs of medical care when a catastrophe occurs. The fact is that one-third of the people of the country do not get any medical care, if our own Government reports are to be believed.

Senator DONNELL. May I ask the witness at that point, Mr. Chairman: You are relying, are you not, Mr. Linder, on a statement printed in 1939 based on studies of the committee on the costs of medical care made in 1929, 1930, and 1931?

Mr. LINDER. Yes.

Senator DONNELL. And on the national health survey made in 1935, just as our Nation was returning from the conditions of depression and financial difficulty?

Mr. LINDER. I am also relying—

Senator DONNELL. You are relying primarily on those sources?

Mr. LINDER. That is just one of the sources. Look at page 2 of our report on the National Health Act. You will find a whole series of documented sources carefully referred to which indicate the bases for our conclusion that there is an absolute need for medical care in our country.

Senator DONNELL. Where is that, page 2?

Mr. LINDER. I beg your pardon. Page 1, footnote 5. There is a whole series of references; and also footnote 7 on page 2.

Senator DONNELL. Footnote 5 on page 1, as I read it, does not pertain to the subject matter we are talking about.

Mr. LINDER. Yes.

Senator DONNELL. It tells the number of persons disabled, by sickness, and the period for which they are disabled, and those in the labor force.

Mr. LINDER. I would like to call your attention to this, Senator, that appears on the top of page 2.

Senator DONNELL. Where is there any relevancy of footnote 5 to the point we are discussing?

Mr. LINDER. The applicability of footnote 5 is that it indicates the enormous amount of sickness in our country.

Senator DONNELL. That is not the point at issue. The question is: What porportion of the people have medical care? The question is not how many are sick.

Mr. LINDER. I would like to call your attention to this, the American Medical Association, in a report entitled "Factual Data on Medical Economics," published in 1939.

Senator DONNELL. 1939?

Mr. LINDER. Yes. It declares that aside from the indigent, families earning up to \$3,000 a year are unable to meet the cost of major sickness and need some measure of assistance. I submit, Senator, that even today probably three-quarters of the people in the United States of America do not earn over \$3,000 a year.

Senator DONNELL. Pardon me, Mr. Linder. The statement of 1939 to which you referred is based, is it not, on the studies of the committee on the cost of medical care made in 1929, 1930, and 1931, and on the national health survey made in 1935, as our Nation was emerging from depression; is that not true?

Mr. LINDER. Senator, I think you are in error in the assumption in your question. The footnote 8 on page 2 gives the authority for the AMA publication, as a publication which was published in 1939.

But I have no desire to get off into what seems to me to be a tangential discussion as to whether we are more prosperous today or less prosperous today and as to whether more people can afford medical care or less. It seems to me undeniable that the cost of catastrophic illness cannot be borne by the overwhelming majority of the people of our country.

Senator, you have no difficulty, I am sure, in appreciating that fact that if a worker earning \$50 or \$60 or \$70 a week, with a wife and a few children, should develop anything as serious as an appendicitis operation or should break his leg, something which would cost him a few hundred dollars, that such a situation would seriously disadvantage him. I am sure that you have no difficulty in appreciating the fact that, according to Senator Pepper's committee, 10,000,000 people in

the country earn less than 40 cents an hour today at prosperity levels.

Senator DONNELL. Mr. Chairman, may I say I have no doubt as to the seriousness of a situation to which the witness refers in any individual instance. I think it is a problem that should be dealt with, but the question that we now have is whether or not it should be dealt with by voluntary methods such as Blue Cross, in which, according to Mr. Martin, who testified today, there are today 21,000,000 people availing themselves of the system, when Blue Cross is considered technically, as to bodies which call themselves Blue Cross; and some 40,000,000 people, I believe he said, if you take in all voluntary insurance. Further, there is a question as to whether it should be done by Federal or State act; and, further, whether it should be done by a type of regimentation which tells the doctors of the country: "It is to your financial advantage to come in under the system. If you come in, it is going to be left to the vote of the particular majority as to whether or not a limitation shall be placed on you." Also, there is the system under which the Surgeon General can say to any given doctor how many patients he may take.

It is not a question, Mr. Chairman, as I see it, primarily as to whether there is a serious situation in any family. It is a serious situation with me if I have a sort of thing like that happen. But that is not the primary question, though it is of high importance, of course.

I do say, assuming that to be true, which of course it is true, then is this a proper way to solve the problem?

Mr. LINDER. That is why I say we were getting off into a tangent.

Senator DONNELL. I do not think it is so much of a tangent, because he was laying down categorically the proposition that not more than one-third of the people today can have medical care.

Mr. LINDER. I did not say that.

Senator DONNELL. If I have misquoted you I am in error.

Mr. LINDER. I said that one-third of the people received nothing at all.

Senator DONNELL. All right. No medical care. The point or the query that I made was whether or not that study was based on studies of the committee on the costs of medical care made in 1929, 1930, and 1931, 15 years ago, and on the national health survey made in 1935, as the country was coming out of the depression, rather than on up-to-date 1946 figures.

Mr. LINDER. Assuming the answer to that question is "yes," it would make no difference, because we know today that the amount of poverty and destitution and malnutrition and disease in the country is stupendous. We know today that there are 10,000,000 families in the country who earn less than 40 cents an hour, or who earn not more than 40 cents an hour. I say that there are millions of Americans who cannot afford medical care and who are deprived of medical care; and I say that the scandal of that situation requires the Senate of the country to take some action.

#### VOLUNTARY INSURANCE IS NOT ADEQUATE

Now, the question is, what kind of action? You say, "What about private insurance?" It seems to me it would be obvious that voluntary insurance is an evasion; and if you insist that the need exists, that the problem is serious, and we have to do something, but you want

to let it be done by voluntary insurance—if we do that it seems to me that you are evading your responsibilities to the people of the country. It will never be done by voluntary insurance. It is too expensive. It is more expensive than the poor people can afford to pay. It is too restrictive. No voluntary insurance system in the country compares or could compare with the coverage and with the benefits provided by this system. It seems to me that you have either got to say honestly: “I do not care whether this need is going to be covered or not. If millions of people die, it is too bad. It is all in the spirit of free enterprise.” Or you say: “This is a situation which cannot be solved without a system of social insurance which is genuinely designed to meet the need.”

Now, to say, “Let the States do it.” We know perfectly well that it would take years and years for the States to do it. I am a citizen of the State of New York, and Governor Dewey has been appointing commissions year after year to study; and I think they will still be studying when I am ready to pass on, because after they study they come in with a report with 14 different opinions, and we still have no system of health insurance in the State of New York, and I doubt if we will have one.

President Truman was correct when he said, “If we were to rely on State-by-State action many years would elapse.”

It seems to me you must say: “We do not want to do anything about it, and we want to cover up the evasion of the problem by leaving it to the States.” Or else you will say, “We have to do something about it.”

Now, I appreciate, and I do so with the fullest humility, that there are many dangers involved in any system of Government regulations; but I say that we have no choice. I say that if there are any poor people in Webster Groves who today go without any medical care at all because they have not got the money to pay for it, I would rather have a system that gives them that, with the attendant danger and disadvantages, than to have no medical care at all.

The CHAIRMAN. Right there, is not this right to select somewhat overexaggerated? I know a case from my State of Montana where a member of my family traveled to Baltimore to be operated on by a well-known physician. When she got there, she found out she could not have his services and was operated on by a total stranger and was entirely satisfied in every respect. I think there is gross exaggeration there.

Mr. LINDER. I think so, too.

The CHAIRMAN. And I think in the Army the boys did not select the surgeons that operated on them over in the battlefields, and they were treated pretty well.

Mr. LINDER. They got better medical care than most of them had got in their lives.

The CHAIRMAN. That is right. They were benefited in health in every way.

#### NO FREEDOM OF CHOICE TODAY

Mr. LINDER. I think the whole subject of free choice of doctors is an exaggerated, hysterical bugaboo that has no real relationship to reality. The truth of the matter is that our choice of doctors is restricted. It is restricted by the number of doctors available. It is

restricted by the amount of money we have got. It is restricted by the willingness and the ability of the doctors to take us on. It is restricted by many, many different factors.

Senator DONNELL. But not by any governmental prohibition against his taking the case.

Mr. LINDER. So what?

Senator DONNELL. There is a very great difference between restriction by governmental prohibition against a doctor taking on a case, and an economic and professional situation which makes it impossible for him to do so.

The one point is governmental discipline, direct compulsion, while the other is a situation which arises under the operation of natural forces uninfluenced by governmental regimentation.

Mr. LINDER. Senator, if you had a violent bellyache, and you had no doctor except the public-health surgeon, you would be tickled to death and thank God for the public surgeon.

Senator DONNELL. But if, on the other hand, I had a choice between the public-health surgeon, whom I do not know, and Dr. Jones, of Webster Groves, whom I do know, I would want Dr. Jones to treat me.

Mr. LINDER. And there is nothing in the bill which prohibits Dr. Jones from treating you.

The CHAIRMAN. It seems to me that we are living in a democracy. We are living in a democracy, and if the majority of the people want some sort of national health insurance which will enable them to have access to modern medical care, I think they should be able to have it, regardless of the fact that a few people make carping criticisms and objections.

You could oppose every beneficial measure ever enacted by Congress for the welfare of the people if you wanted to be technical. I do not think any law is absolutely perfect or could be justified 100 percent. It is the general benefit involved.

I would like to ask Mr. Watson Miller to make an observation. He has been a witness here.

Mr. MILLER. I have been very much interested in this colloquy, and I do not desire to gild the lily or paint the rose. I very much appreciate the spirit of democracy, the Senator's good humor, and his self-control and interest. It seems to me that the 250 people we are talking about could be defined in such a manner as this—that that represents a figure of not necessarily individuals. For instance, I might want a doctor as a surgeon but not in obstetric work. It could be elastic in that system being discussed here indicated in this colloquy.

Senator DONNELL. I would like to thank Mr. Miller for his very kind expression toward me, and I assume toward Mr. Linder, also. We realize this is not a personal matter, but one in which we are all concerned.

Mr. MILLER. In that expression, I did not mean to be trite. It was deeply felt.

Senator DONNELL. I appreciate it very much. I am sure it was.

The CHAIRMAN. This is democracy in action here.

Senator DONNELL. Yes.

Mr. LINDER. I would like to summarize my analysis of the items which I quoted from the ABA report.

Senator DONNELL. Pardon me. Is this in your report that I followed?

Mr. LINDER. Yes. If you will turn to the medical case provisions report, which is not the recent report, but the older one. I want to expatiate on material on page 5.

Senator DONNELL. In addition to the fact that he should have been

Mr. LINDER. In the second column.

The statement is made by the ABA that—

The measure will subject to bureaucratic control and supervision the intimate and confidential relationship between doctor and patient.

Also, that the freedom of choice of doctors and patients will be impaired and that it would seriously disturb existing relationships between doctor and patient.

#### RELATIONSHIP BETWEEN DOCTOR AND PATIENT

On the contrary, the fact is that there will be no interference between normal relationship between doctor and patient. Every person insured under the act will have the absolute right, within the framework, of choice, subject to the right of the physician to refuse to accept the patient and the patient to choose the doctor who may treat him. That is provided for in section 205 (b). The choice will be no more limited than it is now. No doctor is compelled to render services under the act, and no doctor is compelled to accept any person as a patient whom he does not wish to treat.

Of course, any physician who does not wish to treat patients under the insurance system may continue his private practice; and private practice may also be combined with practice under the system.

This choice remains unimpaired. When an insured person is refused by a physician, he has the right to make another choice, and, of course, subject to routine regulations, will have the right to change physicians.

Senator DONNELL. Who makes those "routine regulations" subject to which he has the right to change?

Mr. LINDER. I should say the local area doctors, subject to the decision of the Surgeon General, and his regulations must be reasonable.

Senator DONNELL. But the right to change physicians is, as you say, subject to regulations made by these authorities?

Mr. LINDER. Of course. Senator, there are people who are crazy, who run from one doctor to another. If a patient ran from 1 doctor to 15, and you were the Surgeon General, and you imposed a regulation that a patient could not see more than 20 doctors for the same ailment within 2 days, you would not think that was bureaucratic regimentation.

Senator DONNELL. May I ask the witness, Mr. Chairman: Who does he think is best qualified to determine whether or not a change shall be made, the Surgeon General in Washington or William Smith in Sedalia, Mo.?

Mr. LINDER. William Smith.

Senator DONNELL. William Smith does not think he is crazy. Maybe he is, but he wants to change; but in order to make the change he is subject to routine regulations made by the doctors which must come to Washington for approval, so that the ultimate power is in the

Surgeon General here to determine whether William Smith can or cannot go across the street to get another doctor.

Mr. LINDER. I say that you cannot assume an unreasonable regulation and then beat the act with that. You must assume a reasonable regulation.

The CHAIRMAN. I prefer to let the witness answer the question completely and give a very clear statement.

Senator DONNELL. Mr. Chairman, I want to ask you to pardon me, as well as the witness.

The CHAIRMAN. I am glad to have you ask these questions, Senator. You always ask very intelligent questions, and you are very helpful to the committee, and I am glad to have everything brought out here. I am sure that you know that I welcome you to question any witness to the fullest extent.

Senator DONNELL. I realize that, and appreciate the courtesy of the chairman, and I should not have interrupted the witness. I have no desire to interrupt him, and I appreciate the good humor of the chairman in his suggestion to me.

The CHAIRMAN. Very well.

Mr. LINDER. Senator, you must assume a reasonable regulation. If you assume an unreasonable regulation you assume a regulation which could be, upon review by the courts, declared invalid. So if you assume with me a reasonable regulation, then you cannot reasonably be dissatisfied with it. May I continue?

The CHAIRMAN. Yes.

Senator DONNELL. Mr. Chairman, I think that I may say that silence does not mean consent.

The CHAIRMAN. Go ahead with your statement.

Mr. LINDER. Even today patients meet with obstacles in changing physicians during treatment.

Mr. CHAIRMAN. I must explain that I request permission to read something which is on file only because I think I can do two things in reading it. I can correlate the criticisms of the act, and I can make it possible to get inquiries and cross-examination with respect to particular sentences.

Dire objectionable result is foreseen by repeated emphasis, and I must say, if I may, that the Senator has by repeated emphasis justified this very program.

Senator DONNELL. This dire objectionable result.

Mr. LINDER. From the provisions that the Surgeon General will have the right to allocate among the doctors in an area those patients who have not made a selection of a physician, and to prescribe the maximum number of insured persons who may be on a doctor's list. It is asserted that these provisions nullify the freedom of choice between doctor and patient and compel doctors to treat patients whom they do not wish to treat; and compel patients to be treated by doctors by whom they do not wish to be treated.

I think that it is a fair statement of your observations, is it not, Senator?

Senator DONNELL. Yes; I should say so, with some differences.

Mr. LINDER. There is a complete lack of justification for those assumptions.

Among the methods of payment which the physicians in any area may themselves select by the democratic procedure of a majority vote

as to the method under which they will be paid for rendering services to insured persons under the act is the per capita method of payment. Under that system every doctor is paid a certain amount periodically for every insured person who has selected him as his physician, whether or not that person requires any treatment. In turn, the physician is obligated to render treatment to every such person who has selected him and whom he accepts as a prospective patient. Thus the physician is paid per capita for every insured person on his list.

Senator DONNELL. That sentence—

In turn, the physician is obligated to render treatment to every such person who has selected him, and whom he accepts as a prospective patient—

that should be modified by the provisions of subdivision (j) which permit the Surgeon General to prescribe maximum limits?

Mr. LINDER. Yes. I am going to discuss precisely that in a few minutes. But the Senator does agree that we are only talking about the situation where the doctors want a per capita method. This has nothing to do with the situation where the majority of the doctors want to be paid on a fee basis. We are only talking about a capitation method.

Of course, the act provides that physicians may choose other methods, any or all of the three methods.

Obviously, in an area where physicians have decided that they wish to render services on a per capita basis it is important to assure (1) that the doctors in the area receive payment for all the insured persons in that area, those who have selected a physician as well as those who have not, because with this particular method of payment the aggregate amount of the doctor's income properly depends upon their being paid for all such persons; (2) that all insured persons who have been rejected by doctors and who have not made another selection or who have been unable to find a doctor who will accept them be assigned to some doctor so that they may receive care when necessary.

Senator DONNELL. Mr. Chairman, may I ask a question? Mr. Linder, under the bill you assign a given person to a given doctor?

Mr. LINDER. When an insured person has been refused by doctors and is unable to find any doctor under this bill, the apparatus is created by the Surgeon General, which would presumably be the men in the local area administration, in Webster Groves, who would make the assignment. You would not reasonably assume that the Surgeon General would run to Webster Groves to make the assignment. The local area at Webster Groves would make the assignment.

Senator DONNELL. It is a governmental official who makes the assignment?

Mr. LINDER. That is for these people who have been refused by all the doctors.

Senator DONNELL. That is going to mean that you are going to have governmental representatives all over the United States.

Mr. LINDER. There is no question about it.

Senator DONNELL. Yes.

Mr. LINDER. In the same way we have them all over for the old-age security. The same way we have for price control, and for many other things.

Senator DONNELL. I might suggest that a good many people think we have enough on the question of price control, and that there should

be some change. My question is, Has there been any estimate made as to how many new governmental situations would be created to handle this job of making assignments of doctors to individuals?

Mr. LINDER. I have no idea, but whatever number are needed to do the beneficent purposes of this act are not too many.

Senator DONNELL. So if the man in Webster Groves needs one he will not have to go 15 miles?

Mr. LINDER. That is right.

Senator DONNELL. So you would have to have them in great profusion.

Mr. LINDER. As many as are necessary. If you were the administrator and were acting under the act, as many as you would think necessary.

A doctor shall not accept on his list such a large number of persons as not to be able to render service to them, for it is obvious that if a physician accepts 5,000 insured persons on his list, he cannot render adequate service to all.

It is also reasonable that the physician should not undertake to treat more persons than he can treat adequately. Accordingly, the Surgeon General is given authority to limit the number of persons which any doctor may have on his list.

He also is given authority, but only in those areas in which the per capita system of payment is chosen by the doctors, to allocate pro rata persons who after due notice have not made a selection of physicians and those who having made a selection have been refused.

Senator DONNELL. May I ask a question right there, Mr. Chairman? He says that the Surgeon General is given authority, but only in those areas in which the per capita system of payment is chosen by the doctors, to "allocate pro rata persons who after due notice have not made a selection of physicians," et cetera.

Mr. LINDER. Or having made a selection have been refused.

Senator DONNELL. I would like to take that up first, though. So that if in Webster Groves 4,000 people have not made a selection of physicians—

Mr. LINDER. And they have been refused.

Senator DONNELL. I understand there are two categories.

Mr. LINDER. Yes.

Senator DONNELL. Those who after due notice have not made a selection and those who have made a selection and have been refused.

Mr. LINDER. Yes.

Senator DONNELL. My question is confined to those who have not made a selection. Say 4,000 people in the city of Webster Groves, who after due notice have not made a selection, I understand from this that the Surgeon General is given authority to allocate to those 4,000 persons the individual physicians who shall individually treat each one of those 4,000 persons. So that the Surgeon General may say to me, "You are to be treated by Dr. William Jamison." And he may say to Mr. Linder, if he were to move to Webster Groves, "You will have to take Dr. Miller." And the Surgeon General has the right to make that system of designation.

Mr. LINDER. The answer is "Yes," with this explanation: That whenever the act says the words, "Surgeon General," and whenever the report refers to the words "Surgeon General," it means the Surgeon General and all persons delegated by him. It makes obvious

sense that the Surgeon General at Washington does not do the allocating. It means someone at Webster Groves does the allocating.

Secondly, there is no reason for anybody to be horrified if they do not make a selection that they should be assigned. Remember, we assume that the doctors in Webster Groves have decided that they want to be paid per capita. That means that all the people have to be divided between the doctors available. Many people make a choice. A lot of people do not make a choice. Say that 3,000 do, and 1,000 do not. What happens to the 1,000? Shall we forget about them? The doctors depend on the allocation of all the rest, so they do not want to forget about them. What conceivable objection is there in all sense of fairness to allocating them among the doctors? Say a man might prefer Dr. Miller, but he has not made any choice. Dr. Miller wants his list, on the basis of which he gets payment, as large as possible within the limits. It makes sense that the local authority should make an allocation. What is the objection?

Senator DONNELL. The fact is that a governmental official determines it.

Mr. LINDER. So what?

Senator DONNELL. The governmental official determines, as to the person who does not make the selection, who shall treat that individual, and if an emergency shall arise even though he may prefer some other doctor he must go to the one designated.

Mr. LINDER. That is right; but there is nothing horrifying in that. You are assuming someone who did not care. If he did not care why should he object? I do not follow the difficulty.

Senator DONNELL. Regardless of whether it is injurious, the fact is that the governmental official does the designating.

Mr. LINDER. That is right.

Senator DONNELL. Not the Surgeon General, although the language used does say "he," referring to the Surgeon General; but I assume that he would act through an agent; but a governmental official will make that selection. That is correct, is it not?

Mr. LINDER. That is right. For those persons who have not selected a doctor. And this is a point that must be borne in mind: The allocation and practice is of dollars, not of patients. You are worrying about people being assigned. This is a financial distribution. The doctor is going to be hurt if we do not make the assignment. This is to insure the doctors all the money they are entitled to.

Senator DONNELL. I am unable to agree as to the meaning of that sentence.

Mr. LINDER. Let me explain.

Senator DONNELL. The sentence says:

For those persons who have not selected a doctor the allocation and practice is of dollars, not of patients.

I say that the allocation is of patients, and the physician's compensation is determined by the number of such patients, but the allocation is not merely dollars but one of patients given individually by names. Is that correct?

Mr. LINDER. Yes. Let me make this assumption: Assume that there are 5,000 people. That is perhaps a fantastic hypothesis on my part. Assume that the doctors in an area decide they want to be paid on a per capita basis, and that the per capita basis should be \$50 a person

for a year. The figures, of course, may be ridiculous. But just for the sake of understanding, let me assume that \$50 for the per capita amount.

Senator DONNELL. If I may interrupt. That is widely divergent, is it not? I call your attention to the fact that in Great Britain the doctor is allowed 2,000 to 2,500 patients at 9 shillings a year.

Mr. LINDER. In England they get along on much less than they do in the United States.

The CHAIRMAN. It is a very much lower scale.

Mr. LINDER. A very much lower scale of living.

Senator DONNELL. Mr. Chairman, what is your idea about our lunch?

Mr. LINDER. May I have 5 minutes to conclude?

Senator DONNELL. Mr. Chairman, I regret that it will be impossible for me to complete my examination of Mr. Linder in 5 minutes.

The CHAIRMAN. Could you come back this afternoon?

Mr. LINDER. I would like to make the Congressional.

The CHAIRMAN. We can come back at 2 o'clock.

Mr. LINDER. Fine.

(Whereupon, at 12:55 p. m., April 5, 1946, the committee adjourned, to meet at 2 p. m., April 5, 1946.)

#### AFTERNOON SESSION

(The committee resumed at 2 p. m., pursuant to recess.)

The CHAIRMAN. Very well, we will go ahead.

Mr. LINDER. I think that I should leave the subject which was under discussion this morning and go to another subject, and if there are any questions to be directed with respect to me to that matter, they can be reserved until I finish the whole statement.

Senator DONNELL. I think Mr. Linder is here to testify, and I would like to have the benefit of examining and cross-examining him.

The CHAIRMAN. I will tell you what you do, you may be able to come back here some time later, the hearings will be going on for a month or 6 weeks; in the meantime, you may go and catch your train because you have prior engagements and we did not tell you that we would hold you any longer. It would be unfair for me to have you miss your appointments.

Mr. LINDER. If necessary, I would be glad to come back.

Senator DONNELL. You can give us the time this afternoon, with the exception of your long-distance calls, up until about 3:30, or should you have to leave by 3?

Mr. LINDER. I should like to leave at 3.

Senator DONNELL. With that understanding, we will proceed.

Mr. LINDER. The American Bar Association report at the very end of it, under "Conclusions," contains a number of sentences that I think require comment. That is on page 18 of the American Bar Association report. [Reading:]

The bill fails to safeguard the rights of patients, citizens, hospitals, or doctors, with respect to disputes arising or rights denied through the arbitrary or capricious action of one man.

Five. The bill fails to provide for any appeal to any court from the action of the Surgeon General.

Six. The vicious system whereby administrative officials judge without court review the actions of their subordinates in carrying out orders issued to them is extended in this bill to a point foreign to our system of government, and incompatible with the adequate protection of the liberties of the people.

I submit that these conclusions are completely unwarranted and that they are refuted by the explicit provision not only of the present bill, but of the very bill which was under consideration by the American Bar Association report.

The administration of the system set up by the bill is provided in section 203 of the present bill, and if the committee will refer to that, the committee will find subsection (a) of section 203 provides:

The Surgeon General of the Public Health Service shall perform the duties imposed upon him by this Act, under the supervision and direction of the Federal Security Administrator, and after consultations with the Advisory Council (hereinafter established) as to questions of general policy and administration—

et cetera.

Subsection (c) provides that—

In carrying out the duties imposed upon him by this title, the Surgeon General is hereby authorized and directed, after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, to negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any State or political subdivision thereof, and with other appropriate public agencies, and with private agencies or institutions, and with private persons or groups of persons, and with combinations thereof, to utilize their services and facilities and to pay fair, reasonable, and equitable compensation for such services or facilities—

and so on.

Subsection (d) provides:

In carrying out the duties imposed upon him by this title, the Surgeon General is hereby authorized and directed, with the approval of the Federal Security Administrator, to enter into such agreements or cooperative working arrangements with the Chief of the Children's Bureau and with the Social Security Board—

et cetera.

Subdivision (e) provides:

In the administration of this title, the Surgeon General shall, insofar as practicable, give priority and preference to utilizing the facilities and services of State and local departments or agencies on the basis of mutual agreements with such departments or agencies.

Subdivision (f) provides:

The Surgeon General may delegate to any officer or employee of the Public Health Service or of any Federal, State, or local cooperating department or agency, such of his powers and duties, except that of prescribing rules and regulations, as he may consider necessary and proper to carry out the purposes of this title.

Subdivision (g) provides:

The Surgeon General, after consultation with the Board, and after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, shall prescribe and publish such rules and regulations and require such records and reports, not inconsistent with other provisions of this Act, as may be necessary to the efficient administration of this title—

and so forth.

Subsection (i) provides:

Except with respect to States or local areas for which other arrangements have been made, under the provisions of this section, the Surgeon General shall appoint local-area committees to aid in the administration of this title.

And I would like particularly to call Senator Donnell's attention to the explicit provisions beginning at line 13 on page 39:

The members of such local-area committees shall be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical, dental, and nursing services and education and with the operation of hospitals and laboratories and from among other persons, agencies, or organizations informed on the need for or provision of medical, dental, nursing, hospital, laboratory, or related services and benefits.

And then there is a provision for the membership of such local-area committees as follows:

shall include (1) medical and other professional representatives—  
and so on.

The CHAIRMAN. I would like to leave you in charge of the hearing. I have got to go back on the floor.

Sit up here; and when he concludes his testimony, we will adjourn until next Tuesday morning at the same hour.

Senator DONNELL. That will be April 9 at 10 o'clock?

The CHAIRMAN. At 10 o'clock, and we will have former mayor of New York, Mr. LaGuardia, and some other witnesses.

(Senator Donnell assumed the chair.)

#### THE RIGHT OF JUDICIAL REVIEW

Mr. LINDER. Now, these provisions with respect to administration, section 203, which I have just read, or rather, summarized, must also be taken with section 207, dealing with appeal, judicial review, and limitations upon the powers of the Surgeon General. That is on page 53, Senator.

Section 207 (a) provides:

The Surgeon General is hereby authorized to establish necessary and sufficient appeal bodies to hear complaints from individuals entitled to benefits under this title—

and then there are elaborate provisions with respect to the appeal bodies which are to be set up for the purpose of considering complaints, and the complaints to be considered are not only from practitioners but from individuals entitled to benefits from participating hospitals and others.

The important section that I would like to call the Senator's attention to is subdivision (b) of section 207:

In the administration of subsection (a), the Surgeon General shall, insofar as they are applicable to this title, have all the powers and duties conferred upon the Board by sections 204, 205, and 206 of the Social Security Act, as amended. Such powers and duties shall be subject to the limitations and rights of judicial review contained in section 205 of such Act.

I have here with me a compilation of the social security laws published by the Social Security Board which contains these sections of the Social Security Act that are referred to, and section 205 of the Social Security Act provides, with great elaborateness and detail for evidence, procedure, and appeals. That is on page 12, section 205.

I refer your attention, Mr. Senator, to subdivision (g) on page 14. This is subdivision (g) of section 205:

Any individual after any final decision of the Board made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by civil action,  
et cetera.

Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business,

et cetera. And then there are elaborate provisions with respect to findings, and so on.

Virtually, the same provisions as I have just now read in the present act were in section 1108 of S. 1161. And just to establish that, I want to read or make just a short quotation:

(a) In administering these titles, including the title involved, the Surgeon General of the Public Health Service shall have all the powers and duties conferred upon the Board by sections 204, 205, and 206 of the Social Security Act, as amended,

et cetera.

I submit that on the evidence I have just now presented, it is utterly incomprehensible how any responsible body of lawyers, or for that matter how any responsible body of literate human beings could possibly have made a statement in writing to the effect that the bill fails to provide for any appeal to any court from the action of the Surgeon General.

I submit that this statement and the others which I quoted at the outset of my hearing are wholly untrue, that they are conclusions wholly unwarranted, and that they justify a consideration of the report as one which was intemperate and ill-advised and based upon inadequate study of the law, inadequate study of the bill itself.

It seems to me there is no excuse for anybody making the statement that the bill fails to provide for any appeal, that it fails to safeguard the rights of patients with respect to disputes arising or rights denied through the arbitrary or capricious action of one man when there are provisions in the bill; that is, in the bill they were considering, S. 1161, and in the present bill, which expressly guard against unreasonable, capricious, improper exercise of discretion.

I have here an instance in which the American Bar Association's statement is caught in a direct misstatement.

Senator DONNELL. May I ask you, Mr. Linder, does S. 1161 contain language substantially, as follows:

Such powers and duties shall be subject to the limitation and rights of judicial review contained in section 205 of such Act?

Mr. LINDER. I have just read that.

Senator DONNELL. Would you read that now from S. 1161?

Mr. LINDER. I said section 1108.

Senator DONNELL. How does it read, please?

Mr. LINDER. It reads:

(a) In administering titles 8 (a), 9, in section 1110 of this title, the Board, and in administering title 9 in section 1110 of this title, the Surgeon General of the Public Health Service shall, insofar as they are applicable, have all of the powers and duties conferred upon the Board by sections 204, 205, and 206 of the Social Security Act, as amended.

And then it goes on.

Senator DONNELL. What does it go on to? What I want to know is, what is the next sentence?

Mr. LINDER. I will read the whole thing. If I have omitted anything it is only because I think it is irrelevant, but I am perfectly happy to read it. It goes on to provide that provisions of subsections (e) and (f) of section 205, and the provisions of sections 207 and 208 shall be applicable to these titles in the same manner and to the same extent as they are applicable to title 2 of the Social Security Act, as amended, et cetera, and nothing in section 205 (i) shall prevent the Board or the Surgeon General of the Public Health Service from certifying payments to such individual, agency, office, institution, et cetera, as the Board may prescribe, et cetera.

Senator DONNELL. It is your conclusion that the section from which you have read, 1108 of 1161, confers the right of appeal to a court?

Mr. LINDER. No question about that.

Senator DONNELL. From the action of the Surgeon General. I want to call your attention to this. You may be right. I am not questioning that. I have not studied it with that in mind, but for some reason, in S. 1606, there was inserted, at page 54, a sentence reading expressly:

Such powers and duties shall be subject to the limitations and rights of judicial review contained in section 205 of such act.

That does not appear in what you read from S. 1161. That sentence is not there. You did not read it.

In other words, the writers of 1606, obviously, considered it necessary in order that the right of judicial review be clearly incorporated in the law to insert a sentence which did not appear in 1161, namely—

Such powers and duties shall be subject to the limitations and rights of judicial review—

et cetera. That sentence is not in section 1108 as you read it. Am I correct in that?

Mr. LINDER. You are quite right.

Senator DONNELL. May I say this further: To my mind, as I say, I have not given this the thought that you have; you have studied this diligently and intelligently, but to my mind the sentence which you read at the outset of section 1108, which, as I understand, is substantially the same as the first sentence of subdivision (b) of section 207 of S. 1606, which last-mentioned sentence reads:

In the administration of subsection (a), the Surgeon General shall, insofar as they are applicable to this title, have all of the powers and duties conferred upon the Board by sections 204, 205, 206 of the Social Security Act, as amended.

I say that that sentence is easily, and to my mind correctly, susceptible of the view that it does not confer any right of judicial review, but is merely definitive of the powers and duties of the Surgeon General, for it says, in the administration of subsection (a), the Surgeon General shall, insofar as they are applicable to this title, have all of the powers and duties conferred upon the Board by sections 204, 205, and 206 of the Social Security Act, as amended.

So, Mr. Linder, I respectfully submit for your consideration, and when you return to discuss it more fully, if you like, perfectly proper, or you may do so now, to my mind, however, obviously two things are true:

First, the draftsman of S. 1606 found it necessary, or at least advisable, to insert a sentence which did not appear in section 1108 or S. 1161, namely—

Such powers and duties shall be subject to the limitations and rights of judicial review contained in section 205 of such act.

Secondly, that the first sentence of subdivision (b) of section 207, S. 1606, is certainly susceptible of the view, and to my mind it is the correct view, that all it does is to define the powers, or rather confer the powers, and duties on the Surgeon General without any limitation as to judicial review whatsoever.

To my mind, therefore, your criticism of the American Bar Association report, insofar as you have stated that in your opinion not only is it incomprehensible how any lawyer or how any literate person might come to the conclusion that S. 1161 did not confer the power of judicial review, the right of judicial review, to my mind your criticism falls absolutely flat and is baseless. That is said in the utmost of good feeling.

Mr. LINDER. Senator Donnell, Mr. Martin has said that. What he said in this report which he filed this morning applies substantially to the present bill. If Mr. Martin were willing to say that the addition of the sentence on the fourth line of page 54 now made it clear that there was an absolute right to judicial review, then he would have to take back his statement this morning that his report applies to the present bill.

In all fairness and fair dealing, he should have said what I said in my report in February 1944, that the bill fails to provide for any appeal to any court from the action of the Surgeon General, that no longer applies in view of the new sentence which has been added on page 54, but he did not so qualify it.

I would like to say this: I appreciate the point that you make that when 1108 declared that the Surgeon General should have all of the powers conferred by section 205, that that may not mean that he has all of the powers subject to the limitations of 205, but I submit, with all due respect, that such a conclusion is unreasonable.

Senator DONNELL. If it is unreasonable, what is your idea as to why the draftsmen of 1606 put in a sentence specifically saying, "Such powers and duties shall be subject to the limitations and rights of judicial review contained in section 205 of such act"?

Mr. LINDER. As a lawyer who says the same thing sometimes in four different ways for the purpose of making sure that through an excess of caution I have not overlooked anything, I can very well understand why they added this sentence out of an excess of caution.

It seems to me that if you say the Surgeon General has all of the powers or duties conferred under section 205, that that must mean that those powers are subject to the restrictions in 205, and I cannot see that there are any other constructions reasonable. And that therefore, it is wholly unnecessary, from my standpoint, it is wholly gratuitous to add this sentence. They added it. I see no objection to adding it. I think it is complete surplusage.

Senator DONNELL. We do agree, however, that the draftsmen of S. 1606, for some reason, did add this sentence which did not appear in S. 1161?

Mr. LINDER. No question about it.

Senator DONNELL. And may I respectfully suggest, also, to the consideration of the witness, that lawyers sometimes disagree on matters, do they not?

Mr. LINDER. Yes, sir.

Senator DONNELL. And courts do. The Supreme Court of the United States, especially, at times disagrees in its component parts upon different matters.

Is it not true, Mr. Linder, that it may well be on reconsideration that there may be some merit in what the American Bar Association said here as to the absence of any judicial review provision in S. 1161 when particularly borne in mind that the draftsmen of S. 1606, obviously, thought it advisable to insert in S. 1606 a distinct provision that the powers and duties shall be subject to the limitations and rights of judicial review mentioned in said section?

Mr. LINDER. But I should still ask you to concede that in fairness, fair play, that that then requires, assuming that we follow your reasoning, that the representative of the American Bar Association, sitting here today, should, in submitting a report which says the bill fails to provide for any appeal to any court from the action of the Surgeon General, say that was something we said about the old bill which did not have the sentence about the limitations of section 205, but since, in view of that new sentence, perhaps we better withdraw that part of our report.

Do you not think so?

Senator DONNELL. May I say in answer to that, three things:

In the first place, I do not undertake to determine what Mr. Martin's duty was.

In the second place, obviously, this morning he was not studying that report with minute reference back to each detail of it, and it may very well be that in the utmost of good faith that he overlooked that point.

In the third place, I have not studied this and I may be in error in the third place, however I observe that subdivision (b) of section 207 which is the one which contains the sentence that such powers and duties shall be subject to the limitations and rights of judicial review contained in section 205 refers only to the administration of subsection (a) of section 207.

You will note it says, in the administration of subsection (a) the Surgeon General shall, et cetera, have these powers and duties, and then such powers and duties shall be subject to the limitations and rights of judicial review.

It may be, I am not saying this categorically, because I have not studied this bill with one-tenth the thoroughness that you have, I have not read this bill in its entirety, and you have, doubtless, realized that before, but it is a fact nevertheless, I expect to study it with what I think will be reasonable care, but it may be that Mr. Martin might construe that the provision for judicial review in subsection (b) of 207 is applicable only to a limited portion of the provisions of the act.

Mr. LINDER. That would be impossible.

Senator DONNELL. As I say, may I make this perfectly clear, I do not want you to be under any misapprehension. I am only presenting that as a thought that has occurred to me momentarily and I may be in error on it, but I suggest that that might be borne in mind.

Mr. LINDER. I respectfully submit that is completely in error in view of the fact that 207 (a) covers the whole field of all complaints, all possible complaints by any practitioner, or by any individual, with respect to the whole system.

Senator DONNELL. I shall not dispute you.

Mr. LINDER. It says "the Surgeon General." Look at the language.

Senator DONNELL. Pardon me just a second. I do not dispute your statement at all because I have not studied it. I have not read section 207 (a).

The thought which I referred to occurred to me only as I was reading that portion of subsection (b). You may be thoroughly correct, and I have no doubt that you are thoroughly sincere in your statement, and you may be right. I am not questioning it, and I am very glad for the record to have you state your views as to the error in which you think I have fallen in making that suggestion.

Mr. LINDER. As I see it, 207 (a) covers the whole field of any complaint, any grievance with the operation of the system.

Then (b) says that with respect to that whole field of any complaint, the Surgeon General has the powers, among other things, of section 205 of the Social Security Act, and then to avoid any possible question, there is a sentence, and the powers are subject to limitations of 205.

Senator DONNELL. Mr. Linder, I am not sure that your statement there, to avoid any possible question, is accurate. It may be that in order to give the right of judicial review that that was necessary. Obviously, for some reason, the draftsman of S. 1606 thought it advisable to put it in, and I think the presumption is that it is not surplusage. It may be, but I believe that the draftsman of this bill tried to put in, I judge, only what he thought was essential.

Mr. LINDER. I think, Senator, you would have to admit on a fair consideration of the present act, that the conclusions arrived at by the American Bar Association in its report, the bill fails to provide for any appeal to any court from the action of the Surgeon General, certainly, is inapplicable to the present National Health Act.

Senator DONNELL. You may be quite right on that. I would want to study it more thoroughly, but certainly, as I see it, the American Bar Association representatives and Mr. Martin and the other two committee members are not justly subject to the point that you made to the effect that not only can no lawyer, in your opinion make the mistake of saying there was no judicial review provided for in S. 1161, but that no literate person could come to that conclusion. To my mind, a literate person could, and a lawyer could, and I am not at all sure but what these gentlemen were exactly right in their conclusion as to S. 1161 under the consideration that I have mentioned.

Mr. LINDER. I say that if you are given the powers of a section and that section contains limitations, it is unreasonable to say that the power given is not subject to the limitations. I just cannot understand the English language if that were not true.

Senator DONNELL. But the draftsman on S. 1606 thought that the limitation should be put in expressly for some reason. I think we understand one another.

Mr. LINDER. I think so, too.

Senator DONNELL. You may proceed.

Mr. LINDER. The statement of the American Bar Association report that the bill fails to safeguard the rights of patients, citizens, hos-

pitals, or doctors with respect to disputes arising or rights denied through the arbitrary or capricious action of one man, seems to me to be wholly refuted by the express language not only of the present bill, but which is more pertinent, the bill which was then under consideration, because the old bill contains section 914 which is substantially like 203 (g) of the present bill. The old section provided that the Surgeon General, after consultation with the Social Security Board, and with the approval of the Federal Security Administrator, shall make and publish such rules and regulations not inconsistent with other provisions of this act as may be necessary to the efficient administration of this title.

It seems to me that no reasonable and fair-minded lawyer could say that such a provision calls for anything other than reasonable provisions, reasonable from the standpoint of consistency with other provisions, and reasonable from the standpoint of necessity for the efficient administration of the title.

Senator DONNELL. What section of S. 1606 did you say that section 914 of S. 1161 is analogous to, please? I did not understand.

Mr. LINDER. Section 914 of the old bill, S. 1161, is analogous to 203 (g). In the present 203 (g) they have just added a proviso with respect to further consultation with respect to regulations affecting the performance by Federal, State, or local departments.

You see, the language, from the words "provided," on, in line 18, that is what is added, substantially. I have not made a word for word comparison, but I think that 914 is alike. Let me read 914 and you follow me; that is, section 914 of the old bill:

The Surgeon General after consultation with the Social Security Board, and with the approval of the Federal Security Administrator shall—

Senator DONNELL. Pardon me. There is an insert here. Instead of saying "Social Security Board," it says "the Board."

Mr. LINDER. It means the same thing.

Senator DONNELL. "And after consultation with the Advisory Council as to questions."

Mr. LINDER. "Of general policy administration," that is added. Well, I might say that 914 is perhaps broader because it does not limit it to questions of general policy. It says, "and after consultation with the Social Security Board."

Senator DONNELL. There is a slight difference, perhaps.

Mr. LINDER, if you do not mind, in the interest of expedition of the matter, if you could give us a copy of that for the record.

Mr. LINDER. I will read it.

Section 914:

The Surgeon General, after consultation with the Social Security Board and with the approval of the Federal Security Administrator shall make and publish such rules, and regulations not inconsistent with other provisions of this act as may be necessary to the efficient administration of this title.

I say the sense of that is substantially the sense of 203 (g).

Under any rules of constitutional interpretation, it is entirely clear that the rules and regulations which may be promulgated by the Surgeon General would have to be reasonable, complying with the tests of necessity, consistency, and so forth, and that from that standpoint it is utterly unwarranted for the American Bar Association to have urged that this bill provides for the arbitrary or capricious action of one man, and I think that there, too, there is another point.

I notice that in paragraph 2 of the conclusions, S. 1161, a section to invest in the Surgeon General the power arbitrarily to make rules and regulations having the force and effect of law which directly affect every home. That seems to me wholly unreasonable and unfair to make any such assertion as to the provisions of this proposed bill.

I have indicated also the specific language for administration which indicates the extent to which the framers of the bill endeavored to provide for local administration and local initiative, and so forth. There are a few other points that I would like to make with respect to the American Bar Association report.

I find it extraordinary that the American Bar Association should contrast, as it does, the Canadian system with the proposed American one. Let me see if I can find the page.

On page 17, the American Bar Association says, at the bottom of the first column on page 17, "The total cost per annum would be \$250,000,000." That is health insurance for Canada. "This figure is to be compared with approximately \$3,000,000,000 in this country."

I must say that this is an extraordinary way to argue when you remember that the population of the United States is 12 times the population of Canada.

It does not make much sense to object to a cost 12 times as great.

I notice that the American Bar Association report finds that the Canadian plan is one which would be administered Province by Province and not federally.

Senator DONNELL. Where is that?

Mr. LINDER. That is on page 17, also page 16, the last paragraph on page 16. It says, for Senator Wagner to compare his bill with the proposed Canadian measure is not justified. It provides for adoption by province. The Canadian Government has no constitutional power to impose such a plan. The special committee fails to indicate that a national plan is not constitutional in Canada because the constitutional system of Canada and the Canadian limitations are not, therefore, a guide to us, where under the decisions of our highest court Federal plans in the field of old-age security and unemployment compensation and a whole variety of other matters have been held expressly constitutional.

I notice that the American Bar Association report is very much concerned with its hostility to State medicine. I would like to point out, that is, as to its conclusion in No. 4, on page 17, that 42 percent of the expenditures for hospital services and for doctor services rendered hospital patients in 1942 were either tax supported or otherwise without cost to the patient and without recourse to Federal regulation and control as proposed, so that we have a tremendous amount of Government-financed medicine in the country at the present time.

Senator DONNELL. The report says without recourse to Federal regulation and control as proposed.

Mr. LINDER. That is true, but the fact that 42 percent of the expenditures for hospital services are now tax-supported—

Senator DONNELL. It does not say that. Were either tax-supported or without cost.

Mr. LINDER. I should have said that, without cost to the patients. That would seem to indicate that we have in our country found that it was necessary, with respect to a very large proportion of the Ameri-

can people, to abandon private initiative and private enterprise in medicine, because these people simply had to be taken care of.

Senator DONNELL. Do you know what part of the 42 percent, if that figure be correct, of the expenditures for hospital services and doctor services rendered in 1942 were tax-supported?

Mr. LINDER. I cannot say. There are one or two other points I would like to make in concluding my testimony.

Senator DONNELL. Mr. Linder, also, it is true, is it not, that a very considerable part of the Government financing, I do not mean the National Government, but all governmental financing of hospital or doctor services, is for mental diseases?

Mr. LINDER. And tuberculosis, a considerable part is; yes.

Senator DONNELL. Institutional care?

Mr. LINDER. Yes.

Senator DONNELL. Being involved in both cases?

Mr. LINDER. As in the case of other governmentally supported ventures where private enterprise could not profitably handle the rendition of services, the Government has had to step in.

Senator DONNELL. And this paragraph in the American Bar Association report, which you have read about the 42 percent, refers only to hospital services and doctor services rendered hospital patients, and does not have any applicability to services rendered to a patient in his home. That is correct, is it not?

Mr. LINDER. That is correct, I believe.

#### HEALTH INSURANCE IS IN THE AMERICAN TRADITION

In concluding my testimony, I want to summarize some material which is in the last part of the main report on the National Health Act. I refer to page 7.

The medical care provisions of the bill have been attacked on the ground that they are foreign to our system of government and also are incompatible with the adequate protection of the liberties of the people. There is nothing foreign to our system of government in the provision of medical care for the people of our country by an insurance system. It is no more foreign to our system of government than is the system of old-age security and unemployment insurance. In fact, one of the very first health insurance systems introduced in the modern world was established in the United States in 1798 when Congress enacted the health insurance system for merchant seamen. With some variation, this has existed for nearly 150 years.

Providing its citizens with the right to medical care, with the opportunity to enjoy health, with the ability to prevent suffering and destitution caused by illness and the inability to obtain medical treatment is not an attack on the rights and liberties of the citizens of this country. On the contrary, it establishes conditions of health and decency under which citizens of this country can enjoy their rights and liberties.

The opponents of health insurance ignore the fundamental problem which health insurance is designed to meet; how to distribute the costs of medical care so that those who need medical care will receive it. It is because sickness is unpredictable that it is impossible for a majority of the American people effectively to budget to meet its costs. It is because catastrophic sickness most frequently falls upon those who can least afford to pay for its costs that a method for distributing the costs is necessary. It is because the whole nation is concerned with the health of all the people that this problem must be solved on a national scale. The bill provides a sound and effective means of dealing with the problem.

Upon analysis, we conclude that the provisions of the bill are urgently needed for the protection of the health and welfare of the American people. Because

the National Health Act would meet an urgent need of the people of this country, we approve it and urge its immediate enactment. As President Truman has so well said:

"We are a rich nation and can afford many things. But ill health which can be prevented or cured is one thing we cannot afford.

"By preventing illness, by assuring access to needed community and personal health services by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic-productivity. We shall increase the professional and economic opportunities of our physicians, dentists, and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people."

We find nothing in the bill which will diminish or impair the rights and liberties of the citizens of this country. On the contrary, its enactment would serve to make these rights and liberties real and effective. For the sick are not free, and only a healthy America can exercise its rights and enjoy its liberties.

I should say in concluding my formal statement, that I want to express my appreciation of the courtesy of the committee, and I should also like to express to the committee the personal regrets of Attorney General Robert W. Kenney, the national president of the National Lawyers Guild, who has just come back from Nuremberg, Germany, where as an officer of the National Lawyers Guild he was invited by Justice Jackson to be an observer of the Nuremberg trials, and has had to go to California, and he cannot come personally to present his views.

I should like permission of the committee to submit a written statement by Attorney General Kenney, which will express his personal views with respect to the National Health Act, supporting it, as well as those of the National Lawyers Guild.

Senator DONNELL. That permission is granted. I assure you that we appreciate your courtesy in coming here and giving us the benefit of your views, Mr. Linder, and we shall find it necessary, I am quite sure, to ask you to return for further examination, because I do not think, in the course of 20 or 25 minutes, it will be possible to complete the consideration of the various points that I should desire to question you upon.

You mentioned, Mr. Linder, pursuant to inquiry, something of your own personal educational experience. You are a graduate of which law school?

Mr. LINDER. Columbia.

Senator DONNELL. I thought you said the City College.

Mr. LINDER. I am a graduate. I got my bachelor's degree from the College of the City of New York. Subsequent to graduation from the College of the City of New York, I attended Columbia Law School and was graduated with the degree of bachelor of laws from that university.

Senator DONNELL. What year was that?

Mr. LINDER. 1923.

Senator DONNELL. Have you been practicing law in New York City ever since that time?

Mr. LINDER. Since 1924.

Senator DONNELL. What has been your specialty?

Mr. LINDER. I am a corporation lawyer, and my work is primarily concerned with corporate problems and problems of unfair competition and the problems which arise when corporations collide with each other in the market.

Senator DONNELL. You have not studied medicine, have you?

Mr. LINDER. No, sir.

Senator DONNELL. Or surgery?

Mr. LINDER. No.

Senator DONNELL. And have not engaged in a specialty along those lines except insofar as your duty as a member of this committee, that is, as chairman of the Committee of the National Lawyers Guild, has called upon you to study this problem; is that right?

Mr. LINDER. That is purely an avocational thing.

Senator DONNELL. Who is Mr. Morris A. Wainger?

Mr. LINDER. He is a lawyer practicing in New York.

Senator DONNELL. And he cooperated with you, I believe, in the preparation of the report which you have presented?

Mr. LINDER. That is right.

Senator DONNELL. Has Mr. Wainger specialized in any degree along the lines of social security or insurance or health or medicine or surgery?

Mr. LINDER. No, in his practice he has nothing to do with these matters. He has been, as I have been, a student of the whole subject of social insurance for many years.

Senator DONNELL. Mr. Linder, you referred to the fact that Mr. Kenny had been unable to be present. We are happy to have you here. And you have amply and very excellently substituted for Mr. Kenny. I am sure that he may feel that the matter has been adequately presented by yourself.

#### THE NATIONAL LAWYERS GUILD

Mr. Kenny is the president of the National Lawyers Guild, is he not?

Mr. LINDER. That is correct.

Senator DONNELL. How old an organization is the National Lawyers Guild?

Mr. LINDER. About 10 years.

Senator DONNELL. As you doubtless know, the American Bar Association has been in existence since 1878, I believe, having been formed in New York State at Saratoga Springs in or about 1878; do you know that?

Mr. LINDER. I have no knowledge of that.

Senator DONNELL. You do know that the American Bar Association has been in existence for many years preceding the organization of the National Lawyers Guild?

Mr. LINDER. It has all of the benefits and merits and disadvantages of age.

Senator DONNELL. Mr. Linder, the Lawyers Guild has approximately how many members?

Mr. LINDER. Approximately 3,000.

Senator DONNELL. So that it is somewhat less than a tenth of the membership of the American Bar Association as it was mentioned by Mr. Martin this morning?

Mr. LINDER. I have no knowledge of the membership of the American Bar Association and, therefore, cannot compare them.

Senator DONNELL. Has there been any feeling of hostility on the part of the National Lawyers Guild toward the American Bar Association?

Mr. LINDER. The organizations, as corporate entities, have no hostility to each other whatsoever.

Senator DONNELL. As distinguished from corporate entities I am referring now to the actual physical entities; has there not been considerable feeling of hostility on the part of the National Lawyers Guild against the American Bar Association?

Mr. LINDER. There is a difference of opinion between them on some subjects, but not on all subjects. I should think that on many subjects dealing with technical matters of jurisprudence that the American Bar Association and the National Lawyers Guild may very well see eye to eye.

Senator DONNELL. Mr. Linder, in a very recent issue of PM there appears an article, very interesting indeed, in regard to Mr. Robert Walker Kenny. That is the gentleman who is the president of the National Lawyers Guild, is it not?

Mr. LINDER. Yes, sir.

Senator DONNELL. In the course of this article appears this statement to which I call your attention:

Kenny's story of his handling of the Lawyers Guild storm went like this, "The boys just made the mistake of allowing a few scrappy individuals to sidetrack them into debating their individual political philosophies. I had been one of the founding fathers of the organization. It seemed worth sticking through a little trouble. We were to the American Bar Association as the CIO is to the American Federation of Labor. The American Bar Association which pretended to speak for the lawyers of the country was supporting the Liberty League trying to bust the Roosevelt social program, butcher the child labor law. It was a moribund, decadent outfit. I believe in keeping alive in your times.

Does that express the general feeling, so far as you have observed, of the officials of the Lawyers Guild with respect to the American Bar Association?

Mr. LINDER. I should not be able to characterize the general feeling of any large body of men who differ in their views, but without desiring to avoid your question at all, I should say that I personally have very strong views with respect to it and I will be very glad to state my own views.

Senator DONNELL. Would you state them?

Mr. LINDER. Surely. I believe that the American Bar Association is dominated by lawyers who represent large corporate interests in this country and who reflect the views of the largest corporate interests in our country. Insofar as there are reactionary, antiprogressive elements in industry, I think that the American Bar Association is dominated by lawyers who express that point of view.

I think that it is not accidental at all that the American Bar Association should echo so completely the views of the organized hierarchy that dominates American medicine in the American Medical Association, and I think it is no accident at all that the Lawyers Guild should emerge as the champion of the people's rights and needs in opposition to the American Bar Association.

Senator DONNELL. Now, Mr. Linder, I observe in what I read as quoted from Mr. Kenny, the statement referring to the American Bar Association, that it was a moribund, decadent outfit. I have had the word "moribund" looked up in the dictionary and I find it means, "on the point of dying." Do you concur in that view with respect to the American Bar Association?

Mr. LINDER. I have no knowledge of whether it is dying or is not dying. I have only a knowledge as to whether it should die.

Senator DONNELL. And you think it should; is that right?

Mr. LINDER. No.

Senator DONNELL. What did you mean by that statement?

Mr. LINDER. My view is that the American Bar Association is dominated by reactionary men and that—

Senator DONNELL. What did you mean about whether it should die?

Mr. LINDER. As an organization dominated in the manner I have described, it seems to me that it ill serves the welfare of our country.

Senator DONNELL. Therefore, if it ill serves the welfare of our American country, it ought to die, is that your view?

Mr. LINDER. That is right.

Senator DONNELL. As regards whether it is dying, however, I recall to your memory the testimony of Mr. Martin this morning that the membership is 35,000, which he stated is the largest in the history of their organization. I refer, also, to this quotation from page 141 of the proceedings of the American Bar Association, volume 69, 1944:

President Henderson—

who, I may say, is President Joseph Henderson, a well-known lawyer of Philadelphia, continuing the quotation—

in his statement to the house first expressed his appreciation to the staff and the official family as well as the general membership of the association for their cooperation. He reported that the membership as of September 1 was approximately 32,654 which exceeds by 1,000 the highest previous total which occurred in 1939.

You would not consider, in fact, regardless of your own views as to the merits of the American Bar Association, that in view of these figures and the further increase from the 32,564 mention by President Henderson in 1944, up to 35,000 testified to by Mr. Martin, you would not consider that in fact that the American Bar Association, to adopt the language assigned to Mr. Kenny, is a moribund organization, to wit: on the point of dying, would you?

Mr. LINDER. Well, an organization may be moribund and have all of the trappings and all of the outward appearances of great life. There is more than one person who has a cancer that will kill him who is walking around with all of the appearances of good health.

Senator DONNELL. You do not mean to say that the great American Bar Association is a moribund, decadent organization that is dying from a cancer; you do not indicate that when it is increasing in membership at this very time, do you, Mr. Linder?

Mr. LINDER. Senator, may I make this suggestion?

Senator DONNELL. Please answer that question first. Do you consider that that organization is dying from a cancer or any other reason?

Mr. LINDER. I think the American Bar Association is a large organization of lawyers in this country that is dominated by a hierarchy of lawyers who are conservative and who express a reactionary point of view.

I think that it is fruitless to discuss whether it is dying or should die. I think it should be much more important to ascertain whether the position taken by the American Bar Association in this report fairly reflects the views of the American bar and from that stand-

point, I should like to call your attention, Senator, to a discussion which is contained on page 4 of the analysis of the American Bar Association report, because that will enlighten you, I think, substantially, with respect to whether this report speaks for the American bar.

Senator DONNELL. That is page 4, you say?

Mr. LINDER. That is right.

Senator DONNELL. What portion of that page?

Mr. LINDER. In the second column. The first column says, at the bottom, "The principal objections of the Bar Association are that the bill would abolish the private practice of medicine," et cetera.

Then the next:

These objections are, indeed, the basis upon which the report was approved by the house of delegates.

This is a very interesting report that I think you might well bear in mind. [Reading:]

At its meeting, this is the meeting of the house of delegates.

Senator DONNELL. Of the American Bar Association?

Mr. LINDER. Yes. [Continuing reading:]

One of the delegates stated that the report had not been distributed until it was presented and asked that action on it be postponed until the report was made available for study. Postponement was objected to by another delegate. He appealed to the assemblage of lawyers asking what the reaction of the delegate who asked for postponement would be if Senator Murray introduced in the Senate a proposed bill whereby the Attorney General would tell each lawyer in the United States who his client shall be, what he can charge them, and that he can represent no other person.

Taken from the Journal of the American Bar Association, April 1944, pages 198 to 199.

Thereupon, the delegates, all lawyers, adopted the report.

It is evident that no one except the members of the special committee had studied the bill or had an opportunity to consider the report. No one told or was able to tell the speaker that the dire example that he had presented regarding their own profession in no way resembled the provisions of this bill, for under the bill the Surgeon General cannot tell every doctor in the United States who his patients shall be, what he can charge them, and that he can treat no other persons.

Senator DONNELL. At any rate, Mr. Linder, the American Bar Association does constitute an organization containing approximately 35,000 of the lawyers in good standing of the United States?

Mr. LINDER. That is what you—

Senator DONNELL. The National Lawyers Guild which, I take it, has views pretty largely as expressed by you in regard to the American Bar Association, has been formed within the last 10 years, contains about 3,000 lawyers. Those are facts, are they not?

Mr. LINDER. Well, some of them. You have put a number of things together in one question. Some of them I know something about. Some of them I do not. I do not know anything about the membership of the American Bar Association, and I do not presume to speak for the whole membership of the National Lawyers Guild.

Senator DONNELL. You are here on behalf of the Lawyers Guild?

Mr. LINDERS. I am here on behalf of the National Lawyers Guild.

Senator DONNELL. In connection with the bill?

Mr. LINDER. To present a report. The report I presented has been carefully studied by a committee and then reviewed carefully by a national body.

Senator DONNELL. Now, you said, Mr. Linder, this morning, as I recall, that approximately one-third of the population receives no medical care, is that correct?

Mr. LINDER. I said that there is a technical Government publication which says so.

Senator DONNELL. What is that Government publication?

Mr. LINDER. I gave that to you this morning.

Senator DONNELL. I want to be sure that I exactly know what that is.

Mr. LINDER. I will be glad to give it to you again. "The Report of the Technical Committee on Medical Care" transmitted to Congress by the President on January 23, 1939, House of Representatives Document 120.

Senator DONNELL. Was that based on studies of the committee on the costs of medical care made in 1929, 1930, and 1931, and on the national health survey made in 1935?

Mr. LINDER. I believe so, but I have not got the document before me and I do not really recall.

#### CONSTITUTIONALITY OF S. 1606

Senator DONNELL. Now, Mr. Linder, you referred to the constitutionality of this bill, and you mentioned particularly the *Helvering v. Davis* case, and the *Steward* case, both appearing in 301 U. S. Supreme Court, and both referring to the Social Security legislation?

Mr. LINDER. Right.

Senator DONNELL. Would you state, please, whether or not it is, in your opinion, a correct statement of law that the Federal Government possesses only those powers which are either expressly or by necessary implication conferred upon it by the Constitution of the United States?

Mr. LINDER. That is correct.

Senator DONNELL. I think there may be, in fairness, Mr. Linder, one possible exception under a fairly recent decision of the United States Supreme Court; namely, that involving the dealings by the United States in external affairs.

Mr. LINDER. The War Powers.

Senator DONNELL. Not alone War Powers. I am not sure of that, but I think the Court has, in some way, indicated—

Mr. LINDER. The Government.

Senator DONNELL. That so far as the matter of dealing in external affairs, that the same rule does not apply, but so far as dealing in internal affairs, the rule is as I have stated it; namely, that the Federal Government possesses only such powers as are expressly or by necessary implication conferred by the Constitution of the United States.

Do you agree upon that; do they not?

Mr. LINDER. That is right.

Senator DONNELL. Will you tell us, please, what provision or provisions of the Constitution of the United States, in your opinion,

authorize and confer upon the Congress the power to enact legislation providing for compulsory health insurance?

Mr. LINDER. Section 8 of article I.

Senator DONNELL. Is that the "general welfare" clause?

Mr. LINDER. That is right.

Senator DONNELL. Is there any other section that authorizes it?

Mr. LINDER. That is enough.

Senator DONNELL. Is that the only one?

Mr. LINDER. I am not prepared to say whether it is the only one. I think it is sufficient.

Senator DONNELL. It is the only one to which your mind now reverts?

Mr. LINDER. That is correct.

Senator DONNELL. Is that correct?

Mr. LINDER. Yes.

Senator DONNELL. And that section reads:

1. The Congress shall have power:

To lay and collect taxes, duties, imposts, and excises to pay the debts and provide for the common defense and general welfare of the United States; but all duties, imposts, and excises shall be uniform throughout the United States.

Is that correct?

Mr. LINDER. Yes, sir.

Senator DONNELL. There is also mention of general welfare in the preamble to the Constitution of the United States; is there not?

Mr. LINDER. Yes, sir.

Senator DONNELL. Namely, that "we, the people of the United States, in order to form a more perfect Union, establish justice, insure domestic tranquility, provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and our posterity, do ordain and establish this Constitution for the United States of America.

That is correct, is it not?

Mr. LINDER. Correct.

Senator DONNELL. Now, the language: "promote the general welfare" in the preamble has, however, has it not, been expressly held by the Supreme Court of the United States, not to confer any legislative power whatsoever; we agree upon that as lawyers, do we not?

Mr. LINDER. No, no. The general welfare clause expressly—

Senator DONNELL. I am talking about the preamble, only the preamble. The mention of the general promotion of general welfare, has it not been held by the Supreme Court, expressly in at least one, possibly two cases—

Mr. LINDER. I believe so.

Senator DONNELL. That no legislative power is conferred by the preamble?

Mr. LINDER. I believe so.

Senator DONNELL. I believe that is correct. As to section 8 of article I of the Constitution; namely, the so-called general welfare clause, which starts as I have indicated, with the language "To lay and collect taxes, duties, imposts, and excises, to pay the debts," and so forth, I will ask you to state, please whether or not you have observed that the Supreme Court of the United States has held expressly that said clause does not grant two powers; namely, the power on the

one hand to lay and collect taxes, duties, imposts, and excises, and, on the other hand, to provide for the general welfare of the United States; has it not been held by the Supreme Court in express language almost what I am going to say, that the power conferred by this section of article I is merely a power to lay and collect taxes, duties, imposts, and excises, and that the mention of the general welfare is a definition of the purpose?

Mr. LINDER. Is a qualification of the other.

Senator DONNELL. That is correct. It is a definition of the purposes for which taxes, duties, imposts, and excises may be made; that is correct?

Mr. LINDER. It is so broad a qualification I could not really regard it as a qualification.

It is the objective. I think it is correct to say that the language states the objective to be accomplished by the laying of the imposts, et cetera.

Senator DONNELL. In other words, the point I am making is that the Supreme Court has indicated very clearly, has it not, that there is no general power conferred by the Constitution of the United States by section 8 of article I to provide for the general welfare except insofar as that provision is based under the power and dependent upon the power to lay and collect taxes, duties, imposts, et cetera; that is correct, is it not?

Mr. LINDER. I believe so.

Senator DONNELL. In other words, has not the Supreme Court of the United States held, in substance, that the power that is conferred is one to lay and collect taxes, and so forth, and that there is no separate second power granted by this section to provide for the general welfare?

Mr. LINDER. That is correct, but you must bear in mind that Mr. Justice Cardozo uses this language on page 640 of the *Helvering* decision: "Congress may spend money in aid of the general welfare," Constitution, article I, section 8. And I think that I cannot cite any greater authority for what the Constitution provides Congress may do than that sentence, so that the Supreme Court often has said that Congress may spend money in aid of the general welfare, and the Supreme Court has also said that Congress decides what serves the general welfare, and Mr. Justice Cardozo said, "when a contention comes here," that is, a contention of unreasonableness or exercise of this power in an arbitrary fashion "we, naturally, require a showing that by no reasonable possibility can the challenged legislation fall within the wide range of discretion permitted to Congress." So that the burden is upon him who asserts that this, the expenditure, involved is not in aid of the general welfare, to show that by no reasonable possibility can the challenged legislation fall within the wide range of discretion permitted.

Senator DONNELL. Mr. Linder, you have gone somewhat beyond the point to which I was addressing myself.

The point that I was addressing myself to was, namely, that the Supreme Court of the United States has held that there is no general power to provide for the general welfare created by section 8 of article I, that the reference to general welfare is solely as definitive of the purposes for which taxes, duties, imposts, and excises may be laid and collected.

Mr. LINDER. That is clear.

Senator DONNELL. And the power to spend money as pointed out by Mr. Justice Cardozo has been indicated by the Supreme Court to arise as a necessary incident of the power to lay and collect taxes; in other words, if Congress has the power to collect, inferentially, there is an implied power to spend money which it has laid and collected the taxes to secure it. That is correct, is it not?

Mr. LINDER. Correct.

Senator DONNELL. I regret to say that it is 3:15, and in compliance with my promise to you, we shall excuse you, but we shall appreciate greatly your coming back to continue not only with this constitutional question as to which there are some further questions I desire to address to you, but I have no doubt that the committee would like to hear with respect to quite a number of other points, and I hope you will come prepared to stay a sufficient length of time to discuss them with us.

Mr. LINDER. I have an appointment in Washington on the 25th of April.

Do you know anything about the calendar of the committee?

Senator DONNELL. The next meeting is to occur next Tuesday.

Mr. LINDER. I have to be back in Washington on the 26th, in the afternoon.

Senator DONNELL. Could you appear with us in the morning of that day?

Mr. LINDER. I can appear in the morning, and I could start at 10 o'clock and keep going as long as you want.

Senator DONNELL. Would you be kind enough to make a note of that, and I am sure that the committee will see that requisite notice is given Mr. Linder, and if that should not prove convenient, an appropriate date suitable to both himself and the committee can be arranged.

Mr. LINDER. I will be happy to come again. I should like, as a point of personal privilege, to take 1 minute on one point.

Senator DONNELL. Certainly.

Mr. LINDER. I should like to make clear my personal view with respect to the American Bar Association. If anything that I have said here indicates any personal hostility to the organization, as such, I regret it. I regard the American Bar Association as an organization of lawyers. Many lawyers who belong to the American Bar Association are my friends and are well known to me and both professionally and otherwise. I think the American Bar Association, insofar as it deals with technical matters, dealing with subjects within the realm of civil and criminal jurisdiction, contributes, takes positions that are frequently taken by the National Lawyers Guild. However, in the tremendously important field of social legislation, in all of those with respect to that whole body of legislative matter which so directly affects the interests of the people of the United States, I think it is true that during the last 10 years, at least, the American Bar Association has consistently taken a view which, in the opinion of the National Lawyers Guild, is a view not in the interests of the people of this country.

The American Bar Association has regarded the Social Security Act as unconstitutional. Its representative here this morning appeared before the United States Supreme Court and argued the un-

constitutionality of that statute. Not persuaded by the United States Supreme Court and unmindful of the fact that that decision is binding upon him, he still continues his assertions about the constitutionality.

The American Bar Association, in connection with this specific legislation, I think, has taken a position which serves the interests of the people of our country very badly.

In echoing the position of the American Medical Association, the American Bar Association, I think, has taken a very unfortunate position and it is a matter of some regret to me that they have done so.

I think in taking that position, however, the American Bar Association does not bespeak the views of the overwhelming majority of the lawyers in this country.

I will be glad to come back here, Senator.

Senator DONNELL. The committee will be in recess until 10 a. m., Tuesday, April 9, 1946, in room 301, the Banking and Currency Committee room.

(Thereupon, at 3:20 p. m., Friday, April 5, 1946, the committee recessed to reconvene Tuesday, April 9, 1946, in room 301, the Banking and Currency Committee room, at 10 a. m.)

# NATIONAL HEALTH PROGRAM

TUESDAY, APRIL 9, 1946

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

The committee met at 10 a. m., pursuant to call of the Chair, the Honorable James E. Murray (chairman) presiding.

Present: Senators Murray, Wagner, Ellender, Aiken, and Donnell.

The CHAIRMAN. The hearing will come to order.

The first witness this morning is Fiorello H. LaGuardia, former president of the United States Conference of Mayors, and formerly mayor of the city of New York. We welcome you here this morning, Mr. LaGuardia, and we are glad to have your testimony for the record.

## STATEMENT OF FIORELLO H. LaGUARDIA, FORMER PRESIDENT OF THE UNITED STATES CONFERENCE OF MAYORS

Mr. LaGUARDIA. Mr. Chairman and gentlemen of the committee, this indeed is an opportunity that I have long sought. I have been waiting for this for the last 20 years, and I want to congratulate the committee on reaching the stage where at least citizens can come and talk on something that should have happened many years ago.

The highest function of government is the protection and preservation of life. That is accepted, but it stops short of the real preservation of life. Great progress has been made in the last 10 or 12 years and what today is accepted as a national policy only a few years ago were matters that were left to private generosity and charity.

### APPROPRIATIONS FOR TITLE I ARE LOW

I take it that there is little opposition to the provisions in the early part of the bill on maternal and child health, on the contributions and Federal grants for tuberculosis and venereal disease. Am I correct in that?

The CHAIRMAN. Yes.

Mr. LaGUARDIA. I just want to point out—and I speak from actual experience—your authorization for appropriations is extremely low. I have spent a great deal of money during the past 12 years and I am very proud of what we accomplished in New York City; and the program which I left for my successor.

There is great need of hospitals in our country. We have county after county that has no hospital services at all, and some counties have no medical service. It is not in keeping with the dignity of our

country, or what we pretend to be and what we hold out ourselves to be to the world. I am very glad to hear that those provisions are at least hopeful of favorable consideration.

#### HEALTH INSURANCE MOST IMPORTANT LEGISLATION EVER BEFORE CONGRESS

Now we come to the health insurance. I consider that a most important piece of legislation, the most important piece of legislation ever before the Congress of the United States, second only to the original first commandments.

Now, gentlemen, in our country today the very poor and the very rich can get proper and complete medical and surgical care. Medicine has made such progress that it could afford to stop today and do nothing for 50 years, and the Government could not catch up with it. It is possible now to avoid diseases, to avoid sickness, and that is why your public health provisions in this law are so important.

We have already eliminated what at one time were accepted as acts of God, epidemics in cholera, malaria, yellow fever, and diphtheria. Why, Senator, I remember when I was a boy out in Arizona, when little children were infected with diphtheria, we knew that they would die. We were quarantined and kept in our houses. Today diphtheria is not an epidemic disease at all. It is the same with yellow fever and the same with cholera, and it is the same with tuberculosis.

Tuberculosis can be licked in this country in 25 years if we have proper controls as provided in this bill. That is not enough, the medical side is not enough, but you must also have proper housing, proper nourishment in the prenatal stages, and in infancy and childhood, and proper ventilation and sanitation, and then we will lick tuberculosis. There is no question about that. It is just waiting for the Government to step in and do it.

We are greatly in need now of more public-health doctors and nurses, public-health nurses. I would like to see a program started immediately for the training of this personnel. In the unhappy job that I have temporarily, I could use 10,000 public-health nurses in this world. The conditions in some parts of the world are a tragedy.

I have come to talk about the health insurance. I hope nobody will believe that the provisions of this bill are shocking, are extreme, or if I may use the pet expression which was used when I was a Member of Congress, are paternalistic. I suppose today they would say that they are communistic.

I do not care what you call it. It is a good plan and it is one that cannot be stopped. If this Congress does not do it, another Congress will, but I would like to see this Congress do it.

Now, I have just stated that in my city the very poor and the very rich can get full benefit of all of the progress of medical science. This is because the city of New York maintains and operates public free hospitals for the lower income group, and we have 20,000 beds. Some of our hospitals operate in connection with universities, and have scientific research departments. The very best surgeons and the very best doctors of the city are attached to these hospitals as visiting surgeons, so that the people, the members of families with an income of say under \$1,800, will get this treatment.

## HOSPITALS AND MEDICAL RESEARCH IN NEW YORK CITY

I have provided, and I will not bore the committee but I have the details here, something over \$100,000,000 for hospital expansion in New York City, and for research. As I said we carry on the research with agreements with the New York University Medical School, Cornell Medical and Columbia Medical Schools. One is the Nightingale Cancer Hospital. I had the foundations completed when war broke out and it was stopped. We will resume construction. That will be a 500-bed cancer hospital, with research in connection with the Presbyterian Hospital of Columbia Medical School. Then recently there was authorized a custodian cancer hospital in connection with Memorial. There we will have 300 beds and we will take chronic cases for two purposes—one is to find ways and means of alleviating pain and suffering, and the other to see what can be done with these cases.

Then we have the expansion of our present chronic-disease hospital which I built, and that has 1,200 beds, and there we carry on research in what is known as middle-age and old-age diseases, arthritis and hearts and things like that. Then we had the expansion of our tuberculosis service, rebuilding entirely a hospital, and we ought to take 1,800 or 2,000 there.

There is an expansion also at Kings County and Bellevue and the Tri-Borough Tuberculosis Hospital.

Then we have our medical research institute, and in connection with that we are building a hospital for research on tropical diseases. That is something that is spreading around the world now, and it requires a great deal of immediate and intensified research. We think that we can lick it.

I am very hopeful, gentlemen, that our public-health institute, the research institute, will be able, before long, to announce a startling discovery. We have been working on it for some time, and we had hoped to have it completed before this, because it would have saved a great many lives in the Pacific. That research is progressing very hopefully.

Now, in between the very rich and the very poor you have America. That is folks like you and me; and medical treatment, gentlemen, is necessarily and unavoidably extremely expensive. The cost of operating a hospital has increased from the time I took office on January 1, 1934, to the time I left, the end of 1945, I would say from 350 to 400 percent. It costs a great deal to operate a hospital and a great deal for medical care. It is not that the doctors are getting rich on it, it just went up with the general cost of medical supplies and all costs have increased.

Before we had the sulpha drugs, we manufactured a pneumonia serum in our health laboratory and we distributed it on the prescription of a doctor, and the average family could not afford it.

You can take a simple tonsil operation that almost every child must have, and by the time it is over it will cost \$100 or so. The routine dental attention of growing children costs money, and we figure that a baby in New York City, I do not know how much it is elsewhere, costs about \$100 a pound, if you give it proper treatment and give the mother proper prenatal and delivery treatment.

You will find that when you get your maternal-care provisions of this bill in operation, you will then realize how woefully short this country is of proper maternal care. You will have to build hundreds and hundreds of lying-in hospitals, and it will take you some time to get the necessary personnel to man these hospitals.

#### FINANCIAL BURDEN OF ILLNESS

That is why we have a great deal more sickness than we should have considering the economic condition—it is bad in some parts of the country—and we have too much sickness because of the lack of proper medical care.

A major disease, a major operation or a serious disease will throw a family budget out of gear for a year or a year and a half, and the family is compelled to borrow, and then they get into a worse disease, and that is the loan sharks. Do not get me started on that, because I would never stop.

There is nothing new in this plan, it is just pooling the health of the country, that is all there is to it. We pool our health so that the sick, regardless of economic conditions, can get proper care when it is needed. And in 5 years, gentlemen, if this plan is operated properly, you will be able to reduce your hospital cases and sickness by 50 percent, and that is no exaggeration.

I am not worried at all about the cost. No matter what the cost is, it is a good investment. Your operating costs will be greater the first 5 years and then will diminish. If you have the money on the table at this moment and say that you are going to start this plan all over the country on July 1, you cannot do it. It will take time to get this going in the entire country, and it is of great importance that it starts right, and if it starts right, it will be perfected and it will click. If it starts wrong, it will take a generation to correct the mistakes.

Now, I have said that I do not care what you call the bill, the purpose is to provide the best medical care, the most skillful surgical services to all, and that is the objective and that is all-important. The plight of the pill doctor does not concern me at all. But you will find that the outstanding physicians and surgeons of this country will support this bill individually. I know, because I have talked with them. We have been working on a health insurance plan in New York City for the last 5 years. It is just about ready to go into operation, and I announced 5 years ago, and I have announced it every time that I have mentioned it, that the minute that this goes into operation, we go out of business and we will turn over our experience to the Federal plan.

Senator ELLENDER. Do you not think that your plan might be as good as this or better?

#### NATIONAL INSURANCE BETTER THAN LOCAL PLANS

Mr. LaGUARDIA. No. I think that we would be better the first years in services, but I believe that the broader and the larger the plan is and the more people that it takes in, the cheaper it is of operation, and our plan is an emergency plan to take care of 7½ million people in New York City until such time as Congress enacts a national plan, and I am strong for a national compulsory plan. Ours is purely voluntary.

Now, there is provision here about all physicians being eligible, and that is all right. But we have to be realistic, and there is a great deal of misapprehension and misunderstanding as to medical care. A great many do not know the difference between public health and the practice of medicine, and that they are two distinctly different branches of medical science.

One is to prevent people from getting sick, and the other is to cure the man who is sick. No one doctor can handle a community. Oh, yes, you can tell me, "The old country doctor, he used to do it." Sure he did it because we did not know any better. I was raised with a post doctor, a regimental doctor, out in Arizona. That did not do us any good, but that is all that we had in those days. Now, no doctor can attend a community of and by himself any more than a man can pitch a game of ball by himself, or a quarterback can play a game of football by himself. You must have a team, and that is the way that we are organizing in New York City with these medical groups. Let us call them a medical team. This is the way you do it. You have your clinics. We did not invent that. The Mayo brothers did and others. We have an excellent clinic in Boston and one in Rochester, Minn. You start with your clinic and every insured person has the services of that clinic, and he goes at regular stated intervals, once a year or twice a year, and he gets a thorough overhauling, and they know all about him.

All right, if he has a belly ache on the way home, he can stop at the doctor's office or the clinic and get fixed up. If he is sick at home, he can choose from a panel of doctors, and he gets treatment at home, and if the patient is so sick that he must be hospitalized, he gets a specialist of his particular case. If consultation is ready, they are right there in that panel. If an operation is necessary, the right man operates.

Now, in the first years we are going to have a heavy load, not because there are more people sick, but there are more people who will have the benefit of getting medical treatment that now neglect themselves. This bill is going to be tough on the undertakers, it is going to reduce their bills, because a large number of people die because they have not any medical care, or improper medical care, that is why they die.

#### THE BILL DOES NOT REGIMENT DOCTORS

There has been a great deal said that this would regiment the medical profession. Well, I could almost hear some of them say it. It will not regiment them at all, but it will certainly given an opportunity for the skillful doctor, the studious scholarly physician, that keeps abreast, to develop and grow and to practice his profession. No one contemplates for a moment that skill should not be recognized. Under our plan in New York City, we estimate paying some salaries of \$25,000 or \$30,000 and here is the opportunity for the young graduate of medical schools to have a chance of really getting a start, and in many sections of our country they have no such opportunity.

We are limited in our capacity, in our hospitals, for interns, and in smaller communities the young graduate just has to grope his way along. This would provide a constant 24-hour medical service, emergency cases would be cared for by the younger doctors, who would immediately call for help if they found a serious case, and provide for office treatment, in the offices of the doctors, and provide for home

treatment and for the complete hospitalization including nursing.

What you have here that we have not got yet—and we are a little scared of it because we could get no figures on the cost—you very sensibly provide for dental care and that is very good, because we have learned that neglect of the teeth, particularly in children, leads to disease and sickness, or weakens resistance to such an extent that the child or the person is more susceptible to contagion. That is very wise.

I do not believe you will have any trouble at all in the limitations proposed by the bill for the time of treatment. I think that that would take care of itself. No one wants to remain sick. You will have no trouble with that.

#### IMPORTANCE OF GROUP PRACTICE

We will have a little trouble in such communities where you will not be able to form a complete team, and it is just left deuces wild, and you will have some cases of collusion. Now, we had them in New York City during the home relief days. During the home relief days when I had a load of about 350,000 families and 1,000,000 people, we established medical care for the home, and we did not have room in the hospitals for all of them, and there we found cases of collusion. It is quite true we have had cases of collusion in employers' liability work and that recurs from time to time. That is just human weakness, and there is nothing that you can do about that.

But by providing the proper balances and completed medical teams, all that will be avoided, because they arrange among themselves for pooling all of the fees.

Now, I want to be very frank in saying that I feel very strong about that.

Senator ELLENDER. You mean under your plan that you had in New York?

Mr. LA GUARDIA. That we are planning.

Senator ELLENDER. In New York?

Mr. LA GUARDIA. Yes.

Senator ELLENDER. You said all of that was on a voluntary basis?

Mr. LA GUARDIA. Yes, sir.

Senator ELLENDER. How did you raise the funds in order to fill the kitty, as it were?

Mr. LA GUARDIA. By groups, a large industry coming in with all of its employees. The city of New York I expect will come in with all of its employees.

Senator ELLENDER. And a certain percentage of the salaries is put up.

Mr. LA GUARDIA. We figure on 4 percent, 2 and 2. We think that can be reduced once we get started.

Senator ELLENDER. How much more or less would it cost the city if your plan should go through than it has cost in the past?

Mr. LA GUARDIA. I think the first year, Senator, I think it would cost us more the first couple of years, and after that I think that our hospital budget would reduce materially, because provision is made for paying the hospital expense.

Senator ELLENDER. Well, most of the money that has been spent in the past in New York City has been for preventive medicine, has it not?

Mr. LA GUARDIA. And cure. I have the hospital budgets of nearly \$50,000,000 in addition to the health.

Senator ELLENDER. How much of that was to operate hospitals for cure, curing people?

Mr. LA GUARDIA. You see, our hospitals are separated from health. When I say hospitals, I mean just hospitals.

Senator ELLENDER. Are they operated on a more or less charity basis to patients, or must they pay?

Mr. LA GUARDIA. I understand what you mean. We do not use the word charity, I do not in my vocabulary. They are operated on the basis of need, free. If we pick up an emergency case on the street for instance, and it does not qualify for free treatment, then arrangement is made to transfer it to a hospital, or then they pay what they should until he can be moved. But it is on the basis of free treatment.

Senator DONNELL. Do any of the hospitals that treat people free make charges for those who can pay?

Mr. LA GUARDIA. Only if they are brought there through emergency, and otherwise we do not admit them.

Senator DONNELL. I see.

#### PLAN SHOULD BE PUT INTO EFFECT GRADUALLY

Mr. LA GUARDIA. Now, what I want to stress is that the bill make it very clear that States should be able to qualify by presenting a plan containing sufficient medical and surgical personnel, and States should be also able to divide their territory, because it will take several years before some States and parts of States will be able to provide the necessary medical talent. It just does not exist today. You have an opportunity to get a splendid start here by taking it in localities where they are able to give the service, because it would be manifestly unfair to make a charge and not be able to give the proper kind of service.

Senator DONNELL. I am not clear as to which part of the bill you are talking about when you speak about qualification by the States. To make my inquiry somewhat more concrete, title I of the bill pertains to grants to States for health services, and on page 35 you take up title II in regard to prepaid personal health service benefits. Now, is it not a fact that title I proceeds on the theory of grants-in-aid to the States who shall operate the facilities, and title II, on the contrary, contemplates not an operation by the States, but an operation by the Federal Government?

Mr. LA GUARDIA. That is right

Senator DONNELL. So is your qualification of States that you are speaking of confined to title I of the bill?

Mr. LA GUARDIA. No.

Senator DONNELL. Just what do you mean by "qualification of the States" as referred to in title II?

Mr. LA GUARDIA. In title I, to provide adequately there were certain qualifications. Now, on title II, perhaps the word "State" is bad. You can say area, if you please, because title II covers people, it is a Federal operation, is that right?

Senator DONNELL. That is the point that is in my mind. I could not understand what you were referring to by State qualifications under the nationally operated system.

Mr. LA GUARDIA. I say that we should not go in a given area, unless we are able to provide the proper kind of medical service, because the people are paying on that.

Senator DONNELL. But, Mr. LaGuardia, is not title II Nation-wide and does not involve State administration at all?

Mr. LA GUARDIA. No.

Senator DONNELL. Then where is there any necessity for State qualification under title II, that is what I am trying to find out?

Mr. LA GUARDIA. We will call it area qualifications.

Senator DONNELL. Area qualification for what?

Mr. LA GUARDIA. Before you start to charge the people, on the pay rolls, you should have the ability to give the service, is that not right?

Senator DONNELL. I would think so; yes.

Mr. LA GUARDIA. And I say you cannot do it overnight. We ought to start the system in areas where it is possible to give the proper kind of medical, surgical, and hospital care.

Senator DONNELL. Mr. LaGuardia, pardon me; perhaps I do not get your point, but as I understand title II, it involves a Nation-wide operation, that is to everybody in New York and everybody in Wyoming and everybody in my own State of Missouri, shall be entitled to the benefit of it. Now, I do not find in title II anything that refers to State qualification, and I wish you would be kind enough to point that out.

Mr. LA GUARDIA. There is nothing.

Senator DONNELL. So that you are recommending an addition to title II. In other words, as I understand your testimony, while it is a Nation-wide operation, you would defer the benefits of that operation to any given area until the area shall have provided necessary facilities to enable the operation to be successful; is that your thought?

Mr. LA GUARDIA. Until the administration can get the doctors in there.

Senator DONNELL. Under the Nation-wide administration?

Mr. LA GUARDIA. Your administration is provided for here, and that is quite all right.

Senator DONNELL. Which section is it that you are referring to, Mr. LaGuardia?

Mr. LA GUARDIA. I am referring to the whole thing. I want to point out that if this were to go into effect on July 1, in many sections of our country we cannot provide proper medical care.

Senator DONNELL. The point I do not understand of your testimony is where the States are required or can practicably be required under title II, to qualify, because title II is a Nation-wide insurance plan.

Mr. LA GUARDIA. I grant you that.

Senator DONNELL. And when the man in Dakota pays his percentage, he is entitled to the benefits under title II, and it would not be fair to him to defer his getting the benefits until the National Government should have caused some people to come in as doctors to settle there.

Mr. LA GUARDIA. I hope that they will not charge the man in any area where we are not able to give the services, until such time as we are able to give the services.

Senator DONNELL. In other words, you would not then institute a Nation-wide prepaid personal health service benefit at this time. You would require, as I understand it, that each State or each area, perhaps better stated, shall have first demonstrated its capacity to take

care of the problems before you would impose the tax in that area, is that right?

Mr. LA GUARDIA. I would establish a national system, and I would put it into operation and make the charge wherever there is personnel and facilities to give the service, because it would be manifestly unfair, the charge being uniform, not to provide uniform first-class services for the same cost.

Senator DONNELL. That would necessitate a very different bill from what we have before us here, in order to put into effect your suggestion, would it not?

Mr. LA GUARDIA. Not at all.

Senator DONNELL. There is nothing in title II that undertakes to say that this Nation-wide prepaid personal health service benefit shall only go into effect piecemeal here and there throughout the United States, is there?

Mr. LA GUARDIA. I would put it in.

Senator DONNELL. What would you provide there in substance?

Mr. LA GUARDIA. I would provide that the Surgeon General may establish health insurance zones, and as such zones are established, people resident therein shall be entitled to the benefits herein provided, and the Surgeon General shall provide as rapidly as possible proper medical facilities and hospitals, as well as personnel, in all areas, and when such areas have been certified by the Surgeon General, they shall become eligible under the plan.

Senator DONNELL. You would not assess a pay-roll tax then in area No. 7, for illustration, until the benefits of the bill shall have been put into effect with respect to area No. 1?

Mr. LA GUARDIA. That is right.

Senator DONNELL. Now, Mr. LaGuardia, that is a very interesting suggestion, and I am sure our committee is glad to have it, but to my mind it would necessitate a tremendous change in this title II of this bill, because this is a Nation-wide proposition encompassing and envisaging, as I understand it, an assessment of some kind of a tax, Nation-wide, rather than starting a tax in Missouri and Oklahoma and Kansas 1 week and waiting 6 months before you put the Federal tax into effect in three other States.

Mr. LA GUARDIA. You would not put on the Federal tax unless they were getting the service.

Senator DONNELL. Well, Mr. LaGuardia, do you think it would stand the test of the uniformity of taxation throughout the Nation to impose a Federal tax in two or three States and then wait 6 months before you imposed a Federal tax in two or three other States?

Mr. LA GUARDIA. Certainly, people in my city drink French champagne, and they pay the tax on that; and the people in Iowa do not drink the champagne, and they do not pay any of that tax.

Senator DONNELL. But the tax is uniform throughout the Nation, and the only question that arises in the collection of taxes is whether the champagne has been used. But, as I understand your suggestion—and if I am wrong I would like to be corrected—it is that the Surgeon General shall be authorized to establish areas—just to illustrate, suppose he established 15 areas consisting, roughly, of 3 States each. Now, as I understand it, you would say that area No. 1 should not receive the benefits of the bill until it shall have qualified.

Mr. LA GUARDIA. Until he qualifies it.

Senator DONNELL. And that the tax imposed by the Federal Government for the operation of this system should not go into effect in those three States until the Surgeon General shall have qualified that particular area; is that right?

Mr. LA GUARDIA. That is right.

Senator DONNELL. I think that that involves an exceedingly interesting legal question, namely, whether the Federal Government can impose a tax, a Federal tax, applicable only to an area, we will say, of three States of the Union; if that can be done, that is something that I have never heard of being done before.

Mr. LA GUARDIA. They get corresponding service and benefits.

Senator DONNELL. Do you know of any instance in the history of the Union where the Federal Government has imposed a tax, a Nation tax, applicable only within three States or any particular portion of the area of the United States? Do you know of any such illustration?

Mr. LA GUARDIA. No; because we have had no similar case before. Where the tax does not go into the general fund, it is earmarked; it goes into a separate tax for certain benefits; and where you cannot provide the benefits, I do not want to give this law a black eye by collecting the premiums and not giving the benefits.

Senator DONNELL. Mr. Chairman, may I ask one more question: Has the legality of your suggestion of this area tax to be imposed by the Federal Government been examined by you Mr. LaGuardia?

Mr. LA GUARDIA. No; but they have not gone out of business across the square.

Senator DONNELL. I understand they would have it presented to them in due time, but they could not give advice or opinions in advance. Has the legality of your suggestion that the Government put into effect taxes applicable only within given specific areas been looked into, do you know?

Mr. LA GUARDIA. No; but you distort the problem, Senator.

Senator DONNELL. Not intentionally; I thought that I had stated your suggestion.

Mr. LA GUARDIA. It is not taxing one section and not taxing another. It is providing benefits and taxing where the benefits are provided, and qualifying as quickly as you qualify them to provide the benefits.

Senator DONNELL. That is what I understood your suggestion to be. Pardon me just a second. I understood your suggestion to be just as you have stated it, namely, to illustrate, that the Government, the Surgeon General, should divide the entire Union into 15 districts, 15 areas, areas 1 and 2, and so on; and as area 1 qualifies, the tax should be imposed and the benefits granted; that is your suggestion?

Mr. LA GUARDIA. That is my suggestion.

Senator DONNELL. Now, the question that I asked you—and I will desist with this question—has the legality of this plan of imposing a tax, a Federal tax, only on one portion of the United States been examined into, to your knowledge?

Mr. LA GUARDIA. I do not think so, sir.

Senator DONNELL. Thank you.

Mr. LA GUARDIA. That should not scare us.

## HOSPITAL CONSTRUCTION

Senator ELLENDER. Mr. LaGuardia, as you know, the bill does not provide for the construction of any facilities. Title I, as you have just indicated, provides grants for the purpose of improving health, and the other is for prepaid personal health service benefits.

Mr. LA GUARDIA. That is right.

Senator ELLENDER. Well, now, what method would you advocate in order to provide the facilities you say are necessary and which you say should be erected in communities so as to afford the benefits of this bill to everybody?

Mr. LA GUARDIA. I think that your public health grants and maternity and child health grants and your needy persons, and where you make provisions for venereal and tuberculosis, they are needed.

Senator ELLENDER. That is for preventive medicine, and I understand it, but I am talking about hospitals in order to carry out title II of the bill. As I have indicated, there is no provision in the bill for building facilities.

Mr. LA GUARDIA. You need them; absolutely.

Senator ELLENDER. I know; but how should we provide them?

Mr. LA GUARDIA. The same as you do by grants or otherwise, or out of the fund.

The CHAIRMAN. There is a hospital bill now.

Senator ELLENDER. It is limited in scope, and it does not provide a sum sufficient for more than a modest beginning.

The CHAIRMAN. It can be expanded, of course.

Mr. LA GUARDIA. You see, under the practice of medicine, you must have hospitals to carry out the complete medical service. You have to have operating facilities, and you provide for the maternity cases, so that you take large areas of our country, and—let us be frank about it—they just have no hospital facilities at all, and you will have to send some doctors down there and some nurses down there to operate under your title II. They will have to provide the medical service.

I do not want the opponents of health insurance to have the opportunity to say, "See, you are being taxed, and you are not getting the medical service"; and that is what they are waiting for.

## GRADUAL INTRODUCTION OF THE PLAN

Senator DONNELL. May I ask another question? On this matter of dividing the Nation into areas and making this prepaid personal health service benefit plan come into existence in one area before it comes into existence in another, there has been made the suggestion here before the committee a few days ago, that the plan be financed in one of two ways, or rather, perhaps, one of three ways, either through pay-roll taxes, applicable both against employers and employees, or through an earmarked income tax, or possibly through a combination of the two. Now, if we take a situation under your plan as I understand it, where the Surgeon General says, "All right, New York, Pennsylvania, and New Jersey, area No. 1, they are all ready for this personal health service benefit to come into effect," would you under your plan have the taxes that the Federal Government secures, levies, and collects, derived solely from that area in order to pay the expenses within that area, of those three States?

Mr. LA GUARDIA. Certainly, on the pay roll.

Senator DONNELL. On the pay rolls?

Mr. LA GUARDIA. Yes.

Senator DONNELL. Now, would you advocate a general income tax earmarked as to this purpose for the purpose of paying part of the expenses of the plan?

Mr. LA GUARDIA. Then I would get in trouble.

Senator DONNELL. You would not advocate that?

Mr. LA GUARDIA. Then I would get into trouble.

Senator DONNELL. Would you advocate it?

Mr. LA GUARDIA. If it is universal.

Senator DONNELL. After it becomes universal, would you then advocate it?

Mr. LA GUARDIA. I would not care how the money was raised.

Senator DONNELL. You would not care how it was raised, but you would advocate that as area No. 1 is qualified by the Surgeon General, well take for example those three States—New York, Pennsylvania, and New Jersey—that a pay-roll tax authorized and put into effect by the Federal Congress shall come into effect in New York, Pennsylvania, and New Jersey by themselves?

Mr. LA GUARDIA. That is right.

Senator DONNELL. And that tax would not be in effect anywhere throughout the United States except those three States until other areas shall respectively qualify, is that right?

Mr. LA GUARDIA. That is right.

Senator DONNELL. Mr. LaGuardia, is not there the greatest of doubt in your mind as to the validity of any such scheme of taxation, whereby the Federal Government can impose a Federal tax on a little isolated area in the country by itself and not make it Nation-wide?

Mr. LA GUARDIA. No.

Senator DONNELL. There is no doubt in your mind?

Mr. LA GUARDIA. Because they are getting direct benefits from it.

Senator DONNELL. You think there is no doubt about that?

Mr. LA GUARDIA. None whatever. That is what I meant, Senator, when I said that medical science has progressed so far ahead of Government. That is a beautiful illustration. Now here we are quibbling over a technicality, whether a premium is a tax and whether the benefits should correspond with the tax, when medical science is ready to go out and cure people and keep them healthy and happy.

Senator DONNELL. But still, Mr. LaGuardia, we still have a Constitution, have we not, that must be followed?

Mr. LA GUARDIA. That is right.

Senator DONNELL. And in order that your plan shall be valid, it must square with the Constitution.

Mr. LA GUARDIA. You must construe the Constitution in the light of the age in which we are living.

Senator DONNELL. Is there any illustration that you know of, Mr. LaGuardia, from the beginning of the Nation down to the present minute, both inclusive, in which the Federal Government has ever levied a tax applicable only against a particular segment of the area of the country and not applicable against the others?

Mr. LA GUARDIA. No; there are some State taxes.

Senator DONNELL. There are State taxes imposed by the States, but I am talking about the Federal Government, the National Gov-

ernment. Is there any case in which the National Government has ever imposed a tax applicable only against two or three States, we will say, of the Union and not applicable against the others?

Mr. LA GUARDIA. Is there any tax on oil and mineral?

Senator DONNELL. It is applicable against all oil and mineral wherever it is found.

Mr. LA GUARDIA. This would be applicable wherever the services are rendered.

Senator DONNELL. But this tax would only be applicable in area No. 1 when that qualifies under the regulations of the Surgeon General.

Mr. LA GUARDIA. When the services are provided.

Senator DONNELL. So we would find a tax gradually becoming applicable in some sections and maybe in some sections never applicable, if they did not qualify.

Mr. LA GUARDIA. But it is the duty to provide the services.

Senator ELLENDER. Under your proposal, Mr. LaGuardia, or suggestion, what about this proposition, that if area No. 1 through sufficient pay rolls can collect enough money to take care of the people in that area, and in area No. 2 it cannot be done, would you want area No. 1 to come to the rescue of area No. 2?

Mr. LA GUARDIA. That is a benefit of the national plan. Of course, the healthy people come to the benefit of the sick, the same way you and I carry insurance and because we live we are paying the benefits of those who died, to their families.

Senator ELLENDER. The great trouble today is, that is in the Hill-Burton bill that the Senate passed about 3 weeks ago, as I recall, wherein a certain sum of money was set aside for the purpose of building hospitals and clinics where needed, and, of course, the thing stressed was need.

Now, your plan, as I understand, would mean that if area No. 1 has the facilities, your idea would be to tax immediately all of the residents in that area No. 1?

Mr. LA GUARDIA. That is right.

Senator ELLENDER. For a sum sufficient to pay the expense of operating those facilities, so that all in that area can receive medical attention.

Mr. LA GUARDIA. I expect to have some left over there.

Senator ELLENDER. Around Mexico and Arizona and places out there where they are not so fortunate in having large pay rolls as you have in Pennsylvania and New York, how would you take care of that area?

Mr. LA GUARDIA. The pool, the fund will take care of it.

Senator ELLENDER. So that you would ultimately, then, make the tax Nation-wide?

Mr. LA GUARDIA. Oh, yes.

Senator ELLENDER. And to be used everywhere to give to all of the people, no matter where they are, irrespective of what the amount collected, the same medical treatment.

Mr. LA GUARDIA. Certainly, but I do not want to charge where we cannot give the service until we are able to give the service, and, of course, the bigger and richer States will pay more, because medical services are pretty costly when you have to cover large areas as in Arizona and New Mexico.

Senator ELLENDER. In order to be able to reach that goal, to provide the necessary facilities to care for all of the people and put a uniform tax over everybody, it will probably take many, many years.

Mr. LAGUARDIA. It will take a few years to build up a proper service, but we ought to take advantage of what we can and get this thing started, but I want to start it right.

Senator DONNELL. I understand in response to Senator Ellender's inquiries, that when the United States, all of it, shall have become qualified, then if there is any deficit in any particular area, it will be met by general taxation of some kind.

Mr. LAGUARDIA. Yes.

Senator DONNELL. Suppose, however, that in the process of development, we will say that New York, Pennsylvania, and New Jersey shall be made area No. 1 and it qualifies on the first day of July, but there is a deficit in that area, we will just assume that for purposes of discussion, deficit from the tax which the Federal Government under your plan would impose solely on the people in New York, Pennsylvania, and New Jersey, how would you meet that deficit?

Mr. LAGUARDIA. For the first 5 years?

Senator DONNELL. For any number of years.

Mr. LAGUARDIA. That would balance the cost of providing facilities in other areas of the county that did not provide them themselves.

Senator DONNELL. I do not think that I made my inquiry clear. Suppose that New York, Pennsylvania, and New Jersey constitute area No. 1.

Mr. LAGUARDIA. That is right.

Senator DONNELL. And suppose that on July 1, 1946, the Surgeon General certifies that that area is duly qualified, and thereupon the Federal Government slaps on a tax applicable to all of the people in New York, Pennsylvania, and New Jersey.

Mr. LAGUARDIA. Yes.

Senator DONNELL. Suppose that that tax which the Federal Government imposes on them shall not prove sufficient to pay the expenditures, we will say in the first 5 years, while some parts of the remainder of the United States are not yet qualified, would you advocate that the Federal Government shall pay the deficit incurred in New York, Pennsylvania, and New Jersey, or would you advocate that those States should pay it, or just what would your plan be then?

Mr. LAGUARDIA. You have two alternatives. If you have a general fund for building up this plan, which would include the training of doctors and nurses and providing facilities as we do in the other bill, there you have a national charge, and if there were any deficit, it could come out of this fund or it could be applied by increased rates locally. But to have a health insurance plan in our country successful, it has got to be national in every State of the Union.

Senator DONNELL. Then if it should take 2 or 3 years before these sparsely settled sections of our country shall have qualified, and a deficit shall have accrued in the meantime in some of these larger and more popular sections of the country, you would advocate, would you, that the deficit be paid by taxation upon all of the people of the United States?

Mr. LAGUARDIA. No; you could increase the contributions.

Senator DONNELL. You mean in the local area?

Mr. LAGUARDIA. Yes.

Senator DONNELL. You would have a local area until the entire country shall have become qualified, you would have each such local area severally meet its own deficit?

Mr. LA GUARDIA. You see, Senator.

Senator DONNELL. Is that correct? Pardon me, I did not get your answer.

Mr. LA GUARDIA. The answer is that areas that can now qualify can operate without a deficit. The deficit will not come from the areas that have medical services now. The deficits will come in sparsely populated areas and in certain sections of our country that have hardly any medical services at all. There is where the deficits are going to come.

Senator DONNELL. Assume that to be true. However, for the purpose of argument, just assume that for some reason, due, we will say, to epidemic or something of the kind in these three States of New York, Pennsylvania, and New Jersey, there should be a deficit before the areas all over the country have become qualified. Would you advocate that the local communities—New York, Pennsylvania, and New Jersey—should meet those deficits, or would you have the deficit met by general taxation all over the United States?

Mr. LA GUARDIA. I will not fall for that one. I would increase the rates locally. I will not fall for that one.

Senator DONNELL. Just one question. I take it that we are clear on the fact that title II of S. 1606 does not contain the suggestion that you have made here today about this formation of areas, gradual qualification of them, and the imposition of a Federal tax applicable solely to each qualified area. It does not contain such provision.

Mr. LA GUARDIA. No.

Senator DONNELL. Thank you.

The CHAIRMAN. Do you think there is any likelihood of deficits under this system occurring in the rich industrial areas of the country?

Mr. LA GUARDIA. No; we will have no deficit there at all. Where you will have the deficit, if you want to know, will be such States as Mississippi, Alabama, parts of Georgia, large States like New Mexico, and Arizona and perhaps Montana, where you have to provide certain minimum requirements of services, and you are bound to have deficits. We in the industrial centers are happy to contribute to that.

The CHAIRMAN. And the policy of developing facilities in those backward areas has already been established by the United States.

Mr. LA GUARDIA. And we are paying part of that.

The CHAIRMAN. And it is now on foot. We are planning on constructing hospitals and facilities in those backward areas. You could not believe that that would take any great length of time to set up the necessary facilities in those areas, if the funds were made available for that purpose.

Mr. LA GUARDIA. Not for physical facilities. I think if you had the money ready now and assuming that we had building material, if we had the building material, we could build all of the hospitals. Look what we do in a war, and this is a war against disease, and against poverty, and against hardship. We could build all of the hospitals we wanted with our resources in the course of two years and a half, or 30 months, if we had the material and the money. The personnel will take a little longer.

## HOSPITAL PLANS IN NEW YORK

The CHAIRMAN. Is there need of further hospitals and facilities in the New York area?

Mr. LA GUARDIA. I will give you an idea, gentlemen, and this is not false. Here is what I provided for: This is all new. The new general hospitals at East Bronx will provide for 750 beds, estimated authorized amount, \$6,034,000.

The new general hospital in Queens, authorized, 750 beds, \$6,000,000. The Queens General Hospital, new out-patient department, that is out-patient department to our existing general hospital, that is \$2,368,000.

I will not bother you with laundries, but that is a big item in a hospital. Now, the Bellevue reconstruction, they now have about 3,000 beds, and, gentlemen, we are going to rebuild that whole thing and that will be the greatest medical center in the world.

The CHAIRMAN. Is this a State program?

Mr. LA GUARDIA. A city program. That is \$16,200,000. All of this money is well spent.

Senator ELLENDER. You mean in addition?

Mr. LA GUARDIA. This is \$16,000,000 alone, each one is money.

The CHAIRMAN. That has nothing to do with the Federal program of hospital construction.

Mr. LA GUARDIA. We would like to get some of your money for my successor. The new chronic disease hospital at Welfare Island, with a bed capacity of 2,000 and 1,000 of these are for custodial bedridden patients.

You see what happens today, gentlemen, you take chronic diabetes cases or just old-age disability, people take them and bring them to one of our hospitals and that is the end of it. And they occupy a bed that is needed for an active case. That is why we are providing these new custodial hospitals. Here is a new general hospital in East Harlem, that is 750 beds, \$6,000,000. Here is a new Bellevue Hospital Nursing School, this is for training of nurses, that will provide 950 nurses at \$5,085,000.

Here is a nursing school in Queens General Hospital, 200 students, \$1,400,000. Here is my Cancer Memorial Hospital I told you about with 300 beds, advance cases, \$1,500,000.

Here is Nightingale Hospital, cancer research, \$4,023,000. Here is Kings County Hospital, tuberculosis extension, 750 beds at 254 chronic tuberculosis cases, that is \$3,250,000. The reconstruction of Seaview Hospital on Staten Island, 2,000 patients, tubercular, \$7,500,000.

Reconstruction of Harlem Hospital, that is in addition to the new Harlem Hospital, and an increased bed capacity from 754 to 934, that will cost us \$3,800,000.

The hospital downtown East Side section, 500, at \$3,800,000. There is a hospital we are going to increase from 389 to 637. You see a hospital under 500 beds, the overhead is so much greater that it just does not pay. When you get a 250-bed hospital, unless it is definitely for research, the overhead is enormous and so we are increasing that.

Cumberland Hospital is still in its planning stage. Green Point Hospital reconstruction, 500 beds, \$4,100,000. Coney Island, we are going to rebuild, that is 500 beds, that is \$4,000,000.

Now, that is an idea of what the needs are today to give to the people the full advantage of progress in medicine, and that is only one little town on the Hudson.

The CHAIRMAN. You are president, or former president, of the United States Conference of Mayors. Do you know whether or not in other metropolitan areas programs of hospital construction are going forward?

Mr. LA GUARDIA. Yes; they all have programs. I can tell you how I will give you that. They have all filed their plans. Now, I have received planning money on two or three of these hospitals under the planning bill that Congress has passed, and I am hopeful of getting grants.

Senator ELLENDER. Mr. LaGuardia, in the various instances or examples that you have given to the committee as to what is being planned in that "little city on the Hudson," the aggregate amount of expenditures alone, with a quick guess, would be around \$35,000,000 or \$40,000,000?

Mr. LA GUARDIA. It is about \$100,000,000. Laundries and things like that, I did not bore you with.

Senator ELLENDER. The Burton-Hill bill that the Senate passed 3 weeks ago provides for only \$75,000,000 per year for the entire Nation.

Mr. LA GUARDIA. It is a start.

Senator ELLENDER. That is most inadequate?

Mr. LA GUARDIA. It is modest, but it is a start.

The CHAIRMAN. A larger sum was suggested, but the Congress held it down.

#### MEDICAL EDUCATION

Senator ELLENDER. Now, in addition to the hospitals to take care of the sick, can you not also see the necessity for educating more doctors?

Mr. LA GUARDIA. I have stressed that.

Senator ELLENDER. How would you do that?

Mr. LA GUARDIA. With these hospitals. You cannot educate doctors unless you have hospitals.

Senator ELLENDER. How would you provide for that? Would you say that the Congress ought to provide means by which doctors are to be educated?

Mr. LA GUARDIA. Senator, there are 25,000 able, competent young students in this country today that cannot get into medical schools because we have not the facilities. That is no exaggeration.

Senator ELLENDER. Would you provide for the education through Federal means or Federal funds?

Mr. LA GUARDIA. No; they would take care of themselves.

Senator ELLENDER. They would.

Mr. LA GUARDIA. Yes; we had no trouble getting students. The trouble is in facilities.

You see, a medical school is not like a law school. A law school you just jam them in, and you throw them in, and they listen some-

times and sometimes they do not listen, and it makes no difference. But in a medical school you have to have the facilities, and you have to have your dissecting rooms, and you have to have your "labs," and you have to have the facilities, and they are limited in number.

Senator ELLENDER. Would you provide for any funds in order to help them in their education?

Mr. LA GUARDIA. No; the hospitals will do that. I am not exaggerating when I say that there are from 20,000 to 25,000 young students trying to go into medical schools and cannot get in.

#### PROFESSIONAL INCENTIVE UNDER HEALTH INSURANCE

Senator ELLENDER. What incentive would there be for those young doctors, who propose to take up medicine, when they would be confronted with a proposition whereby they would have to submit to a plan, or, say, they would have to qualify under a plan originating in Washington before being employed or their fees would be fixed in advance?

Mr. LA GUARDIA. I think the same incentive that you and I had when we went to law school, we would go to Congress some day.

Senator ELLENDER. That may be, but the trouble is, you would have a board here in Washington fixing a set of fees applicable in various areas of the country, by which a doctor would have to abide.

Mr. LA GUARDIA. He would make a nice living and render fine services.

Senator ELLENDER. And of course, it might lead to being put on a salary basis.

Mr. LA GUARDIA. It is better to be on a salary basis than have fees and be unable to collect them.

Senator ELLENDER. You still think that young men would have the incentive?

Mr. LA GUARDIA. Certainly.

The CHAIRMAN. There are a great many young doctors today that are unable to exercise their profession because they cannot get any place where they can get business. If they go to the backward sections of the country, they cannot live.

Mr. LA GUARDIA. Those people are really martyrs, doctors in this country, there are thousands of them, who are just rendering a community service and eking out an existence. Why old man Defoe told me he never made over \$300 a year until Mrs. Defoe came along and then he was living in clover, and he got the allowance from the Dominion of \$1,800 and he used to come down to my town to celebrate. He is a great old man.

The CHAIRMAN. The establishment of this system would result in greatly increased incomes for the average medical practitioner.

Mr. LA GUARDIA. And for the average American family, too, in savings. The only ones who will suffer are the loan sharks and the undertakers. It will be tough on them.

The CHAIRMAN. The State of Virginia, according to the morning press, has made appropriations for scholarships for young men who want to study medicine.

Mr. LA GUARDIA. That is fine.

The CHAIRMAN. That could be done in other sections of the country where there is need for physicians, could it not, to give their local

young people an opportunity? For instance, in my State of Montana, we are losing population because there is no opportunity for young people out there. There would be nothing wrong with the State of Montana making some appropriations and having some of their young men study medicine and come back and practice medicine in the State where there is great need for doctors. We have to call upon the Red Cross in sections of our State. A few years ago we did that because no doctor could live there, and he could not make a living, and we had to have Red Cross relief. It seems to me that there is great opportunity in this country for bringing students out to the backward sections of the Nation and giving them an opportunity to make a splendid living.

Mr. LA GUARDIA. I do not think that they are backward sections in the real sense of the word, they are fine sections of the country needing medical services.

Senator ELLENDER. I would say our State has done a little better than Virginia has. We have a splendid medical school wherein a boy can get a medical education free of charge.

Mr. LA GUARDIA. That is pretty generous.

#### WHY NOT LEAVE IT TO THE STATES?

Senator ELLENDER. That is why during the course of these hearings, I have advocated that if we were to leave a little more of the planning to the States and help the States to carry it through, we might do better than to try to create a plan here that is national in scope and under the thumb of Washington.

Mr. LA GUARDIA. Well, Senator, some years ago, I think many years ago, that argument would have been all right. But I lived 14 years on the other side of this building, and every time something would come along, they would say, "Let the States do it." Now, there was one time, and the whole thing has shifted now, and people who would argue against States' rights, the old Hamiltonians, they have all become States' rights people all of a sudden, and I cannot help it.

We have to live in accordance with growth and development and progress. We are growing, and the State argument just does not click any more, Senator.

Senator ELLENDER. Would you suggest that we do away with States altogether, and just have one United Nation, is that your view?

Mr. LA GUARDIA. We have a great many united ethics, and we did not have any public health originally, none at all.

Senator ELLENDER. All of that has been done by cooperation between the Federal and State Governments.

Mr. LA GUARDIA. Yes, until they found that a microbe did not recognize a State line, and public health had to step in.

Senator AIKEN. You have not heard all of the States' rights champions coming in here and asking for all kinds of Federal legislation to control labor, have you?

It is something that I cannot understand, sometimes the most ardent advocates of States' rights are asking for Federal regulations to control labor and keep union labor in the State of New York, for instance, and other States, from committing acts of violence.

Mr. LA GUARDIA. The States' rights people never object to agricultural relief.

Senator DONNELL. Mr. Chairman, may I ask Mr. LaGuardia a few more questions. Mr. LaGuardia, do you in your opinion generally speaking, do you think that this bill would prove a financial benefit to the physicians of the country?

Mr. LA GUARDIA. I think it will give them security and give them what every physician likes more than anything else, an opportunity for the full expression of his profession, because it will give him plenty of practice.

#### ATTITUDE OF THE AMERICAN MEDICAL ASSOCIATION

Senator DONNELL. You know it to be a fact, do you not, that the American Medical Association is strongly against this type of legislation?

Mr. LA GUARDIA. Mr. Fishbein is.

Senator DONNELL. Well, the association has so expressed itself, has it not?

Mr. LA GUARDIA. I think Mr. Fishbein is neither "fish" nor "bein." He is mostly "bein," and it is in his head.

Senator DONNELL. Regardless of that, the American Medical Association has gone on record very strongly, has it not, against legislation for compulsory health insurance, of a Federal nature?

Mr. LA GUARDIA. Yes, as an association they have some resolution, but like every other kind of an organization I suppose they have a board of directors. But actually I have talked with the best physicians in this country, I think, on this question—not today or yesterday but for the last 10 or 15 years, and they all recognize that this is coming.

Senator DONNELL. But the point I am making is that the American Medical Association which as I understand it is the largest association of physicians in the country, has expressed itself in opposition to compulsory health insurance, has it not?

Mr. LA GUARDIA. As an organization, yes.

Senator DONNELL. Now, Mr. LaGuardia, let me ask you, I know that you have given us very courteously and interestingly this morning your general views. Have you examined the entire bill in detail?

Mr. LA GUARDIA. Not in detail.

Senator DONNELL. You mentioned earlier that there is nothing new, as I understood you to say, in this plan. It is simply a pooling of resources, is that your thought?

Mr. LA GUARDIA. Yes. I said a pooling of health.

Senator DONNELL. A pooling of health, very well. Have you read that portion of the bill which appears on page 50, and which authorizes the Surgeon General to prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish general medical or general dental benefits?

Mr. LA GUARDIA. Certainly.

#### FREEDOM OF CHOICE OF DOCTOR

Senator DONNELL. That of course, as I see it, and I am wondering if you agree with me, would mean that if the Surgeon General had prescribed, we will say, for Mr. Smith, in Jonesville, N. Y., or Dr. Smith, a limit of 500 patients, that if you desired to consult him and

desired him to be your doctor and you were the 501st patient, that you could not get him, that is correct?

Mr. LA GUARDIA. He may drop somebody else.

Senator DONNELL. But suppose that he did not drop anybody else?

Mr. LA GUARDIA. Then he is limited.

Senator DONNELL. And you could not get on his list?

Mr. LA GUARDIA. That is right. Let me say this: That is a very good provision.

Senator DONNELL. Why do you regard that as good?

Mr. LA GUARDIA. Well, I will tell you, Senator. We have had some experience on that, and this is what happened: We had the situation where we had a great deal of sickness and we could not take all of the hospitals, and you cannot take a patient and put him in a hospital. So we could not put the patients in the hospitals, and then we had doctors that had so many cases in one month that without figuring the time of travel, he could not have given his patient more than a minute and a half; and therefore we hit upon the idea of having a maximum number of visits or patients in a month, in order to curb the soliciting of business and collusion. I think that this is a good provision and the doctors like it.

Senator DONNELL. The point I was getting at was this: if in a small community, like the one in which I live, a suburb of one of the mid-western cities, if I desire to consult with a given doctor, say, Dr. Jones, and his quota is made up, he has 500 patients allotted to him, and I am 501 or 502, I cannot receive his services?

Mr. LA GUARDIA. He can drop someone else, can he not?

Senator DONNELL. I am not sure about that.

Mr. LA GUARDIA. Suppose Dr. Jones has just one patient. You come along, and he can say, "I don't want you."

Senator DONNELL. He can do that, of course; but if he and I are willing, there is nothing to prevent that from existing under the present law existing today, at this minute.

Mr. LA GUARDIA. No.

Senator DONNELL. But if this law goes into effect and he does have his quota of 500, and he is satisfied with his quota, and I come along and want to get in myself, there is no way I can engage him without having him drop someone off his quota?

Mr. LA GUARDIA. I think that is an extreme determination, Senator.

Senator DONNELL. It is true, is it not?

Mr. LA GUARDIA. Yes.

Senator DONNELL. I wonder if you have observed, Mr. LaGuardia, on page 45, subdivision (c) of section 205, that the Surgeon General has the right to determine who shall be considered "specialists or consultants". I think I am correct in my interpretation of the bill that only those persons that he may designate to be specialists or consultants can operate or practice in those capacities.

The CHAIRMAN. Before you answer that question, I would like to suggest that the bill contemplates an advisory committee made up of physicians.

Mr. LA GUARDIA. That is the practice today, Senator. That is in the canon of ethics today, that if someone wants him to act as a specialist he has to have certain experience and qualifications.

Senator DONNELL. But the point I am getting at, Mr. LaGuardia, is this: although under section 205 A, to which you referred earlier

in your testimony, provides that any physician, dentist, or nurse legally qualified by the State to furnish any services, including personal health service benefits under title II, shall be qualified to furnish those benefits under said title, there is an apparent exception set forth, namely, specialists and consultants?

Mr. LA GUARDIA. That is right.

Senator DONNELL. The point I am getting at is, that if you have been consulting over a period of years with a given doctor for any type of specialist service, heart trouble, for instance, and you deem him to be proper and want to continue with him as a specialist in that line, as I understand it, the Surgeon General here in Washington, through his agent up in New York, can determine that that man is not qualified to be a specialist or a consultant, and you cannot under this plan be entitled to use his services as a consultant or specialist?

Mr. LA GUARDIA. I think you are entirely wrong.

Senator DONNELL. Is that not the provision of the act?

Mr. LA GUARDIA. No.

Senator DONNELL. Where do you find anything to the contrary in the act?

Mr. LA GUARDIA. Let me explain.

Senator DONNELL. Yes.

Mr. LA GUARDIA. Take the case where you say you have a doctor whom you consider a specialist.

Senator DONNELL. Yes, sir.

Mr. LA GUARDIA. You can continue him to your heart's content, but if this specialist wants a consultation, if he wants a specialist for his patient for which a special and extra charge is made, therefore this plan properly and wisely and practically provides that these men who give these consultative and specialized services and are paid for such must have the qualifications. That is all this means. That is the practice today, Senator. That is the practice in every well-regulated community in this country.

Senator DONNELL. I think, Mr. LaGuardia, subdivision (c), section 205, expressly states, and I quote:

Services which shall be deemed to be specialist or consultant services, for the purposes of special rates of payment under this title, shall be those so designated by the Surgeon General, and the practitioners from among these included in subsection (a) of this section who shall be qualified as specialists or consultants and entitled to the special rates of compensation provided for specialists or consultants shall be those so designated by the Surgeon General as qualified to furnish such specialist or consultant services.

Your interpretation is as you have given?

Mr. LA GUARDIA. Yes.

Senator DONNELL. And you may be quite right, but as I understand it, there is a restriction even under your interpretation. If an individual wants to avail himself of the benefits under this act, to have specialist aid, and the Surgeon General in Washington has said, "That specialist is not qualified," then the individual is not entitled to have him?

Mr. LA GUARDIA. He can have him as a doctor.

Senator DONNELL. He can pay for him personally, but not as a benefit of the act.

Mr. LA GUARDIA. He can have him to treat him, and he can have him. This provision of the specialists and consultants is not any different,

Senator, I assure you, than the practice and canons of ethics of the medical profession today.

Senator DONNELL. And you base your view on this wording which I have referred to?

Mr. LA GUARDIA. It is very well worded.

The CHAIRMAN. And, of course, the bill carefully provides for an advisory council.

Mr. LA GUARDIA. Oh, yes.

The CHAIRMAN. That advises the Surgeon General on these technical questions.

Mr. LA GUARDIA. And then, of course, they have these organizations that are really professional organizations, not lobbying organizations, like some I know, the A. M. A., that establish the experience and qualifications of a surgeon who holds himself out as a surgeon.

Senator DONNELL. However, this bill would provide that the persons who shall determine whether a given doctor is a specialist and a consultant under the terms of the act, and entitled to these special compensation fees, are not the medical profession, but the Surgeon General here in Washington, D. C.?

Mr. LA GUARDIA. Sure, but he will do it on advice of the proper authorities. That is provided all through the bill. You have got all sorts of advisory boards here. No one Surgeon General would take it upon himself to designate anybody as a specialist. This is not a job in the Internal Revenue service.

The CHAIRMAN. Mr. LaGuardia, do you think that this right of selection is somewhat overemphasized by the medical profession in connection with this proposed legislation?

Mr. LA GUARDIA. Senator, if we had a dollar for everybody who was operated on today thinking that his doctor did the operation, we would not be fussing around.

The CHAIRMAN. That is the point. I have known people who travel all across the continent for a specific surgeon, and when they get there they find that he is too old or in ill health, and a younger surgeon operates very satisfactorily.

Mr. LA GUARDIA. True.

The CHAIRMAN. And is it not true in the late war that the young men who went out to fight for their country did not have any right of selection when they were injured or when they were sick, and were given very adequate care?

Mr. LA GUARDIA. The medical care of the Army and Navy are the best in the world. They are very good.

The CHAIRMAN. And in this country under a bill of this kind where specialists have to qualify, the services today are pretty well established and pretty uniform, and as a general rule an assistant to a surgeon can frequently perform an operation a whole lot better than the older surgeon.

Mr. LA GUARDIA. The patient does not know much about it now.

The CHAIRMAN. And the patient who undertakes to select his surgeon is very frequently disappointed and finds that he probably made a mistake?

Mr. LA GUARDIA. Senator, the practical provisions of the bill just follow the established custom in our country in the practice of medicine.

Senator DONNELL. Mr. LaGuardia, you would not favor, would you, generally speaking, the right of a public official to determine for you individually whom you shall have as the doctor for yourself or a member of your family? Would you favor that general plan?

Mr. LA GUARDIA. No; but I would favor providing medical service in cases where no medical service would be possible.

Senator DONNELL. But, Mr. LaGuardia, this document here, S.1606, is a Nation-wide plan, and it provides, as I see it, in New York City just as well as in Marysville, Mo., that the Surgeon General may say how many patients a given doctor has, and if you live next door and in an emergency case wanted to consult him, for illness in your family, if he has gone up to the complete limit you cannot get that doctor?

Mr. LA GUARDIA. For an immediate emergency?

Senator DONNELL. Under any circumstances.

Mr. LA GUARDIA. Oh, sure.

Senator DONNELL. Just where is the provision in the act authorizing it?

Mr. LA GUARDIA. You say the doctor lives next door?

Senator DONNELL. Yes.

Mr. LA GUARDIA. You have an emergency, and you cannot call on him for this emergency and he will not respond?

Senator DONNELL. I think that shows the absurdity of this provision that limits the number of patients.

Mr. LA GUARDIA. That is all right.

Senator DONNELL. I understand your point, but if you are a person suffering from a disease of quick emergency, or even not of quick emergency, for instance, suppose you have a chronic illness and you would prefer to have the right to pick the doctor of your selection, you would find him unable to serve you because his quota is filled, would you not?

Mr. LA GUARDIA. I think as a practical matter there would be no difficulty in cases of that kind at all. You are just seeing things.

Senator DONNELL. Well, the statute is pretty clear in its language, I think.

Mr. LA GUARDIA. The statute is for the protection of the patient, so that the doctor would not overload himself with too many cases, and that is necessary. We have learned that by experience.

The CHAIRMAN. You do not think there would be any great difficulty in handling a situation of that kind?

Mr. LA GUARDIA. None at all.

The CHAIRMAN. Even though the doctor did have his quota, it would be a simple thing for him to take another case?

Mr. LA GUARDIA. There would always be latitude.

Senator DONNELL. Yet the act does provide, and I am reading:

The Surgeon General may prescribe maximum limits.

Mr. LA GUARDIA. That is for the protection of the patient.

Senator DONNELL. But he does have the power to prescribe these maximum limits?

Mr. LA GUARDIA. Absolutely. I am strongly for it.

The CHAIRMAN. If there are no other questions I wish to thank you very much for your very fine presentation here this morning.

The next witness will be Mr. Fichter.

**STATEMENT OF JOSEPH W. FICHTER, CHAIRMAN, JOINT SUBCOMMITTEE ON HEALTH OF THE NATIONAL PLANNING ASSOCIATION**

The CHAIRMAN. Mr. Fichter, you are chairman of the Joint Subcommittee on Health of the National Planning Association?

Mr. FICHTER. Yes, sir.

The CHAIRMAN. You are anxious to get through with your testimony this morning so that you may leave the city. Do you have a prepared statement?

Mr. FICHTER. Yes.

The CHAIRMAN. You may proceed.

Mr. FICHTER. Mr. Chairman, and members of the committee, I believe that the statement I have here has been distributed to the members of the committee. If it has not, I shall get you extra copies.

I am very happy to be invited to report to you on the findings of the Joint Subcommittee on Health of the National Planning Association. I am master of the Ohio State Grange and chairman of the Committee on Health of the National Grange. Since I am appearing before you as chairman of the National Planning Association Subcommittee, it may be useful to those of you who may not be entirely familiar with National Planning Association's background to have a brief explanation of its approaches to the study of national problems.

**THE NATIONAL PLANNING ASSOCIATION**

National Planning Association is a nonprofit, nonpolitical organization established in 1934. For the past several years NPA's work has been carried out mainly by four standing committees: three on national policy—the Agriculture, Business, and Labor Committees; and one on international policy, which weights the international implications of the problems under consideration by the Committees on National Policy. I have here a leaflet, which I will be glad to submit to you, which includes the names of NPA's board and committee members.

The joint subcommittee on health—for which I am speaking this morning—was set up by the committees on national policy in 1945, and includes members from each of those committees. Incidentally, I serve regularly as a member of the Agriculture Committee.

The subcommittee is trying to find out the economic effects of a program to provide adequate medical care to the people of the United States. During the past months we have held a number of meetings, have had staff members diligently sifting published and unpublished material, and have consulted many experts in the varied fields of medical care. Our report is not yet complete. The information which I am presenting to you this morning is more or less in the nature of a progress report. We hope soon to submit a complete report to the standing committees which they will wish to endorse. Perhaps after consideration of the facts we have been able to assemble, the committees may feel justified in going further with recommendations on a national health program which would have the joint support of farmers, businessmen, and workers.

In the meantime, in this preliminary report to you I will try to reflect as nearly as possible the views of my associates on the NPA subcommittee and staff. If in the course of our discussion you ask questions about which I seem to hesitate, it is because I want to keep my personal views in the background as much as possible, and bring to the foreground the thinking of the group as a whole—a type of presentation which I believe is NPA's most unusual and useful contribution.

The subcommittee recognizes that the reduction of human misery is the most important reason for trying to improve the health of the people, and that the intrinsic value of the individual human being is such that no justification is needed for helping to save his life. Nevertheless, a program to provide adequate medical care for all the people would have its economic repercussions and we think it useful to try to find out of what sort and how great these would be.

Our subcommittee has completed a preliminary study of two parts of this project. First, we have investigated the cost of a campaign to wipe out tuberculosis and compared this with the costs of going on with this disease year after year, as we do now. Second, we have examined the cost of building enough new hospitals to provide beds for all who need hospital care and the amount of materials and manpower required to build them. I might add that the subcommittee is planning to study other important factors entering into the provision of adequate medical care with a view to discovering their economic effects. Facts developed in our future studies will be included in our final report, which I will be glad to send to all of you if you care to see it when it is published.

#### TUBERCULOSIS CAMPAIGN

The subcommittee chose to study tuberculosis because it is a costly and communicable disease which we could virtually eliminate by putting into practice the knowledge we now have concerning its treatment and the way it is spread. Much excellent work is being done by private and public groups, whose experience we have been able to draw upon in making this study. However, much still remains to be done if we are to attack the problem on the same scale throughout the country.

Congress itself, the State and local governments, are to be congratulated for providing our best lesson on a national, coordinated, and highly successful program to wipe out tuberculosis—tuberculosis in cattle.

We have studied this campaign, which began in 1917, and are impressed with the fact that the United States has already succeeded in practically wiping out tuberculosis in cattle. But we think it even more important to do this for human beings.

I'd like to refresh your memories on the campaign to eradicate tuberculosis in cattle. This disease was causing increasing losses to the farmers of this country. The peak loss occurred in 1917 when 40,746 cattle and 76,807 hogs, which were infected by the milk and droppings of cattle, were condemned for tuberculosis under the Federal meat inspection laws. The loss to the livestock industry from this disease was estimated to be \$40,000,000 annually at that time. In addition, it was recognized that boviné tuberculosis could cause

tuberculosis in man if he used the milk or other unpasteurized dairy products from infected animals.

Accordingly, in 1917 Congress appropriated \$75,000 for tuberculosis eradication in livestock, and in 1918 it provided for paying an indemnity for the tuberculosis cattle slaughtered. In 1935, the Federal, State, and county appropriations totalled 26 million plus, which was the maximum amount for any year. Since then the amount necessary for this work has decreased until now only a small amount is required.

In 1917, about 5 percent of the cattle in the country were found to be tuberculosis, and there were varying degrees of tuberculosis in every State. When the infection is reduced to less than one-half of one percent of the cattle population a county is called a modified accredited area, and is considered to be practically free of bovine tuberculosis. By November, 1940 all States as well as Puerto Rico and the Virgin Islands were 100 percent modified accredited.

How was this accomplished? First, a campaign of education to explain how infected animals spread the disease to the uninfected was undertaken by many groups. The Bureau of Animal Industry in the Department of Agriculture, practicing veterinarians, State livestock sanitary officials, members of cattle registry associations, and others, all aided the educational work.

Then, under a cooperative program between the Department of Agriculture, State livestock sanitary officials and livestock owners, all cattle were tested for tuberculosis, and cattle found to react positively to the tuberculin test were slaughtered under the supervision of veterinarians after being given an appraised valuation.

In the case of animals, the difficulty of providing effective treatment, and their relatively short lives made it more economical to slaughter the diseased ones. The owner receives, in addition to the value of that beef which passes inspection, indemnity payments from the Federal and State Governments.

These indemnities averaged \$18.75 and \$27.50 per head, respectively in 1943. Although the testing was voluntary at first, many States made it compulsory after a large majority requested this.

If recognition of the costs of bovine tuberculosis to the livestock industry caused the undertaking of such a successful campaign to eradicate the disease, it seemed to us at the NPA that it would be worth while first to examine the present costs of the disease in human beings.

In presenting figures on these costs you will note that we have called them "approximate" in the summary table which we have labeled exhibit A, and you might want to follow that table in the back as I read. It is the first one. We used the year 1943, as it was the most recent year for which we could obtain some of the information. We found that there were no precise figures available on a number of the points involved, but we had the help of several experts in tuberculosis in estimating the amounts spent, and we believe that these figures present a reasonable picture of the size of the expenditures. However, they are preliminary, and we may revise them in the course of our study.

#### ANNUAL COSTS OF TUBERCULOSIS

About \$104,000,000 was spent in 1943 on the care of those sick in tuberculosis sanatoria. The amount spent for the care of those with tuberculosis at home was about \$9,600,000.

What was spent on control measures exclusive of sanatorium care? These include health education; finding the cases; following up and examining people who have been in contact with such cases; and rehabilitation work so that those who have been ill can earn their living with less danger of relapse. About \$15,000,000 was spent on these measures. The State, local, and Federal public health departments spent \$1,580,000 plus in cooperative work on tuberculosis in the fiscal year 1943-44; the National Tuberculosis Association, which raises all the money it spends on fighting this disease by the sale of Christmas seals, received \$12,000,000 plus from this sale at Christmas, 1943. It is estimated that about \$1,000,000 is spent on tuberculosis by the health services of civic and welfare associations, private physicians, hospitals, school systems, industry, labor unions, foundations, and by State vocational rehabilitation agencies.

The Veterans' Administration spent about \$38,000,000 in the fiscal year 1943 on pensions for veterans whose major disability was tuberculosis. They also spent money on out-patient treatment for tuberculosis, but could not tell us how much since they do not separate their out-patient expenditures by disease.

Probably about \$19,000,000 was spent on aid to families where the wage earner was ill for a long period with tuberculosis.

About \$1,250,000 was spent in 1943 on medical research on tuberculosis. The United States Public Health Service, including the National Institute of Health, spent about one-third of a million dollars and the groups with whom it cooperates on this problem spent about two-thirds of a million. Other institutions probably spent around a quarter of a million dollars. This money was spent on search for more efficient control techniques, for a chemical or penicillin-like treatment, and for special problems such as vaccination and laboratory investigations.

If we add up all these amounts we find that a total of about \$186,850,000 public and private funds was spent on this disease in 1943; and because this was a war year, practically no construction of new hospital beds was undertaken.

Yet this very large sum which is spent on tuberculosis annually takes no account of the personal income lost to families which occurs when wage earners die or are disabled by this disease, nor of the output of goods and services lost to the Nation from this cause. Such losses are especially important in the case of tuberculosis, since this disease tends to strike men and women during the most productive period of their lives—between the ages of 20 and 45. Nearly one-half of all deaths from tuberculosis in the United States during the period 1939 to 1941 occurred among persons in this age group. From early adulthood to age 35, tuberculosis is the leading cause of death. It is one of the first three causes of death from ages 15 to 49. In addition, there are great numbers of people at these productive ages who are disabled from tuberculosis but who do not die. Since the treatment takes months or years, and since there is danger of relapse if the arrested case overexerts himself, tuberculosis is likely to have a permanently depressing effect on the individual's output and his income.

What would the adults who died of tuberculosis in 1943 have earned if they had been alive and employed in that year? The number of potential wage earners who died of tuberculosis in the United States in 1943 was 41,631. Average incomes for the population as a whole,

according to age of worker, ranged from \$555 to \$2,548. Applying these figures to the potential wage earners, we found that the entire group might have earned \$87,277,000 if they had lived and had been employed in 1943.

Disability from tuberculosis also results in loss of earnings. It is estimated that 17,000,000 calendar days were lost in 1943 because of tuberculosis by persons who were employed that year. Assuming an average wage of \$5.55 per calendar day, the wage loss for these days of disability was \$94,350,000. And this estimate does not include those disabled persons so ill that they were unable to work at all in 1943.

To sum up, 1 year's deaths and illness from tuberculosis caused a loss in potential wages for that year alone of over \$181,627,000.

Faced with an annual expenditure of \$186,850,000 and an annual wage loss of \$181,627,000 it would certainly seem worth while if for economic reasons alone, to try to eliminate tuberculosis.

The essentials of a campaign to eradicate tuberculosis in a human population are well known. Of course, we also recognize the importance of adequate nutrition, clothing, and housing.

First, it is necessary to find all the cases and to see that every case is brought under good modern treatment, either at home under continuous medical observation, or in a sanatorium. Finding cases is essential because the person with tuberculosis does not feel any symptoms when the disease first attacks. In addition, we also need to provide health education, pleasant living conditions at sanatoria, a program of vocational rehabilitation, and financial aid to families when the wage earner has tuberculosis.

By using these methods, the Metropolitan Life Insurance Co. has been able virtually to stamp out tuberculosis among its 50,000 wage earners. Dr. L. I. Dublin, vice president of this company, has described this experience in *Collier's* magazine for December 29, 1945. The disease was such a serious problem that this company built a sanatorium of 200 beds in 1913, and later enlarged it to 350 beds, to care for its tuberculosis employees. By June 1945, only 26 of these beds were occupied, and the company sold the sanatorium because it was no longer necessary or economical to keep it open.

How was this done? Every employee had a routine chest examination with X-ray at least once a year. Examinations were made more often if the employee was frequently ill, or ill for a long time. Thus when tuberculosis was found, it was usually in its earliest and most curable form. Employees found to have the disease were sent at once to the sanatorium. This procedure protected not only the sick man but also his office companions, his wife, children, and neighbors. The Metropolitan succeeded in holding a patient in the sanatorium in part by freeing him from financial worries. It paid all his hospital expenses and about two-thirds of his salary as well. Also, the sanatorium doctors tried to hospitalize patients until they were practically ready to resume normal activity. And when the patient was back on the job he was kept under observation as long as necessary and given the kind of work that the doctor said he should have. In the experience of the Metropolitan Life Insurance Co., over 80 percent of the early cases treated at its sanatorium were alive, well, and at work 10 years after discharge.

## COSTS FOR A 10-YEAR CAMPAIGN

With such facts as these in mind we tried to estimate the cost of carrying out a campaign to rid the United States of tuberculosis in the next 10 years. We began with the problem of finding the cases. Children under 5 should be given tuberculin tests, which could be done by their own doctors as a part of their routine examinations. They need X-rays only if these tests prove positive. Older children can be X-rayed on entrance to school and if found negative, need not be examined again until they are 15. The new cost would be the examination of the adult population.

It would be feasible to examine the entire population above 15 years of age in the United States in the course of 5 years. Taking this population in 1943, we find that it would require 102,508,000 X-rays to examine it once or about 20.5 million X-rays a year. Of course, one examination would not be enough and the procedure should be repeated in the second 5 years. In addition, we should follow up "the contacts"—people who had been in closest contact with those found to have tuberculosis—and probably should X-ray them every 6 months. If all those ill with tuberculosis were treated in sanatoria during this period, so that the disease was not being communicated to others, we should have reduced the disease to such negligible proportions by the end of the 10 years, that only occasional testing would be necessary and, of course, testing for people who came into this country after they have been in other countries.

The new techniques of mass X-ray have greatly reduced the costs of such examinations. At a cost of 25 cents a case, the 20.5 million X-rays would cost about 5.1 million dollars. And this yearly cost would continue throughout the 10 years of the campaign.

How many people would be needed to carry out this undertaking? It has been found that a unit, consisting of one medical officer, one technician, and one clerk, can efficiently take 1,000 pictures a week, or 50,000 a year. It would require at least 410 such units to examine the 20.5 million people each year of the campaign because each unit cannot work at peak efficiency in sparsely settled areas.

The cost of following up "the contacts"—the group in the population most in danger of breaking down with the disease—is estimated to be about \$1,800,000 a year for the first 5 years of the campaign, but thereafter it would diminish. This figure is based on an average of three contacts for every case of tuberculosis found and a cost of around \$10 a year for follow-up work on each contact.

It does little good to find cases if we cannot provide places for them to receive treatment where they will not infect their families or neighbors. We would have to provide new tuberculosis beds for the new cases found, but this would be a nonrecurring cost and the task should properly be undertaken before the mass X-rays are started, so we will discuss this construction cost a little later.

Assuming that we have enough beds to permit all who needed them to have one, what would it cost to maintain the patients in those beds throughout a year? According to our estimates, we would probably have about 133,000 patients in hospitals for tuberculosis in the early years of the campaign. After that there would be a considerable reduction. Using a 1943 cost of \$3.50 per patient-day, the maintenance cost would be about \$173,000,000 for a peak year.

We found that we would need, to care properly for this number of patients, approximately 47,900 professional personnel: 3,000 physicians, 27,800 nurses, 4,600 technicians, 9,200 clerks, and 3,000 others. About 6,900 attendants and orderlies would be needed, and about 30,900 domestic workers.

We should also have to spend a large sum on health education, because people would need to understand the value of the examinations and treatment, the need for continuing treatment until they were really well, and the care needed to avoid infecting others with the disease. Probably we should have to spend about \$12,000,000 a year on such work at least during the first years of the campaign.

The provision of rehabilitation services for patients with tuberculosis is another essential of the campaign. Such services are those necessary to render a patient fit to engage in a normal economic and social life. Because tuberculosis is a chronic relapsing disease, patients have to avoid overexertion even after their cases are arrested and apparently cured. It is often necessary for the patient to learn a new way to earn his living and this is especially true if his former occupation involved excessive physical exertion. If we fail to keep the tuberculous person permanently well, we waste the funds spent on finding the case, and on the medical care and hospitalization of the patient.

Instruction for those who need further education and vocational guidance and training should be available for all people in sanatoria who could profit by them as soon as the physician has said that it is medically safe for the patient to start some activity. Librarians, occupational therapists, vocational counselors, and medical social workers are needed for this work in addition to teachers. In the peak years of the campaign when all the beds were being used, an adequate rehabilitation program might cost \$20,000,000.

Financial assistance to families where the wage earner has tuberculosis is a necessary part of the campaign. Many a patient refuses to go to a hospital when he is first told of his condition because he is worried as to how his family will manage. Instead, he continues to work until the far-advanced stage of the disease forces him to bed, and by then medical care can do little for him. Or, he accepts bed rest in a sanatorium until he feels stronger and leaves before he is well, to earn more money for his family. After a few months of work he often breaks down again with an advanced stage of the disease. Also, he may have been spreading tuberculosis among his children and his fellow workers.

Financial assistance under the three public-assistance titles of the Social Security Act may give some help to the family of the tuberculous patient. For example, aid to dependent children provides assistance to families when incapacity prevents a parent from supporting the children. Payments under this program are financed by State and Federal funds, and vary among the States. In May 1945, monthly payments ranged from an average of about \$21 to \$89 per family. Unless the family has other resources, these amounts are not adequate for today's living costs. Dr. L. I. Dublin of the Metropolitan Life Insurance Co. suggests that \$1,500 might be the average annual compensation for such a family. Allowing \$1,500 for families who needed it, the cost would be about \$57,000,000 in the peak years of the campaign. This is based on an assumption that about 80 percent of the

tuberculous male heads of families would have had incomes of less than \$5,000 and hence would not have enough savings to tide them over a year or more without earnings.

The last of the recurring items of expense in the campaign years would be for medical research. Probably \$3,000,000 a year should be available until satisfactory results are obtained in the search for a drug that would kill the bacillus, especially in view of the rapid travel that will bring people into contact with the disease in other parts of the world.

When we add all these expenditures, we find that it would cost about \$309,900,000 annually for recurring items in the peak years of the campaign.

However, we must also consider the cost of construction of the necessary tuberculosis beds. These should be started before the mass X-rays are begun and should be completed in the first year of the campaign, as the cases found must have places to go for adequate treatment. Although this would mean a large initial expenditure, the elimination of the disease would release the beds for use for other chronic diseases, or for homes for convalescents and the aged. Accordingly, as part of an adequate hospital construction program, the new hospitals for tuberculosis or new tuberculosis additions to other hospitals should be so located and built that they would be suitable with the least alteration possible for these other hospital purposes. The real value of these facilities at the time that they were turned over to other uses could then be deducted from the total cost of the tuberculosis campaign.

It is estimated that we would need about 154,000-plus tuberculosis beds in the first years of the campaign. Since there are about 79,000 adequate beds now in existence, we should build 75,550 new beds. Although we recognize that present costs of building these beds would be at least \$7,000 a bed, we have made our analysis in terms of 1943 prices as we have done in the rest of the study. Figured in this way, the beds would cost \$5,000 each, or a total of \$377,000,000-plus, which would include the cost of construction and equipment.

The value of these beds at the end of the 10-year period would be about \$309,000,000-plus, assuming a straight line depreciation and a life of 50 years for the facilities. Accordingly, it may be said that only \$67,995,000 of the costs of the hospitals should be assigned to tuberculosis.

To sum up, expenditures during a peak year of the campaign to eliminate tuberculosis would be about \$309,900,000 and they would decrease as the campaign progressed and virtually cease at the end of 10 years. In addition, about \$68,000,000 could be charged to the campaign as the cost of tuberculosis hospital construction. We can see that this is not an extravagant campaign when we compare it with the \$186,850,000 now being spent annually on this disease; and when we remember that tuberculosis causes a loss of wages and of production. As I said earlier, one year's deaths and illness caused a loss of potential wages of over \$181,627,000. Furthermore, these present expenditures and losses will continue for many years; the campaign would end in 10 years.

## THE HOSPITAL PROGRAM

The other part of the health study on which we have completed preliminary work is the investigation of the economic effects of building enough new hospitals to provide beds for those needing hospital care from whatever cause.

We believe that it is essential for the practice of good medicine today that physicians have available good hospitals, clinics, and other facilities with which to work. And to bring good medicine within reach of all sections of the population, such facilities should have wide geographic distribution. We first looked into our existing facilities and found that they had a number of limitations. We shall not take your time to describe these now because there has been considerable testimony on this point before this and other committees. We then selected one plan for a coordinated hospital system which would provide efficient general hospital service, and we explored the amount of employment this would create.

The suggested plan, which has been described by the United States Public Health Service, would require a careful analysis of the hospital needs of each State and of areas within the State as related to distribution of population. It would aim to extend facilities and service to all individuals regardless of geographic location in such a manner that some health facility would be available within a reasonable distance of every home in the State. The plan assumes that financial barriers would not keep patients from using the hospital services when needed; its effectiveness would depend on the degree to which this was possible.

The different facilities in the plan would be coordinated so that each unit would act as one part of total community health. In order to avoid unnecessary expense and duplication of equipment and personnel, only limited facilities would be contemplated in outlying districts, with the understanding, that where necessary, patients would be referred to larger and more central institutions. Large base hospitals could thus serve a broad region. Existing hospitals could make arrangements to fit into the integrated system according to the types of service which they are able to perform.

To equip the United States with sufficient facilities to make this plan effective, it was estimated that it would be necessary to build 231,000 general, 75,550 tuberculosis, and 212,556 nervous and mental hospital beds, or 519,000 beds of all types.

Of these 340,000 would be new and 179,000 would be replacement beds. These estimates were taken from the testimony of Dr. Parran, the Surgeon General of the Public Health Service, before the Senate Committee on Education and Labor in hearings on Senate bill 191 in 1945. This estimate does not include the beds which might be needed for long chronic diseases, nor does it include the plans of the Veterans' Administration.

Using 1943 prices, we found that construction and equipment of these beds would cost about \$2,600,000,000 plus. We assumed a cost per bed of \$6,000 for the general bed, \$5,000 for the tuberculosis bed, and \$4,000 for the nervous and mental bed. We realize that present

construction costs are considerably higher but, to keep our estimates throughout the report comparable, we have had to use the year 1943.

Under this plan, it would also be necessary to build about 14,000 health centers at prices ranging from \$35,000 to \$75,000 a center. These centers would be equipped to diagnose and to treat ambulatory patients and to perform the more traditional health department services. In communities which lack other medical facilities, the health centers might also include some hospital beds for emergency cases. The total construction and equipment cost of those centers would be about \$679,765,000.

Thus, the total cost of building and equipping hospital beds and health centers would be approximately \$3,000,000,000 plus. Carrying out such a program would have a direct effect upon the construction industry and an indirect effect upon many other industries. In studying this effect it is necessary to separate the construction and equipment costs.

The total construction cost of the program would be about \$3,000,000,000. Information derived from Labor Department figures show that according to past experience, this would mean (in 1943 prices) an expenditure of \$921,000,000 plus for labor at the construction site, of \$1,485,000,000 plus for materials, and of \$604,000,000 plus for "other" expenses and profit. Exhibit B shows the type of materials, such as electrical wiring and fixtures, forest products, iron and steel, and so on, and the values of the orders which would be placed.

Approximately 2,000,000,000 plus man-hours would be created by the proposed construction program. Of these, 771,000,000 plus would be at the construction site and 1,310,000,000 plus would be in mines, forests, factories, in transportation, and in administration.

How many jobs would this mean each year during a 10-year construction period? It would depend upon the amount of work which was undertaken in each year. If a curve based upon experience in other long-range construction programs is used to estimate the value of construction work begun in each of the 10 years, the man-years of on-site employment created by the work begun each year would be 20,000 in the first year, increase evenly to 50,000 for the fourth and fifth years, climb to 60,000 for the sixth and seventh years and then diminish. Exhibit B shows this in detail. For purposes of comparison, it is interesting to note that the man-years of employment during a peak year of the program represent about 2.5 percent of the total employment on construction (public and private) in the pre-war year 1941.

The amount of off-site employment created by a given building construction project is usually greater than the amount of on-site employment created. In this instance, off-site man-years of employment created by work begun each year would start at about 33,000 for the first year, increase to over 100,000 for the sixth and seventh years and then decrease.

It should be noted that the man-years of employment do not equal the exact number of men who would be employed during the course of a year. They represent the number of persons who would be employed full time were work spread evenly throughout the year and were men to begin employment the first of the year and remain steadily at work until the close of the year.

The cost of equipment for the 519,106 hospital beds and the 14,000 health centers would be about \$281,637,000. Here again employment and materials will be required. The economic repercussions cannot be analyzed in detail, but approximately 88,000,000 man-hours or 45,000 man-years of work would be created in the factories of final fabrication.

The real impact of the proposed construction program will depend upon the condition of the entire construction industry as well as upon that of related industries at the time hospital building takes place. In a pamphlet, *Stabilizing the Construction Industry*, the National Planning Association points out that—

public works constructed under boom circumstances are certain to be excessive in cost and that they create a risk to the whole construction industry.

However, it continues—

the necessity of providing special funds for advance planning and acquisition of land or land rights for public works must be recognized along with the desirability of maintaining a flexible timing policy.

Senator ELLENDER. Are there any question? [No response.] Thank you very much. Is Miss Helen Hall present, and Mrs. Caroline Ware?

Miss HALL. Yes.

Mrs. WARE. Yes.

Senator ELLENDER. Would it be convenience to return at 2:30? The committee will assign a recess until 2:30.

(Whereupon, at 12:10 p. m., April 9, 1946, the committee adjourned to meet at 2:30 p. m., April 9, 1946.)

#### AFTERNOON SESSION

(The committee resumed at 2:45 p. m., pursuant to recess.)

Senator DONNELL. The committee will come to order, please.

Miss Hall, I believe you are to testify first this afternoon.

Now, Miss Hall, will you please state your name and proceed with your statement in your own way.

#### STATEMENT OF HELEN HALL, DIRECTOR, HENRY STREET SETTLEMENT, APPEARING FOR NATIONAL FEDERATION OF SETTLEMENTS

Miss HALL. Yes. I am Helen Hall. I am director of the Henry Street Settlement, and am testifying for the National Federation of Settlements.

Senator DONNELL. Will you be kind enough to state what the National Federation of Settlements is?

Miss HALL. It is an organization of all the settlements in the United States, the settlements at the different industrial districts. And I am representing the national organization.

Senator DONNELL. Could you tell us, please, approximately the membership of the federation?

Miss HALL. Two hundred and fifty settlements.

Senator DONNELL. Two hundred and fifty settlements. And in how many cities are those settlements located?

Miss HALL. I am not sure. One of our last studies was made in 23 cities but I think there were a number of cities not replying.

Senator DONNELL. How is the National Federation of Settlements financed?

Miss HALL. Financed through the dues of its membership and through voluntary contributions.

Senator DONNELL. Will you proceed, Miss Hall.

Miss HALL. There are those who will tell you to go slow in setting up the "Nation-wide system of prepaid personal health service benefits" projected in section II of the national health bill (S. 1606). That section means health insurance; and in supporting it I am reaffirming a stand which our National Federation of Settlements took as early as 1917.

Senator DONNELL. Was that the stand taken by a formal resolution as early as that?

Miss HALL. Yes.

Senator DONNELL. Do you have a copy of that resolution present with you?

Miss HALL. No, not present.

Senator DONNELL. Would you be kind enough to send us a copy of that for our files?

#### HEALTH INSURANCE IS OVERDUE

Miss HALL. I might say that the reasons the settlements are particularly interested in insurance is that we live in industrial neighborhoods and we see first-hand, as I have for 25 years, what really happens in industrial neighborhoods, and what their needs are. That is why we have been interested in this health bill over the years.

Senator DONNELL. And you will provide us that copy of the resolution back in 1917, please?

Miss HALL. Yes.

To argue for delay is only too often a shabby device to defeat some progressive move that can't be downed on its merits.

It would be out of the question for anyone to live as we do in industrial neighborhoods without recognizing that it is high time for working people to be protected against a double hazard—against sickness compounded with loss of wages. That is why settlement workers have so long been concerned about it. Year after year, it has been driven home to us what the lack of such protection can and does do to family life.

Over the years we have seen opposition to an American system of health insurance—built up around false assumptions, at least so they seem to us. One of these assumptions hinges on an unwillingness to face the actual lack of adequate medical care among millions of American families. Witness the devastating evidence of this in the vast number of recruits rejected by the draft in World War II. Yet we all know that American physicians, surgeons, and laboratory men have pointed the way for tremendous advances in medical science. The very brilliance of that technical achievement seems to blind some of them to the great mass of Americans who only partially share, or do not share at all, in its benefits.

## TWO RUSTY CLICHES

Another false assumption has been that prepaid medical care—such as this bill proposes—must necessarily be bad. That contention was used in the 1930's when health insurance was struck out of Franklin Roosevelt's initial program for social security.

Senator DONNELL. Miss Hall, whom do you mean it was who struck out that health insurance from this program?

Miss HALL. The opponents of it.

Senator DONNELL. Was there a measure pending?

Miss HALL. I sat on the President's Advisory Committee on Social Security, and in the early days there was a plan for health insurance in the bill, and the opposition was so great that it was taken out.

Senator DONNELL. Was the bill on the floor of Congress when the provision for health insurance was taken out, or was it taken out preceding the introduction?

Miss HALL. Preceding the introduction. I presume it was taken out so that the whole bill would not be killed.

The same thing had been said in the 1920's when Herbert Hoover's Committee on the Cost of Medical Care aroused Nation-wide discussion of comprehensive coverage for the United States.

To support this contention, two rusty cliches are repeated over and over again.

One is that the doctor-patient relationship would be impaired.

Another is that the free choice of physicians would be endangered.

As to the doctor-patient relationship, our National Federation of Settlements in 1938 made a first-hand study in 23 cities located in 16 States of what their neighbors do when they are sick. This inquiry brought out that two-thirds of those interviewed had no family doctor at all. Even in the case of the third that claimed to have one, the connection was often nebulous and unsustained. You cannot have a patient-doctor relationship with a doctor you can't afford to use.

Then there is the free choice of physician. Opponents of health insurance who put such stress on it often claim at the same time that out-patient clinics and hospital wards can be looked to to supply the needs of the low-income sick. Yet they have to admit that there is seldom free choice of doctor and scant doctor-patient relationships of the sort they prize in either a clinic or a ward. They refuse to face the truth that both the relationship and the free choice can only be counted upon in higher income brackets than are dealt with in this bill.

To say this is no reflection on the medical profession, which probably gives more of its time and skill than any other calling. But that is no reason why, when sickness strikes otherwise self-reliant families, they should have to be dependent no medical generosity or on public and private aid at the indigent level. Nor why we should not all frankly recognize that as a whole these families need much more than doctors can or should give away.

It is hard to understand why the insurance principle, which is used to spread risks and to safeguard almost every other contingency of our lives, should be thought so unmanageable when applied to protecting health among people in the low-income brackets—or when the Government has anything to do with it.

## RISKS AND SERVICES

True, the principle of spreading the risks in sickness has been accepted today in various quarters where even voluntary plans were vigorously fought not long ago and group plans, it was held, would degenerate the profession. Now we find ourselves in the position of being told in those same quarters that if you must have insurance against sickness it has to be on a voluntary basis. The eagerness with which people have seized on voluntary hospitalization plans shows how acutely the need is to spread the cost of sickness. However excellent for the income groups they service, they can reach only a fraction of those who need it most and who make up the great bulk of people in this country. They are too expensive. The national health survey showed that 80 percent of all illness in the United States falls in families earning under \$2,000 a year.

The Associated Hospital Service of New York (familiarily known as the Blue Cross) furnishes hospitalization (21 days full cost and 90 days half cost) at a cost of \$24 per year per family. Compare this with the proposed national health program which as I understand it, contemplates a 1½-percent contribution from the employee and 1½ percent from the employer to cover sickness costs.

At that rate, a man earning \$30 a week would pay \$23.40 a year—or approximately the same cost as the Blue Cross with its limited coverage. For this \$23.40 he would receive under section II of the national health bill:

All needed preventive, diagnostic, and curative services by a general practitioner.

Specialists' and laboratory services.

Hospital care up to 60 days a year.

Limited dental and nursing services at the beginning, and more as funds and personnel become available.

By July 1, 1947, the limited dental service will include at least examination, including X-ray, diagnosis, prophylaxis, extraction, and treatment of acute diseases of the teeth.

I am sorry to see only limited nursing service in the bill because a good visiting nurse not only speeds the patient's recovery, but teaches the family what to do in the other 23 hours of the day and night when she may not be there. It sometimes seems that the greatest differential between the rich and the poor in time of sickness lies in the nursing care they can afford. Visiting nurses in the United States bridge that gap as they climb tenement stairs, or travel around small towns, or ride over the long stretches in country districts. Anyone who has seen a visiting nurse come into a home and in short order make sickness seem manageable to a scared and sometimes ignorant family will know how important a part the nurse plays in the health plan.

Even in New York City, where health facilities rank high, out of nearly 15,000 families who were accepted last year by the city department of public welfare, nearly 4,500 had to be helped because of the sickness of the wage earner. This represented nearly a third of the applicants.

## BOTH OUT OF WORK—AND SICK

Few people realize that here in the United States we have Federal-State unemployment insurance for the wage earner who loses his job—except when he loses it because of illness. Then he has neither

insurance benefits to cover lost wages, nor assured medical care. May I illustrate how this works when it comes to a real family:

Joe Allen is 29 and his wife 24. They have three small sons, ages 5, 3, and 1. The father first worked steadily as a doorman at \$60 a month; then on essential war work which paid roughly \$50 a week and made it possible for him to provide for a growing family. Through good management the parents were able to move from a district unsuitable for young children into an apartment at \$38 a month in a better neighborhood. Meanwhile they had accumulated savings of about \$300, partly in war bonds.

With the coming of VJ-day, the father was laid off and all last fall he was able to pick up only \$35 in temporary jobs. The mother went to work as a domestic, leaving the children in the care of their grandmother until the latter fell ill.

What followed was a dogged story of efforts to keep their self-dependence. It was not until Mr. Allen became utterly discouraged in his search for work that he applied for unemployment compensation and borrowed \$100 on their household furnishings to tide over the waiting period. Thereafter he received 6 weekly benefits of \$22 until he fell ill in February. That sickness made him ineligible for further unemployment insurance, but there was no health insurance to fall back upon.

Right there you have the nib of our national failure to make social security secure.

By March all the Allen family resources were exhausted. The father was still physically unfit and still ineligible for unemployment compensation. A physician had said that his unemployability was due to a digestive ailment, and that the ailment in turn had been aggravated by his anxiety about his family, his unwillingness to accept the fact that he wasn't able to go back to work. The doctor recommended X-rays costing \$25 which they could not afford.

It was only then that they applied for public assistance and with it whatever medical care was necessary.

In New York, as you know, the department of welfare have a physician paid by the department of welfare that makes a visit. They can choose the one that is in their neighborhood if they wish.

However, even with the most skillful treatment, it will take a long time to get back his health and overcome his sense of failure.

Take another family that, like the Allens, might have remained self-supporting if it had had insurance against illness.

Mr. and Mrs. Bailey were married in 1934 and have four children from 10 years to a baby a year old. This father, also, had always been able to earn enough for his household through steady employment at moderate wages. That was as a transportation worker, beginning at \$85 a month, and going up to \$45 a week by 1941.

Then, because of bronchial trouble, he was advised by a physician to look for less strenuous employment. This he found at \$30 a week, a small income for a family of six. As a result they had to let their insurance lapse and 4 years later had used up their small bank account.

At this bad moment, Mr. Bailey had to undergo an emergency operation for appendicitis. He developed pneumonia and was in the hospital for nearly 2 months. His wife waited until she could no longer borrow small sums and had a dispossess notice from their landlord

before she applied to the department of public welfare. They had always been independent, she said, and hated to ask for help.

When the father was discharged from the hospital he couldn't, of course, go right back on the job. Meanwhile he is worrying over a hospital bill of \$155, other small debts, and the fact that the family had to go on relief.

#### A TEXAS EXPERIENCE

In these examples we are dealing with families who should have had the protection of health insurance but who are better than most Americans in the same fix. They at least had a good public assistance department as a last resort. That would not be true in many parts of the country.

Take the Smith family in Houston, Tex. They are upset and disorganized because of the father's illness. Alvin Smith, 35 years old, was in an automobile accident when he was 20 and in which he suffered some broken bones and a spinal injury. He had care in a free public hospital at that time, and has gone back for examinations since.

Yet he has not had regular medical supervision, for he only returns to the out-patient clinic under pressure. He feels that since he cannot have a continuous relationship there with any one physician, he is never sure just what is wrong with him or what can be done about it. One clinic doctor told him an operation might help. Meanwhile he labors under a great fear of surgery and hospitalization because he cannot choose his own physician.

Nevertheless, in spite of recurrent pain and discomfort he has worked regularly and has supported his wife and three children. His pay, however, has never been more than enough for running expenses. Yet he is intelligent and ambitious, and could perhaps have increased his earning capacity if he could have had relief from pain and worry.

Recently he consulted a private physician only to find that the fee for a complete reexamination was far beyond his means. The once recurring pain has become continuous. As the neighbors put it, both he and his wife are frantic.

Mrs. Smith first tried outside work, but without special training she couldn't clear much over the expense of substitute day care for the children. Afraid that her husband will soon be bedridden, the only thing that she can see is that the family is headed for dependency.

#### MEDICINE'S CAPITAL CITY

Turn next to Chicago—organized medicine's national capital—

Senator DONNELL. Why do you term Chicago the national capital; because of the American Medical Association being located there, its headquarters?

Miss HALL. That is right.

Senator DONNELL. All right.

Miss HALL. From where we get so much assurance as to the adequacy of medical care throughout the Nation. Let me illustrate again concretely with half a dozen instances of what operations and serious sickness does to otherwise self-supporting families.

Remember these are close neighbors of the A. M. A.—that is the answer.

The father in the first family had been ill 3 weeks when he was forced to ask for help. Even steady work at \$39 a week had not left him any real margin for sickness with a family of six children. His employer had demanded a medical statement releasing him from work. The mother had heart trouble and the children were frequently ill. The collection department of a hospital was pressing for a bill for treatment for one child—under threat of cutting off any further medical care. A private neighborhood physician, asked to treat an accident, was insisting on payment for the service.

And then the father was taken sick himself with nothing to serve as money.

Stomach ulcers got the next household into difficulties. There was a wife and five children but the family had been completely self-supporting before the father was ill. At the start he had been afraid to stop work long enough to get proper treatment. He kept on in spite of recurring attacks, until hemorrhaging became continuous. The family was \$400 in debt before they asked for help—what he had fought so hard to ward off.

The father of a third family had hospitalization insurance, but it didn't carry him through a serious operation, plus 4 weeks in the hospital, plus a long convalescence. He still owes on the hospital bill and in addition, for subsequent medical visits. To avoid asking for relief, the wife has gone to work although she is not well, and has a large household on her hands.

The next neighbor is a mother who is the sole wage earner in her family. She not only had to undergo major surgery but they had to go on relief when she stopped work. That upset her more than the operation.

And next—the father of eight children—a steady worker not without savings, when his pay stopped—

Senator OONNELL. Pardon me, you mean "but without savings," did you not?

Miss HALL. Yes; I am sorry.

Senator DONNELL. You said "not without savings."

Miss HALL. But without savings, when his pay stopped, to see him through a hernia operation, hospitalization, and convalescence. (He had almost put it off too long.)

Another father was on his way to get a new job that meant an increase in wages when he was seriously injured. He had a long record of self-support, and had been earning \$55 a week when luck went against him. As he needed nursing care at home, his wife was unable to go out to work herself. His recovery dragged on and their resources were used up before they appealed for help. They were given \$20 a week by a private relief agency and medical care for 6 months until the father could work again.

You will realize that even this last line of defense, the public or private relief agency, is by no means available everywhere.

And, Senator, you realize why I am using illustrations, because those are things we see. We see where the present facilities fall through. It is hard to talk just in statistics or generalities, because it is really what happens to families that matters. And I tried to show there the kind of things we meant.

Senator DONNELL. I understand your reason for using the illustration.

## OUR SETTLEMENT STUDIES

Miss HALL. The stand taken by the settlements back in 1917 in favor of health insurance was activated by their first-hand neighborhood experiences. Ten years later came case studies of unemployment which antedated the stock market crash of 1929 and were put before Congressional committees in behalf of unemployment relief and social security.

In 1931 I made a study of unemployment insurance in Great Britain, talking to working people about what that form of protection meant to them. It was impossible to do this without realizing the necessary relationships between the insurances. At one time it was unemployment insurance, at another time health insurance, that kept British families afloat. And it was impossible not to get a vivid sense of how much it meant to them to be able to go to a doctor of their own choosing at the time they needed him most.

Five years later our national federation commissioned a young American physician to make a first hand appraisal of how the system worked. Dr. Douglas Orr's findings: *Health Insurance and Medical Care: The British Experience*, was the result. I have that here.

I remember a fine old general practitioner, the father of a young doctor friend of mine, saying to me in 1936:

My dear, we English doctors said all the same things in 1911 that many of your doctors are saying now. Why, some of them were so mad they wouldn't open the first record cards which came from the Ministry of Health. But we've learned by experience since then.

Any American physician visiting England in those years who did not confine his inquiries to Harley Street specialists representing only a tiny fraction of the profession could get a picture, not of perfection, but of doctors free to serve the well-to-do, as always, but also freer to serve the poor.

Here in the United States—as things still stand today—a physician cannot rely for his livelihood solely on families with precarious incomes. In that sense the American doctor does not have free choice of patients. If he is to make a livelihood for himself and his own family, he has either to limit his practice largely to those who can pay, or else he must work out what might be called a private insurance scheme of his own by making those who can pay, pay enough for him to carry his poorer patients. It would seem sensible, really, for him to have a part in a more widely organized and better-planned scheme of professional security.

Moreover, private arrangements of this old sort are not feasible in the poorer rural districts, in mining areas and in many industrial towns, where the need for medical services is so pressing.

The fact of the matter is, that national health insurance should give American doctors as a whole a freer choice of patients than they have ever had before along with a freer choice in geographical location.

I was told in England, regarding the use of doctors there, that there had been such a shortage of doctors in the East End among the very poor, and that when their income was somewhat assured, a better quality of man would go down there to serve in the poor districts, so that your working people had a better quality of service through the protection of doctors' income. The doctor was not having to take people who could not pay. He was taking the people whom the

Government was backing with pay and that gave him a security that he had not had.

## SOME WARTIME LESSONS

In 1944-45 we undertook to gather some materials on war workers' resources. Our impression at that time was that many of our neighbors had not been able to save enough to carry them over a long period of postwar unemployment. One of the factors entering into the situation had been that many had had to clean up a hang-over of debts from 10 years of hard times. But what we didn't anticipate was the size of the medical and dental bills contracted since they had war jobs.

Approximately five out of seven of the families reported heavy medical and dental expenses during the war years—some so extensive, running from \$200 to over \$800—as to suggest that they were trying to make up for ravages of neglect during the depression years when they didn't have money to pay for professional services. What we found out was that people want to get their teeth fixed and undergo needed operations if and when they can afford it.

Wouldn't it seem wise to spread the cost so that we can get needed care now without having to wait for another war?

Prepaid medical care, with no choice of physician, served the needs of 10,000,000 Americans in our armed forces in World War II and with only limited opportunities for doctor-patient relationships. But wasn't a magnificent health job done! As I observed it while with the American Red Cross in the South Pacific, competent medical men were still competent; incompetent men still of that stamp. The quality of the man was the determining factor, not Government regimentation nor the method of his payment. While there, I had to have my tonsils out. I hope that I will always be lucky enough to fall into hands as skillful and considerate as those of the Army surgeon who performed the operation.

On the other hand I had some pretty casual treatment from an Army doctor during a serious illness in France in World War I. But I am not advocating salaried doctors at this point—for I believe in all the free choice which is compatible with wide coverage. But I am questioning whether there is any inherent virtue in the direct passing of money from patient to doctor, or that the quality of treatment must depend upon a so-called voluntary set-up. From my experience it will always rest largely upon the quality of the men and women giving the service and the training they have had, rather than upon any framework, whether based upon rugged individualism or joint planning, private or public.

It seems ridiculous to me to argue that the minimum of Government control proposed in this bill will deteriorate medical care in the face of the fact that under the maximum controls of wartime, physicians, surgeons, psychiatrists, dentists, rendered such outstanding account of themselves.

I still have a vivid memory of all the awful things we were told were bound to happen to this country if we got unemployment insurance. The most disastrous was that wage earners wouldn't want to work again. Since the passage of the social security bill these same workers have set the greatest production records in the world's history.

You and I want bedside care when we are sick enough to go to bed, and available help through all our mental and physical vicissitudes.

My low income neighbors want the same thing. They cannot be sure of it unless we devise a workable means for making it available to them. The National Health Act is the outcome of years of study and cooperative effort on the part of progressive physicians and laymen. Haven't we waited long enough?

At best, sickness is a miserable thing. But as I have seen it, combined with poverty, its misery knows no bounds.

Senator DONNELL. Miss Hall, have you finished your direct statement?

Miss HALL. Yes.

Senator DONNELL. I observe in the course of your statement you mentioned two experiences you have had with Army physicians.

One shows a quite satisfactory result; namely, the one in the South Pacific?

The other doctor, on a serious illness in France in World War I, which you described as some pretty casual treatment.

I understand from your experience in one case it was quite satisfactory and in the other, I judge from your language, it was rather unsatisfactory. Is that correct?

Miss HALL. That is right. And I would say I have had exactly the same experience with private physicians. That is what I meant to imply, that I do not think the treatment had anything to do with the fact that they were Army doctors or paid by the Government, but that one was good and the other was not. Exactly the same thing happens in private practice. A good doctor is a good doctor, and one that is not is not a good doctor.

Senator DONNELL. But the point I make in my question is that your own experience was that treatment by a doctor designated for you is not necessarily satisfactory. That is correct, is it not?

Miss HALL. I do not think any medical treatment would be necessarily satisfactory. It is not under any private practice, certainly, and I do not think it would be under any scheme. I think all schemes would depend on the quality of the men and the training they have had. I meant to point out that the determining factor, to my mind, was not the method of payment but the quality of the person giving it.

#### FREE CHOICE OF A DOCTOR

Senator DONNELL. And the compulsory health insurance would be limited to the doctor on whose list you were.

Miss HALL. You would not be limited to one doctor. You have a free choice of doctor.

Senator DONNELL. After you have chosen your doctor, unless you change the choice, you are limited to that doctor?

Miss HALL. You can change the choice. Honestly, it really works exactly the same as anybody in the neighborhood. They go to the doctor they like in the neighborhood.

Something like 90 percent of the doctors in England belong to it. I do not know the exact percent, but a very small percentage does not.

The neighborhood doctors, of course, belong to it, so you have exactly the same free choice of physician.

He also can turn you down, just as they do today.

Senator DONNELL. Under this bill, S. 1606, if you should be assigned to a given physician, Dr. Jones, we will say, and you should

be attacked by illness and decide to transfer to Dr. Smith, and Dr. Smith should have a quota of 1,000, and his quota is filled, you could not go to him?

MISS HALL. If his quota is filled, and that of course is exactly what happens in private practice. If my doctor around the corner is filled, he could not take another patient.

I have a neighborhood doctor who told me the other day he could not take any more patients because he had all he could take care of.

A young man stopping by to see me, back from the services said, "The thing I have to decide is how to limit my patients, my practice, because I cannot take care of all the people that want to see me."

That is not particularly applicable to the insurance scheme. It is applicable to any doctor.

Senator DONNELL. However, under present existing systems, the doctor himself makes the determination as to whether or not he has arrived at his limit?

MISS HALL. Yes, and sometimes the wrong determination.

Senator DONNELL. All right. We all make mistakes, doctors, lawyers, settlement people. But he does have that right on decision?

MISS HALL. Yes.

Senator DONNELL. And if he thinks he could satisfactorily treat a given patient, he is not subject to any governmental restriction; he uses his own judgment in determining whether or not he takes the patient rather than the judgment of the Government?

MISS HALL. The Surgeon General would be taking the advice of other doctors, and that might be perhaps better than the individual's decision. It would be a panel of doctors.

Senator DONNELL. The question I asked you was not that. The question I asked you was, Under the existing system today, in the absence of a statute, every doctor has the right to make his own determination as to whether he can or cannot increase the number of patients he is treating?

MISS HALL. That is correct.

Senator DONNELL. Whereas under the bill, the Surgeon General would be the determining official who would determine whether or not the doctor could take a given person?

MISS HALL. That is right.

Senator DONNELL. Because the Surgeon General could determine, as the act states, the maximum limits to the number of potential beneficiaries.

MISS HALL. That is right.

Senator DONNELL. So we do have a difference between that and the present system under which the doctor uses his own judgment. The system under S. 1606 is the Surgeon General through this limits the number of potential beneficiaries, he makes that decision for each individual.

MISS HALL. That is correct. I would say that the medical profession, as a whole, made the decision rather than the individual doctor, which might be preferable, and I would like to say a word on that.

Senator DONNELL. I would be glad to have you do it, but at that point I notice that subdivision (j) in section 205 does not say that the medical profession makes the decision, but says that the Surgeon

General may prescribe the maximum limits to the number of beneficiaries.

Miss HALL. The Surgeon General is a doctor.

Senator DONNELL. But he is not the profession.

Miss HALL. My understanding of the bill is that the medical decisions are made by doctors alone, by the medical profession alone.

Senator DONNELL. But I am quoting now. Do you have a copy of the bill?

Miss HALL. No, I have not.

Senator DONNELL. I will be glad to give you one.

Turn please to page 50, lines 10 and following.

Miss HALL. I would like to come back and say something.

Senator DONNELL. If you do not mind, may we pursue this first?

Miss HALL. All right.

Senator DONNELL. Page 50, subdivision (j), I will ask you to state if it does not read:

In order to maintain high standards in the quality of services furnished as medical or dental benefit, the Surgeon General may prescribe maximum limits to the number of potential beneficiaries \* \* \*

et cetera.

Miss HALL. That is correct.

Senator DONNELL. There is no provision there obligating the Surgeon General to take the advice of anyone, is there? Is that correct?

Miss HALL. Yes, on that particular point I would have said that somewhere else in the bill—and you can probably turn to it more quickly than I—I would have said that all medical decisions were in the hands of the medical profession. I think the bill takes care of that.

Senator DONNELL. I think this subdivision (j) speaks for itself as to the power of the Surgeon General under that subdivision.

Of course, there are quite a number of portions of the bill which pertain to the advisory council, and says that it shall advise the Surgeon General with reference to questions of general policy and administration, but so far as the prescribed maximum limits to the number of potential beneficiaries, that is to say, the number of patients, subdivision (j) of section 205 confers that power on the Surgeon General. Is that not your understanding?

Miss HALL. That is right.

Could I ask you if that does not seem wise?

Senator DONNELL. Miss Hall, I do not think it would be wise for us to enter into an argument on it. We would like very much to have your ideas, and if you want to supplement what you have said, we will be glad to have you do so.

Miss HALL. Yes, I would like to say my understanding of it is that the medical profession have been very firm about feeling that if a panel is made up or instituted, that there should be a definite limit to the number of patients that one practitioner should take on. I had always thought that that was the medical profession's decision rather than a lay person's decision.

Senator DONNELL. Regardless of whether that decision is by the medical profession, it may have the effect in individual cases of preventing a prospective patient from securing the doctor whom he or she would like to secure? That is correct, is it not?

Miss HALL. That is correct.

Senator, I would like also to say that the lack of money also puts you in the same position.

Senator DONNELL. That may or may not be correct.

Miss HALL. That is true.

Senator DONNELL. I think it was pointed out in your testimony that the generosity of the physicians is well known, and many physicians have given services freely and generously even to their own great detriment.

Miss HALL. But I also pointed out I did not think that could cover the whole needs of the American people and that we should not ask them to do it.

Senator DONNELL. That is quite true. I do not think there is any necessity in asking them to do that, but I think there is an alternative other than the federally controlled compulsory health insurance.

Miss HALL. This looks good to me, anyway.

Senator DONNELL. I think I understand your view. I would like to refer to your reference to the National Health Survey. You said that the National Health Survey showed that 80 percent of the illness in the United States falls in families earning under \$2,000 a year.

Was that not issued in 1935?

Miss HALL. Yes.

Senator DONNELL. That was a WPA project?

Miss HALL. Under the Surgeon General.

Senator DONNELL. And it referred back, did it not, to figures during the period 1929, 1930, and 1931?

Miss HALL. That is right. Some of those were very good years, of course.

Senator DONNELL. Miss Hall, that is what you refer to?

Miss HALL. I think we have no later figures, Senator, on that. That was a very large survey.

Senator DONNELL. At any rate, the figures to which you refer were those back in 1935, which was not so long after the country was coming out of, or perhaps still in, a depression, to some extent. That is correct, is it not?

Miss HALL. Yes.

#### HEALTH INSURANCE AND UNEMPLOYMENT INSURANCE

Senator DONNELL. Now, Miss Hall, you have also referred a number of times in your testimony, to unemployment insurance.

Am I correct in this statement that unemployment insurance does not involve at all any question of the administration of the physicians' services, or surgeons' services?

That is to say, if a man is out of work, he is unemployed, he is unable to get a position, he offers himself, but cannot get it, he is entitled to unemployment insurance?

Miss HALL. That is right. Unemployment insurance has nothing to do whatever with health insurance.

What I was trying to point out was that health insurance has two parts. One that insures medical care for the man or the member of the family that is ill, and the other that pays him his wages or at least pays the equivalent of wages while he is ill.

Now, that is not in this bill, but it is in another part of a bill which, as I understand it, is before the Finance Committee of the House. I may be wrong, but that is my understanding. This is only the medical part, but I do not think the health insurance really does its job until it also gives the man some money in the home while he is sick, as well as the doctor.

The unemployment insurance system, illogically enough, when a man gets sick, when he is unemployed through sickness, he has no insurance. When he is unemployed and is still well he has insurance.

Senator DONNELL. But I want to be correct on this point: The problems involved in unemployment insurance are in many respects very different from the problems involved in compulsory health insurance. This is an illustration: If I am out of a job, I offer myself for a job, I am unable to get it, all that is necessary to establish in order to make my claim are those facts I have described, and I get my money if I am unemployed, go on my way rejoicing with my money. There is no problem in that situation of my being compelled to subject myself to the treatment by a physician who may not be of my selection, or if he is of my selection, may not be the man I want. There is no problem like that at all in unemployment insurance?

Miss HALL. No.

Senator DONNELL. So you are not asserting that the success, if there has been success of unemployment insurance—and I am not implying that it has not been successful—but I am trying to point out that that is not necessarily an argument in favor of health insurance, which is based on very different considerations and very different problems. I am correct in that, am I not?

Miss HALL. No. I feel it is an excellent example of what we ought to do in relation to a man when he is ill. If we protect him when he is well against unemployment, I certainly think we ought to protect him against unemployment when he is sick.

Senator DONNELL. My question is this, Miss Hall: If we have unemployment compensation insurance and it has proved successful based on these simple facts, is he unemployed, has he endeavored to procure employment, has he failed to do so, the mere fact that that system may be successful does not mean that the compulsory health insurance, involving the choice of physicians, payment of physicians, personal relationships of physician and surgeons, the success of the unemployment insurance by no means is determinative of the fact that the health insurance will be successful. That is correct, is it not?

Miss HALL. I would say it is a very excellent example that the family have got protection from one source of insurance which, to my mind, does not seem so very different. The money part of the health insurance bill is certainly not very different. If he is out of work through sickness and you have health insurance, he goes to a doctor and the doctor verifies the fact that he is ill and he gets insurance.

That does not seem to me any different. His family is protected while he is out of work.

If we find otherwise and protect the family because of unemployment, economic reasons, certainly we ought to protect them through health insurance.

If you watched the families and saw what a difference it made when they got unemployment insurance, and they come along and get sick, and they do not get any—it does not make sense.

Senator DONNELL. I see your point, namely, that the receipt of money from unemployment insurance is beneficial and helpful to a family, just as a receipt of money from health insurance would be beneficial, just as the receipt of money from fire insurance would be beneficial, but there are very different problems involved in unemployment insurance than in health insurance?

Miss HALL. Yes, sir.

The CHAIRMAN. Permit me to introduce a question. You are also familiar with workmen's compensation laws?

Miss HALL. Yes, sir.

The CHAIRMAN. Where the workmen are injured, and the service they receive in medical care under those circumstances, they are sent to a doctor and are treated and taken care of under the workmen's compensation laws?

Miss HALL. That is right.

The CHAIRMAN. There is some little analogy between those laws and the present law, especially with reference to the problem of selection of doctors, and so forth, and hospital care?

Miss HALL. Yes. At Henry Street Settlement, of course, we are very grateful to have our employees taken care of by workmen's compensation when they are injured on the job. I think there is a great deal of analogy.

The CHAIRMAN. There has never been any complaint against those laws because of the fact that the workman injured is not able to select a certain physician he would like to have take care of him upon the happening of an accident?

#### FREE CHOICE OF DOCTORS

Miss HALL. Senator, I do not think people in America have the choice of physician. Two-thirds of them do not have a physician.

The CHAIRMAN. And 9 out of 10 people in America would not know how to select a physician?

Miss HALL. And one-third, I have talked to them, I know these people have no choice of physician. It is really a myth.

The CHAIRMAN. I think you are right.

Miss HALL. People talk about a choice of physician. After all, people who cannot afford a physician cannot have a physician.

The CHAIRMAN. And many, if they tried to select a physician, they would make a mistake?

Miss HALL. Do you have any choice of a physician in a clinic? Certainly not. There is very little choice of physician in the case of people this bill applies to. Of course, there is in our case.

The CHAIRMAN. And when they do not have the choice of a physician or the right of a choice of a physician, they get adequate and effective and efficient service. I know of cases where people have traveled all across the continent of the United States to get to Johns Hopkins Hospital, and when they get there the surgeon they intended to be operated by is either too old or sick or unable to operate, and the patient is operated on by an assistant with a very efficient opera-

tion, and it is satisfactory in every detail. That happens frequently. So I agree with you that this idea of the right to select is somewhat exaggerated at least.

Miss HALL. Two-thirds exaggerated.

Senator DONNELL. Two-thirds?

Miss HALL. Two-thirds, in our study, Senator, have no family physician.

Senator DONNELL. Pardon me, Miss Hall. At any rate in the first place, what you mentioned in your testimony was unemployment insurance, was it not?

I do not recall whether you mentioned workmen's compensation or not. I think you mentioned unemployment insurance.

Miss HALL. That is right.

Senator DONNELL. And there are the differences to which I have referred between unemployment insurance and health insurance.

Miss HALL. Yes, certainly. That is what I think is so sad, some of the differences.

Senator DONNELL. Now, I will ask you, Miss Hall—

Senator Murray very clearly indicated to you his doubt as to the ability of the average individual to select a physician, and as nearly as I can recall, his suggestion was that the chances are that 9 times out of 10 the person would not know how to select his own physician.

Do you concur in that view? I did not observe your answer as indicating concurrence.

Miss HALL. I do not think I have any statistics on that subject.

Senator DONNELL. Do you think 9 people out of 10 are not able to select their own physicians in this country?

Miss HALL. I would not for a minute say what percentage, Senator, because I have never made a study of that thing.

I would say this: That people in the working-class areas are often very ill able to know which physician is best in that area for them to go to. Suddenly a child will get sick in the night, and they have not even thought of a physician before, and they run outside, over to a cousin or a neighbor, and they say, "Mary is sick. Whom will we get?" And this one says, "This one took care of us; you had better go down there"; or "This one is on the corner. You will only have to go two blocks."

That is not a very careful choice.

I do not know whether you call it free choice, but it is not very important.

Senator DONNELL. The point I was getting at is whether or not you concur in the view—if I have correctly quoted the Senator, and if I have not, I want him to correct me—that the chances are that 9 times out of 10 people would not know how to select their physicians.

The CHAIRMAN. I think I would like to correct that. I meant that 9 times out of 10 they would not be in a position to. People in this country change residence a great deal. They travel a great deal, especially among the workers of the nation.

I will admit that in the richer class, they think they know how to select a physician. Certain physicians have very attractive "bedside manners" and friendly associations in society. But that does not prevail among the great masses of the American people. They very seldom know a doctor intimately. If a doctor meets them on the street, he does not recognize them, does not recall them.

That situation prevails broadly in the country, and I think among the great masses of the American people.

They are generally in a situation where they would not be able efficiently to select the doctor that they should have in an emergency or in a sudden illness.

Miss HALL. That I would agree to.

Senator DONNELL. You would agree with that?

Miss HALL. That our people are not as a whole equipped to know just on what basis to choose a physician.

Senator DONNELL. Do you regard it to be best that instead of the individual selecting his own doctor, that the Government should select the doctor?

Miss HALL. I do not think this bill proposes that.

Senator DONNELL. Just a minute, please. I am not saying this bill does prescribe that. It definitely recognizes the fact that it is important that the individual shall select his own doctor. But there are certain defects in the bill. The point I am getting at is whether or not you are of the opinion that it would be better for the Government to select the physician rather than have the individual do so, if you doubt the capacity of the average person to select a doctor.

Miss HALL. I think health insurance will give them a great deal of leeway in getting a physician. I think they will use the doctor more often, and I think by that method they will be better equipped to choose.

I think you have to have a little experience in things before you do it well. If you have only had one doctor or two doctors in your life, maybe you do not choose well. But if you have had from the time you were of working age a chance to go to a doctor, perhaps you are in a little better position to choose.

Senator DONNELL. Miss Hall, under the terms of the bill, particularly the section which refers to eligibility, on page 71 of the bill, as I understand it, in order that an individual may be eligible to payments under the bill he must have had a history of six completed calendar quarters immediately preceding the first day of the benefit year for which he gets benefit. That is in subdivision (b), page 71. That is correct, is it not?

Miss HALL. Yes, sir.

Senator DONNELL. In other words, if an individual, John Jones, desires to secure the services of a physician, he must be able to show what his experience was—I mean to say his economic experience under the terms of section 215 (a) and (b) back for a year and a half before the doctor begins the services.

That is correct, is it not?

Miss HALL. I think so.

Senator DONNELL. Yes, ma'am.

Miss HALL. I am sure you know the bill. Yes; I think that is true.

Senator DONNELL. Is it not also true that the selection by the individual of the doctor whom he desires to obtain, or this list of doctors that is to be given to the public for it to make a choice from, would in many, many instances be made a year and a half or thereabouts, or even longer, before the time that the individual calls upon the doctor for the services in sickness?

Miss HALL. Well, how it worked in England is this—

Senator DONNELL. I mean under this act.

Miss HALL. I think eventually this is the way it will work with us. As soon as you become of the age on which you are eligible for health insurance, at that point you go and choose your physician.

Senator DONNELL. I understand, in the testimony before this committee here, not in today's, but before, that age is not a qualification.

I understand that any individual who has this earning record, no matter if he is only 10 years old, is entitled to the benefit.

Miss HALL. That is if you are the child of a wage earner.

Senator DONNELL. No. I understand the child can. In order to eliminate the question of illegal child labor, we will say a boy or girl 17 years of age. As I understand it, if that child has had this economic earning record prescribed in section 215, he is eligible.

Now, am I correct in this: If this bill goes into effect, there will be in some way communicated to the public a list, in every small area, about the size of a school district, for an illustration, perhaps it will be in the post office, or some public place, there will be a notice of the doctors who have agreed to be upon the list of doctors who are going to operate under this bill. That is early among the steps, is it not?

Miss HALL. Yes, sir.

Senator DONNELL. After that list is posted, say in Thorndyke School District of LaFayette County, Ill., posted in the post office, and listing eight doctors who have accepted the terms, then all the people eligible under the bill have or will have under regulations set forth by the Surgeon General, the opportunity to select from that list, determine which doctor they will take?

That is correct, is it not?

Miss HALL. Yes, sir.

Senator DONNELL. Ordinarily, that selection will be made at least a year and a half before the time of rendition of service, because the individual must show a history of a year and a half before taking advantage of the services?

That is generally true, is it not?

Miss HALL. Yes.

Senator DONNELL. And it may well be that in some instances, perhaps many, that the individual will choose the doctor after a large part of that year and a half economic experience has been completed. It may be I am somewhat erroneous in stating that as a general rule, but in some instances the selection will be made a year and a half before the need arises.

Suppose the need arises hurriedly, and the individual says, "I heard last week that that doctor lost a patient in this kind of trouble, and I do not want him." But there is no time to select another doctor. He needs him then and there. And he has to select him a year and a half before.

Is there not going to be there opportunity for a very grave injury to the individual precluded from selecting somebody he wants of his own free will and put back to where he selected someone a year and a half before?

Miss HALL. I would suppose he would do what he does now, select a physician and have to pay him.

Senator DONNELL. He would not get the benefits of this insurance, then, would he, if he paid it out of his own pocket?

Miss HALL. That might be true.

Senator DONNELL. It is true.

Miss HALL. Yes.

Senator DONNELL. If a person pays out of his own pocket individually, he is not getting the benefit of this system.

The CHAIRMAN. Senator, right there, do you assume that if a person selects a physician, and 18 months later he desires to get a new physician, that he cannot get one?

Senator DONNELL. I think he can, but there are limitations he will be subject to that I was coming to.

The CHAIRMAN. You do not think he would be precluded?

Senator DONNELL. Not at all, but there might arise a situation in which an individual would need a doctor right now. Most of us get sick pretty quickly.

Miss HALL. That is right.

Senator DONNELL. I know of one of our Senator friends was taken ill Saturday night, and told me yesterday of his grave condition—not grave condition, but he felt he was in a very acute condition. It comes quickly. Suppose he has to make a quick choice, but he has to select him a year and a half ago, and then he finds that the man he would like to have has a quota filled up and he cannot get him because his quota is filled.

There certainly could, in that kind of a case, be a very grave injury occurring to the individual.

Miss HALL. Senator, could I answer this?

Senator DONNELL. Would you please first give us your answer to the question, could not there be a grave injury? And then explain your answer.

Miss HALL. I think if I could not get the doctor I want at the time I wanted him, it would be a grave situation. That is why I want health insurance, because that is happening all over the country today. I think unquestionably there will be some things about this bill that as you go on working with it you will improve upon, and which will work out.

I have never seen any piece of legislation that did not improve as it went on.

But the things you are worrying about in this bill happening to a few people are happening to people all over the country today. They are in just that situation of not being able to get a doctor they want when they want him.

Senator DONNELL. Well, one more question. We will say in this particular township out in Illinois, there is posted a list of eight doctors, one, two, three, four, five, six, seven, eight, that have accepted the terms of the bill, and the people immediately start registering which doctor they want. Obviously it is true that if, generally speaking, in that little area Dr. Smith is regarded as the very best doctor, there is going to be a rush to take Dr. Smith.

Miss HALL. Yes.

Senator DONNELL. And his quota would be filled more early than the quota of other doctors?

Miss HALL. That is true.

Senator DONNELL. So that the first persons who had come in to register would exhaust his quota, and the rest of the people, who might

be the ones at home or away, or not so diligent as the first 250 or 500, they would be limited down to what might be considered the second class doctors on down the line. That is correct, is it not?

Miss HALL. Senator, right now in the neighborhoods there are popular doctors in that neighborhood, who cannot take anybody. That would not be inherent in this system. That is inherent in life.

Senator DONNELL. But I have stated it correctly?

Miss HALL. I would expect it to work something like that. The more popular one would have a fuller quota.

Senator DONNELL. But in the present condition, today, without such a law as this being in existence, we agreed, I think a half hour or so ago here, that the individual would be the one who would decide whether or not he could take the patient rather than leaving it to the Surgeon General to decide.

In other words, the individual doctor would determine whether his proper quota was filled right now, rather than have the Surgeon General or the deputy make the determination.

Miss HALL. That is right, Senator, and that is what I think sometimes has been bad. I think sometimes the decision has been made that they take the people that can best afford it. I would not like to have that thought the basis of choosing the patients. If you leave it entirely that way it may be an economic choice, for whoever has not got a kind doctor.

Senator DONNELL. In the normal course, under this bill, it would be that the rush would take place to get on the list of the men generally considered to be the best?

Miss HALL. That is right. I think you would be following a human pattern.

Senator DONNELL. That would be the case under this bill?

Miss HALL. That is right.

Senator DONNELL. Now, Miss Hall, you know the organization known as the International Labor Office, do you not?

Miss HALL. Yes.

Senator DONNELL. You know of that organization?

Miss HALL. I know of it.

Senator DONNELL. It is a well-known organization.

Miss HALL. That is true.

Senator DONNELL. I believe you stated you were in Europe some years ago?

Miss HALL. Yes.

Senator DONNELL. How recently?

Miss HALL. 1936.

Senator DONNELL. 1936. Let me read you these two sentences—

Miss HALL. I was also there in 1931. I have been there a number of times.

Senator DONNELL. May I read these two sentences, which I would think are applied to England here, but I would like to ask you, if you observed this to be in England, the effect.

This, by the way, is referring to Chile at this point, because the preceding sentence refers to "Chilean doctors."

The fact is that once the whole employed population, wives and children included—

I pose this interruption. The whole population is not insured over there?

Miss HALL. No. I guess the plan has gone through that takes the family in.

Senator DONNELL. I think that the point I am going to present to you is probably not dependent on the inclusion of all.

The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other.

Have you observed that as the number of insured persons increases that that tendency that I have just read develops?

Miss HALL. You see, Senator—

Senator DONNELL. Have you observed that tendency?

Miss HALL. No. The point is this: The doctor does not have to take a panel patient. He can take as much private practice as he wants. If he wants to take three-quarters private practice and one-quarter panel, he can do it.

So the panel is not forced on him by the Government. If he wishes to take it he can.

Maybe the system in Chile is different. I do not know; but that is the answer to that, that you can take as much private practice as you want and can choose as much panel practice as you want.

Senator DONNELL. If the United States should adopt a plan under which the whole employed population is brought within the scope of compulsory sickness insurance, the great majority of doctors would find themselves in the insurance medical service.

Miss HALL. What I would hope is that we would have enough doctors to take care of the whole population.

Senator DONNELL. But we would find the tendency, with the increase of number of persons insured, that more and more doctors would devote themselves exclusively to the work of the Government?

Miss HALL. That would be their choice, but they do not have to.

Senator DONNELL. But that would be the tendency, a decided tendency, in your opinion?

Miss HALL. I think that doctors who do certain kinds of private practice, probably would stay and take a few panel patients. This is the way it seems to work in England, by the way, and we have not got any other experience.

Senator DONNELL. May I ask you, do you agree with this statement which appears in the report of the National Labor Office, 1944:

A national medical service is already in operation in New Zealand and in the Soviet Union, where every inhabitant is entitled to free medical attendance, drugs, and hospital treatment. In the former country no change has been made in the method of furnishing medical care, which remains that of individual practice; the doctor is refunded by the state a fixed fee per visit or consultation and is not legally entitled to additional remuneration from the patient.

That is national medical service.

Miss HALL. That is not health insurance. The Russian system is that the doctors are paid by the government, but that is not what we are asking for in this bill.

## EXEMPTION FOR CHRISTIAN SCIENTISTS

Senator DONNELL. Let me ask you this question, also.

Take a religious organization, we will say. Take, for instance, the Christian Scientists. I am not entirely familiar with their teachings, but I understand generally that they feel that treatment by physicians is not necessary, that they rely upon their religious views to have healing, at least in large part, perhaps entirely.

What is your comment, if any, with respect to a law which would impose upon the people in great numbers, such as the Christian Scientists, the obligation to pay taxes toward the support of a compulsory health insurance in which they would feel that it is unwise and improper that they should participate?

What is your judgment on that?

Miss HALL. I might say that I pay taxes in the country for schools and do not use them. I do not mean that I do not believe in schools, but I do not use the schools that I am paying taxes for. I think a great many of us pay taxes for the things that we do not use ourselves. I do not think that is a great hardship on the Christian Scientists.

Maybe as the years go on, we can work something out. I would not say that was any great deterrent.

Senator DONNELL. I think you indicated the distinction between the two. You said you would not say you do not believe in public schools.

Miss HALL. That is right.

Senator DONNELL. Take a situation in which a great religious organization does not believe in either the efficacy of or the advisability of submitting their members to health treatment under such a law.

Do you think that in fairness to them they should be subject to the obligation to contribute by taxation to the support of such a system?

Miss HALL. I think a Christian Science witness would do better than I would.

Senator DONNELL. I am asking for your opinion.

Miss HALL. I have not thought about it.

Senator DONNELL. Very well.

The CHAIRMAN. Let me ask a question here, please, Senator.

Do you not feel that if the American people should feel that the national health system is essential for the welfare of the whole country, that there would not be anything unreasonable in seeing to it that all the people of the country contributed to the support of that kind of a system?

Miss HALL. I would feel so, Senator, on the basis that many of us pay for things that are good for the country as a whole that we may not personally benefit from or even believe in.

The CHAIRMAN. That is right. In a democracy the majority rules. If a majority of the American people feel it is essential for the health and welfare of the Nation that we should have a system that would make medical care and hospitalization available to all the people, you think there would not be anything unreasonable in asking all religious sects in the country to support that kind of system?

Miss HALL. Yes.

The CHAIRMAN. There would not be any injustice to them if they did not want to avail themselves of it, and they would not be compelled to.

As a matter of fact, a good many of the members of that organization do fail to avail themselves of medical care or medical service, often to their great detriment in the final end.

We had an Ambassador from England here a few years ago who died as the result of his failure to call medical care, because he was a member of the Christian Science sect, and as the result, he died, and the physician afterward claimed if he had only consulted a physician he could have lived many, many years.

At any rate, you find no difficulty in satisfying your mind that the American people have a right to have that form of health care and hospitalization in this country which is necessary for the protection and for the welfare of the American people?

Miss HALL. Yes; I have no difficulty whatsoever.

The CHAIRMAN. You find no objection to that whatsoever?

Miss HALL. No.

#### IMPOSITION OF FEES TO PREVENT ABUSES

Senator DONNELL. Miss Hall, I call to your attention section 210 (a), appearing on page 57, which, as I understand it, the Surgeon General may, after consultation with the advisory council and with the approval of the Social Security Administrator, determine for any calendar year or part thereof, that every individual entitled to general medical, general dental, or home nursing benefit, may be required by the physician, dentist, or nurse furnishing such benefit to pay a fee with respect to the first service or with respect to each service in a period of sickness or course of treatment.

Do you regard that provision to be proper?

May I amplify that by this observation which I would like for you to have in mind: Here we find some system of taxation divided either by a pay-roll insurance or an earmarked income tax, or both, which are thus far suggested, the taxes are procured through those means, and then the Surgeon General comes along and he announces that the people entitled to this medical, dental, or home nursing benefit, must pay with respect to each service or any service a fee. In other words, that the people shall not secure free services in the instances in which he, after consultation with the Advisory Council, and with the approval of the Administrator, shall so determine.

Do you regard that provision to be proper?

Miss HALL. I think the next sentence makes that a little clearer:

Such determination shall be made only after good and sufficient evidence indicates that such determination is necessary and desirable to prevent or reduce abuses of entitlement to any such benefit, and shall fix the maximum size of such fee at an amount estimated to be sufficient to prevent or reduce abuses and not such as to interpose a substantial financial restraint against proper and needed receipt of medical, dental, or home nursing benefit.

Senator DONNELL. I call your attention, Miss Hall, that in the course of the sentence you have read there is an authority granted to the Surgeon General, after this consultation and approval, to which I refer, to fix the maximum price of the fee to be charged by the physician, dentist, or nurse.

May I ask you two questions in connection with that sentence.

First, can you conceive of what abuses of entitlement to a benefit could arise that would prevent the people of our country from obtain-

ing the free insurance, which I think, generally speaking, this bill contemplates?

And, in the second place, do you think it advisable that the Surgeon General of the United States, after this consultation and approval, shall determine the maximum fee that a doctor, dentist, or nurse, out in Oskaloosa, Iowa, for instance, may charge for the services?

MISS HALL. As I read this provision, and it certainly was not one of the parts of the bill that I thought of as one of the most significant, but I think every part is important, I thought it was to pacify the people who felt that there would be such abuses in determining insurance benefits.

I personally have more confidence in the people. I do not feel there is going to be a great deal. This did not seem important to me as I read it, because I did not feel there would be need of the application. I do not think the people are going to take such misuse of the insurance. It did not seem to me, in talking to the English people, and I only use it because it is the most comparable example, and the people are not too unlike us.

I talked to young working girls and working men in different parts of England, and certainly you did not have any great sense that they were trying to beat the system.

They discussed the doctors just about the way anybody would discuss a doctor, and told how they used them and what it meant to them and so on, and I got no feeling that the great thing we had to guard against in the bill was abuses.

To do not feel very strongly one way or the other about this particular part of the bill.

Senator DONNELL. I infer—and if I am incorrect, please check me—I infer you do not regard the provision of section 210 as necessary to be included in the bill, because you do not feel there is going to be any great abuses?

MISS HALL. I think that is the way I feel about it.

Senator DONNELL. Thank you very much, Miss Hall.

The CHAIRMAN. But these are all technical matters, I presume you recognize, and require very careful study?

MISS HALL. Senator, I think the technical working out of the health insurance bill is a matter for physicians and technicians.

I came here today to tell you especially from my own experience with working people that the present system does not work, and that I had seen also at close hand a system that I thought did a better job in England, the system of health insurance.

And I have read the bill and I have studied the bill, but I certainly am not a technician on the bill.

The CHAIRMAN. You know that in the famous Mayo Clinic people that go there do not get a choice of physicians or surgeons either, do they?

MISS HALL. No; and I do not think we get a choice of physicians.

I think that is just a smoke screen.

The CHAIRMAN. You think that under this system where we provide for an advisory council made up of physicians, doctors, and surgeons, and so forth, which shall advise the Surgeon General with reference to questions of general policy and administration in carrying out the provisions of the title, and in establishing professional standards, and

so forth, that under that kind of a system you think the American people could rely upon the advisory boards in the various sections of the country selecting more qualified men to practice medicine and surgery and the other specialties in medical care, and that the country would be pretty well safeguarded under that kind of system?

Miss HALL. By the same people who are practicing medicine now. Why would not they be a little better, if the reputable members of the community took a little more responsibility for the total health care of that community? I cannot see how it could help but jack up the system as a whole.

The CHAIRMAN. Under the present system and for many years it has been known that we had "quacks" and charlatans who deceive the people and sometimes extract heavy fees for services of no value whatsoever, and also in some cases there are operations performed for high fees when there was not any necessity for the operation at all, or where the operation could not possibly be successful.

That has occurred in this country, and everyone knows it, I am sure.

Miss HALL. Yes.

The CHAIRMAN. Under this system, you think we would be better safeguarded than under the existing system, because of the fact that you have a medical advisory board and the various communities advise with the Surgeon General in setting up the panel of doctors and qualifications, that we would not have to feel any fear but what the services rendered would be proper and efficient?

Miss HALL. This gives the doctors in the country official responsibility for the total health of the Nation, as I see it, for planning for it in a way that they have not done, and I cannot think but that they would rise to that.

The CHAIRMAN. I am sure that that sentiment exists in the minds and hearts of a great proportion of the medical profession today.

I know I have talked to some of the highest men in the medical profession, and they regret very deeply the failure of their own profession to have advocated some way of remedying these conditions long, long ago.

Do you not find that to be true?

Miss HALL. All of us, I think, have talked to many outstanding physicians who feel very strongly that this would improve the work of the medical profession as well as the health of the country.

The CHAIRMAN. I am sorry to have compelled you to remain here so long.

You have been of great help to us, I am sure, and I want to thank you sincerely.

Senator DONNELL. May I ask just one or two very brief questions?

Miss Hall, I am wondering if you have given consideration to this question under this bill, S. 1606, that an individual who travels much of the time, a traveling salesman, who makes his selection in his own home of a physician, and then he takes ill 500 or 1,000 or 1,500 miles away, is there any provision in the bill that you know of which would entitle him to any treatment at the place where he takes ill, and if so, what is that provision?

Miss HALL. I have forgotten how that is handled, if it is handled.

The CHAIRMAN. If it is not in the bill, it is a mere matter of procedure which can easily be remedied.

Miss HALL. That is right.

The CHAIRMAN. And upon thorough examination, it is expected that many amendments will be made.

Miss HALL. I do not remember anything in the bill mentioning that, but it seems that there is.

The CHAIRMAN. There must be, because that is very true in connection with the working people of the country. They travel back and forth from the different States very frequently. I think that the mining population, in the city where I live today, is 75 percent different from what it was 10 or 12 years ago. I think there is a constant change going on all the time, people going back and forth constantly, to select a more favorable climate, or more favorable conditions where they can get jobs; that is going on a great deal, and of course, some provision has been made to protect people that belong to this system so that they get care where they go, to a different section of the country.

Miss HALL. I think one of the reasons I would be for a national bill would be to protect the mobility of the people in this country.

We believe that they ought to go where there are jobs, and would have another chance. We believe they should be free and only under a national system can you do that kind of thing.

The CHAIRMAN. Thank you very much.

#### STATEMENT OF MISS CAROLINE F. WARE, OF THE AMERICAN ASSOCIATION OF UNIVERSITY WOMEN

The CHAIRMAN. Miss Caroline F. Ware, of the American Association of University Women.

#### ENDORSEMENT OF THE BILL

Miss WARE. I am glad of the opportunity to express to this committee the support of the American Association of University Women for the National Health Bill, S. 1606. Many of our 80,000 members and over 900 branches, in communities large and small throughout the country, have been deeply concerned with the health needs of their communities. The fact that we have received more orders for our study guide, *Medical Care for Everybody?* than for any other guide which we have issued in recent years is evidence of the very widespread interest in the subject among our members, and their determination to study and inform themselves on the problems and issues involved.

On the basis of such study throughout the association, our convention last May voted 11 to 1 in favor of Federal:

Measures to enhance the health and efficiency of the population, including: continuation and expansion of the rehabilitation program for both veterans and civilians; an effective nutrition program; and Federal funds, if necessary, for the extension of hospital and other public health facilities and personnel.

The CHAIRMAN. I would like to ask you there, have you a copy of *Medical Care for Everybody?*

Miss WARE. Yes; I have.

The CHAIRMAN. Would you care to leave it with the committee?

Miss WARE. I will be glad to.

Senator DONNELL. May I ask a question here. I do not observe in what you have read as the action of the convention last May any spe-

cific mention in terms of compulsory health insurance. Is that mentioned in it?

MISS WARE. Our latest program also includes extension of coverage of social security.

The national committees of our association, whose responsibility it is to interpret action of the convention in terms of specific legislation, have found that S. 1606 embodies the principles stated by the convention.

Our procedure is this: we never act on anything which we have not studied first. Then a tentative legislative program in terms of general principles is drafted. It is submitted to all the branches of the association who will study and discuss it, and they express their opinions. It is not a vote. It is simply an opinion.

Before the drafting of the program it is in the hands of two national committees, one in the field and one general legislative committee, and of course it is in the hands of the board.

Then this proposal goes to our branches. They study it and discuss it and express their views on it.

On the basis of the views expressed by the branches, the proposed program is revised and it is then submitted for vote by the convention in terms of general principles.

Then as each piece of legislation comes up, the legislation is referred to the same national committee, the committee in the field, in this case the National Social Studies Committee, and the Legislative Committee.

Then those committees determine as to whether in their judgment the principles voted upon by the convention include the legislation in question.

That procedure has been followed with respect to the bill at hand.

SENATOR DONNELL. May I ask you one or two other questions. How large an attendance was there at the convention last May in which this vote occurred, of 11 to 1?

MISS WARE. The convention was not held physically because of the transportation difficulty. It was held by mail from each community, and the numbers of the votes were approximately 2,000.

SENATOR DONNELL. And that vote of 11 to 1 was in favor of "measures" down to the word "personnel"?

MISS WARE. Yes. And also approximately the same or slightly higher for the development of the social security program, including an extension of coverage, protection of veterans' rights under old age and survivor's insurance, and temporary and permanent disability insurance, and other items which I will not take the time to read.

SENATOR DONNELL. The two committees interpreted this resolution?

MISS WARE. Yes.

SENATOR DONNELL. What is the total membership of those two committees?

MISS WARE. Ten or a dozen people on each committee.

SENATOR DONNELL. So from 20 to 25 women constitute the membership of those two committees?

MISS WARE. Yes.

SENATOR DONNELL. And those 20 to 25 individuals have undertaken to interpret the meaning of approximately 2,000 persons' expressions?

Miss WARE. That is a continuing process in our association.

Senator DONNELL. What is that?

Miss WARE. That is the way in which our democratic procedure works, just as you represent your district and interpret as an individual what you think are the ideas of your district.

Senator DONNELL. You state that "our convention voted 11 to 1." That should be revised to say that there was not any convention?

Miss WARE. Yes; there was a convention. It was a convention by mail. It went through all the convention procedures and according to the judgment of our parliamentarians completely conformed with the convention form prescribed.

Senator DONNELL. As I understand it, "convention" means coming together, "con venio."

Miss WARE. You will have to argue with our parliamentarians and the Office of Defense Transportation, who concluded that this was a bona fide convention. The procedure was all gone through. We used transcriptions for the speeches and in every way held a wartime convention conforming with the requirements of the Office of Defense Transportation and with our own bylaws.

Senator DONNELL. How many people were present at this convention?

Miss WARE. The delegates.

Senator DONNELL. Did you come together at all? Did anybody come together?

Miss WARE. No.

Senator DONNELL. And yet you call that a convention?

Miss WARE. Certainly.

Senator DONNELL. I doubt exceedingly if the Office of Defense Transportation would have considered you were violating any regulation which was purely on paper and not actually accompanied by physical attendance.

Miss WARE. We did it in order not to violate the regulation.

Senator DONNELL. You realize, do you not, that there was no convention held?

Miss WARE. No; I certainly do not.

Senator DONNELL. I certainly do. There could have been no convention held when you did not come together.

Miss WARE. I am merely quoting the judgment of our parliamentarians on the basis of our analysis of the rules and bylaws, which call for a convention. It was not my independent judgment, please understand. I am merely giving the source of judgment that we held a convention legally, and conducted convention business last May.

Senator DONNELL. But in the resolution which was voted upon by mail there is no specific mention of compulsory health insurance? I am right, am I not?

Miss WARE. You have the text as I have quoted it.

Senator DONNELL. I say, I am correct in stating that there is no express mention of compulsory health insurance?

Miss WARE. Senator, you can read it.

Senator DONNELL. Could you just answer that question? Is there anything in the resolution other than what is stated here?

Miss WARE. Why do you ask the question when you have the text before you?

Senator DONNELL. I ask you, is there any specific mention of compulsory health insurance in the resolution adopted by the process you have described?

Miss WARE. I have read you the text. I do not see why you are asking the question.

Senator DONNELL. I just want you to answer it.

Miss WARE. Why do you want me to answer it?

Senator DONNELL. I want to know if there is any express mention of compulsory health insurance.

Miss WARE. Do you want me to read it?

Senator DONNELL. No, ma'am. I heard you. Was there any mention of compulsory health insurance in anything that your convention, so-called, adopted?

Miss WARE. I have read you the text.

Senator DONNELL. Do you decline to answer that question?

Miss WARE. I answered it with the text.

Senator DONNELL. May I ask you this, then: Is there anything in this text or anywhere else adopted by this so-called convention which contains express mention of Federal compulsory health insurance?

Miss WARE. No.

Senator DONNELL. Very well. That is all right.

Miss WARE. There is express mention of temporary and permanent disability insurance.

Senator DONNELL. In what?

Miss WARE. In the item on the extension of the social security program. Shall I read the full text?

Senator DONNELL. Does that appear in the action of the convention in May?

Miss WARE. Yes; it does.

Senator DONNELL. Would you read that, please.

Miss WARE. Again, by the same group.

Senator DONNELL. Which group is that?

Miss WARE. By the delegates.

Senator DONNELL. In this vote by mail?

Miss WARE. Yes.

Development of the social security program, including: extension of coverage; protection of veterans' rights under old age and survivor's insurance; temporary and permanent disability insurance; financial aid to the States to provide public assistance for those who are not covered by present categories; and the organization of the social security program into a unified system with decentralized administration, including protection of the principle of State administration.

The two items were both voted in the same convention in the same way.

Senator DONNELL. May I ask you, please—

Miss WARE. May I read this, also.

Senator DONNELL. Yes.

Miss WARE. There was also an item relating to legislation in the interest of the consumer.

Senator DONNELL. Would you be kind enough to furnish for our records a copy of the pamphlet from which you have been reading?

Miss WARE. I am reading from the record of the vote in the report on the convention as it appears in the summer, 1945, Journal.

Senator DONNELL. Would you be kind enough to file one of those?

Miss WARE. I would be glad to.

Senator DONNELL. Very well. Thank you.

The CHAIRMAN. Referring again to this convention that you held by mail, it could very well be more efficient and effective than if they really gathered together in a building, could it not? That would be because the questions were presented in writing and the answers and action were taken in a record form, so there could not be any doubt about this action.

Miss WARE. In actual point of fact, Senator Murray, we have never had so full a representation of our branches as this at any physical convention; because in the ordinary convention the branch which is at a distance and the small and relatively poor branch has difficulty sending its delegates, which it is entitled to do. Actually, this was a more fully representative convention.

The CHAIRMAN. We have schools conducted in this country without having the students assemble in a room, have we not?

Miss WARE. Yes.

The CHAIRMAN. And some people are greatly benefited by that system.

Miss WARE. Shall I go on?

The CHAIRMAN. Very well.

Miss WARE. In adopting this item in its legislative program our members expressed their recognition of the fact that health is a national problem and that federal legislation is appropriate and necessary. The committees of our association whose responsibility it is to interpret our legislative program in terms of specific pieces of legislation have found that S. 1606 embodies the principles stated by the convention.

#### THE NEED FOR HEALTH INSURANCE

In supporting S. 1606, we speak in a twofold capacity, as consumers of medical services and as civic leaders concerned with effective ways to meet the needs of our communities.

As consumers, we know that medical services are not available in many places and to many people, and that they are priced out of the reach of many families. As civic leaders, we know how public health measures have reduced infant mortality and deaths from contagious disease. But we know, too, now, the wastes and costs of ill health and the failure to meet medical needs still burden our communities and their people.

There is no need for me to rehearse for this committee the basic facts of health and medical care. These have been presented to you in detail by representatives of the Social Security Board and the United States Public Health Service. You are fully aware of how unevenly the medical resources of the country are distributed, how many rural areas and smaller communities lack not only special but general facilities. This condition is sharply high-lighted by the fact that in 1942 only about 1 percent of the certified obstetricians in the country practiced in communities where more than half of all the births took place.

You know, too, that even where services are available geographically they are not available economically to lower and middle income families in proportion to their need. The bureau of medical economics of

the American Medical Association found in 1939 that families with incomes up to \$3,000—and that is 85 percent of the population at the prewar income peak of 1941—often could not meet the costs of major illness without outside assistance, while families with incomes up to \$1,500 were likely to need assistance even for minor illnesses.

You do not need to be reminded that a major illness is a financial catastrophe from which many families never recover, and that this, or a succession of minor illnesses, keeps many a family perpetually in debt. Illness is, in fact, the greatest single source of personal and family debt.

The CHAIRMAN. I would like to interrupt you there. Some studies have been made of the reports published in the New York Times of the 100 neediest families, and I understand that investigation has developed the fact that most of those families have been brought to their dire distress as the result of illness in their families starting them on the road to debt and involving them in debts which finally crippled them and put them in a situation where they became members of the 100 neediest families in the city of New York.

MISS WARE. There have been a number of such studies, and I think that the consistent picture is that illness pushes the people over the line.

The CHAIRMAN. You may proceed.

#### POPULAR DEMAND FOR HEALTH INSURANCE

MISS WARE. Confronted with these facts, the American people have repeatedly and clearly asked for better methods of extending health services and of making them available to those who need such services. Public opinion polls have consistently voiced dissatisfaction with the present situation and support for proposals to increase the availability of medical care. A University of Denver poll in 1944 found 68 percent of a representative sample approving extension of the Social Security Act to include medical care, with 58 percent specifically indicating approval of an increased pay roll deduction for the purpose, if necessary.

The medical profession, likewise, has evinced a growing recognition that new methods are needed to assure that their services will reach the consumer. Not only have they thrown their weight back of the recently passed bill for hospital construction in areas where hospital facilities are lacking; they are increasingly indicating acceptance of or support for the principles of prepayment and insurance.

It is a source of great astisfaction to find even the American Medical Association, whose opposition to prepayment has been so intransigent in the past, now fully accepting the principle of health insurance by including in its 195 platform "the development in or extension to all localities of voluntary sickness insurance plans."—

Senator DONNELL. The word "voluntary" is there, as you have indicated, is it not, Miss Ware?

MISS WARE. Yes, I know.

In addition to insurance for loss of earnings due to sickness, many other physicians, and groups of physicians, have fully supported not only the principle of insurance, but the compulsory insurance called for by this bill.

There is, thus, overwhelming agreement on the need for a national health program, and the area of disagreement has narrowed to the issue of whether insurance should be compulsory or voluntary. Even on this point it is reported that the American Medical Association is ready to give qualified acceptance to the compulsory principle on a State basis, and that it may only be a question of whether the Federal Government or the State is the more effective instrumentality.

The full data on need for a national health program and the growing agreement on ways to meet the need have made possible a comprehensive approach to legislation in the health field. Senate 1606 is the result.

The sponsors of this bill are to be congratulated for placing before the Congress a statesmanlike measure which brings an over-all approach to the problem of the Nation's health. We are very much gratified to see this sort of comprehensive, fundamental legislation on major national problems in place of piecemeal legislation addressed to separate aspects. In supporting the Wagner-Ellender-Taft general housing bill, we—I mean our association—expressed our approval particularly for its comprehensive character. The national health bill is the same type of over-all legislation, based on a thorough analysis of all aspects of the problem and an attempt to cover each of the major aspects.

#### GRANTS-IN-AID

The grants-in-aid provided in the bill, for public health services, maternal and child care, and care of needy persons, are made in accordance with the principles which our association has consistently approved in other Federal grant-in-aid legislation—State participation and equalization through larger proportionate grants to poorer States. The purpose for which they are made are necessary and appropriate. In this Nation of mobile and migrant people, public health services everywhere are of potential concern to all of us. The special need for grant-in-aid for maternal and child care arises from the fact that the poorer communities, especially the rural areas, are raising most of the Nation's most valuable crop, its children. We welcome Senator Pepper's amendment strengthening this important aspect of the bill. It is altogether appropriate, too, that needy persons lacking medical care should be added to the categories of people—blind, aged—for which the welfare programs under the Social Security Act now provide grants-in-aid.

#### THE INSURANCE PRINCIPAL

The national system of compulsory health insurance provided in the bill is designed to spread the risk of illness and to make it possible for those who need medical services to secure them. The reasons for putting health insurance on a compulsory basis are clear, both from logic and from experience. Just as in the case of unemployment insurance, only a compulsory program can really spread the risk and keep down the cost. If only those who thought they were going to lose their jobs took out unemployment insurance, and only those who expected to be ill took out health insurance, the insurance fund would be likely to have to pay out more than it was taking in, unless it charged extremely high rates, thereby keeping out the low-income people who need it most.

Only by collecting also from the people who do not expect to be unemployed or ill can a fund be built up through small contributions which will be able to make the required payments. Since no one is free from the risk that illness may strike him, and since illness throws an economic and social burden on the community as well as the individual, it is appropriate that all should share in maintaining an effective insurance system.

#### VOLUNTARY PLANS

Experience with voluntary health plans directly bears out this point. The Blue Cross hospital plans, in spite of efforts to hold people through group enrollment, lose 25 percent of their members each year—presumably those who decide either that they will not need the service or that they cannot afford it. In a Government-sponsored voluntary prepayment medical plan for low-income farmers in Ohio, 76 percent dropped out within 3 years. Voluntary plans sponsored by medical societies in Michigan, California, and New Jersey lost their healthiest members, had to pay out increasing proportions of their funds in benefits, and were forced to reduce their services or increase their fees. Few families in the lower half of the population can afford to pay the cost of participating in a voluntary plan which provides a substantial variety of services.

#### WHY THE PLAN MUST BE NATIONAL

On the question of whether a compulsory health-insurance program should be national or State-wide in scope, all the economic advantages are on the side of a national program. Since the basic principle of insurance is the spreading of risk, the wider the base the less will be the cost to the individual. Moreover, on a State basis, the poorer States would be able to have much less adequate systems than the richer States, and we should be right back where we are now, perpetuating gross inequalities.

On a national basis, we can afford adequate medical care for all. We are now spending 4 to 5 percent of our national income for medical care. With our present methods of spending that money, it has not given us a healthy nation, as the selective-service rejections so dramatically remind us. Distributed by means of a national insurance system, it could make medical care available throughout the Nation. The 3-percent pay-roll tax, which has been proposed as a means of financing a national program, falls well within the Nation's present medical-care bill.

It even seems as if we might well afford more for medical care than we have in the past. We spent nearly twice as much for alcoholic beverages, for example, last year than our average prewar annual expenditure for medical care.

May I point out, in closing, that this whole question of paying for health services and for medical care is primarily an economic problem, a community problem, a consumer's problem, rather than a medical problem. This bill deals with the organization of our economic resources to enable people to secure the services of the medical profession. Because it is a problem of organizing ourselves, our economic resources, and our communities, it is appropriately a question for the people, acting through their Government, to tackle.

It is on this basis that we, a lay organization of civically responsible citizens, herewith record our support for S. 1606 as a comprehensive, statesmanlike approach to the problem of the Nation's health.

Senator DONNELL. May I ask you, Miss Ware, a few more questions?

Miss WARE. Yes.

Senator DONNELL. May I ask you, please, to state for the record your own educational background, where you took your work, and information of that type.

Miss WARE. I hold a Ph. D. in economic history from Radcliffe College.

I have been a professor in several colleges, including Vassar College and Sarah Lawrence College, American University, and Howard University.

I am now professor of community organization on the faculty of Howard University School of Office Work.

Senator DONNELL. I am wondering if Miss Ware—

(Whereupon the bell sounded calling the Senators to vote.)

The CHAIRMAN. We will return here as soon as we vote, if you will wait, please.

Miss WARE. Surely.

(Whereupon the Senators retired from the committee room.)

(Thereupon, at 4:32 p. m., April 9, 1946, the hearing adjourned to meet again at 10 a. m., Wednesday, April 10, 1945.)

# NATIONAL HEALTH PROGRAM

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WEDNESDAY, APRIL 10, 1946

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

The committee met at 10 a. m., pursuant to adjournment, the Honorable James E. Murray (chairman) presiding.

Present: Senators Murray, Donnell, and Smith.

The CHAIRMAN. The hearing will come to order.

The first witness this morning is Dr. Clark Foreman, president of the Southern Conference for Human Welfare. Dr. Foreman, will you take the seat here, please?

## STATEMENT OF DR. CLARK FOREMAN, PRESIDENT OF THE SOUTHERN CONFERENCE FOR HUMAN WELFARE

Dr. FOREMAN. Mr. Chairman and gentlemen: I am president of the Southern Conference for Human Welfare and I have a statement that I would like to present.

### ENDORSEMENT OF THE BILL

The Southern Conference for Human Welfare is a nonprofit organization working for the betterment of the South in order to help improve the whole Nation. We unequivocally endorse the President's national health program and S. 1606, the Wagner-Murray-Dingell national health bill, the main measure to carry it out. We consider passage of this bill the most important single step necessary to improve the health of our people. We ask Congress to pass it this session. The Nation's health needs are serious. We cannot afford the luxury of delay.

### MORE SICKNESS IN THE SOUTH

We in the South know a lot about ill health and inadequate medical care, because we have more of both than any other section of the country. We have worse selective service rejection and infant and maternal mortality rates, than does any other part of the country. We have fewer doctors, dentists and hospitals than any other section; and yet, because of lack of purchasing power, we do not even utilize fully those we do have. Our rural and our Negro populations are hit the hardest, but our industrial workers and the middle-income group are not so much better off.

Let us take a few examples. More detailed health information on the South can be found in the "Good Health Issue" of our news-

paper, the Southern Patriot, which I wish to submit now for the record of the hearings.

(The May issue of the Southern Patriot was introduced for the information of the committee.)

(The matter referred to is as follows:)

[From the Southern Patriot, Nashville, Tenn., May 1945]

These charts tell only part of a sad and shocking story—a story of sickness and bad health the South and the Nation can ill afford.

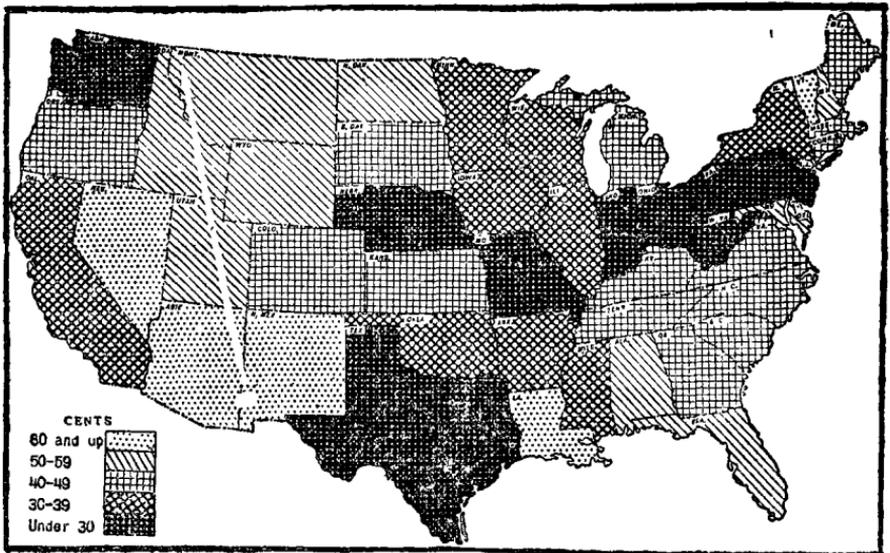
This issue of the Southern Patriot is devoted to a study of health in the South. We present first the symptoms—the facts and figures of our state of health; next, a diagnosis—a picture of the poverty that lies behind our illness; and then a prescription, based on the studies of Senator Pepper's Committee on Wartime Health and Education, and the North Carolina Governor's Commission on Hospital and Medical Care.

A happy and prosperous South depends in the very first instance on a healthy people.

We must not forget that this problem must be studied, tackled and solved if the people of our region are to play their rightful part in building a new South and a peaceful world.

### HOW SICK IS THE SOUTH?

#### PERCENTAGE OF DRAFTEES REJECTED



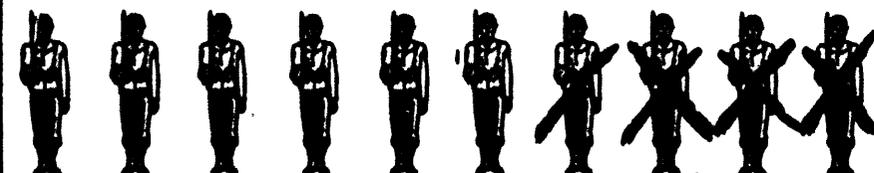
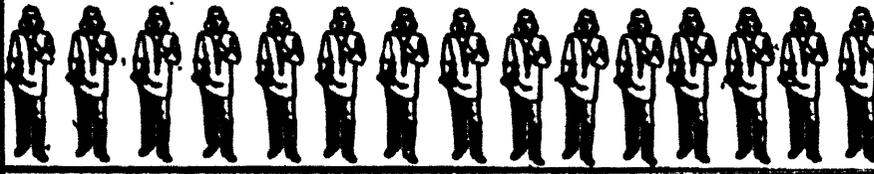
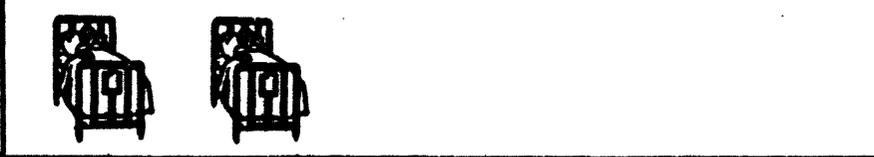
One of every two southern youth—in the prime of life—is unable to meet the minimum physical and mental requirements for military service. While the rest of the Nation furnished 65 eligible soldiers from every 100 men examined, the Southern States averaged only 49.6, a 40-percent increase of IV-F's in the South.

These figures, released by Selective Service, and depicted State by State in the accompanying map, point accusingly to the health standards of the entire southern people.

Many of the diseases which disqualify our young men as soldiers account, too, for the unusually high death rates in the South.

Tuberculosis, for example, caused 45.9 of 100,000 deaths in the Nation as a whole in 1940, but in the Southeast, the figure was 56 deaths and in the Southwest, 63.1. There were 110 counties, or 17.8 percent of the counties in the Southeast, which

**THIS IS THE SOUTH'S CASE HISTORY: POOR PEOPLE, POOR HEALTH**

<p><b>REJECTIONS OF DRAFTEES EXAMINED</b> Feb., 1943-Aug., 1943.</p> <p><small>Source: Medical Statistics Bulletin No. 2, Selective Service</small></p>		<p><b>13 SOUTHERN STATES: 49.6%</b></p>
		<p><b>NON-SOUTHERN STATES: 35.6%</b></p>
<p><b>DOCTORS Per 10,000 people 1940</b></p> <p><small>Source: Based on table tabulated from American Medical Directory, 1940</small></p>		<p><b>13 SOUTHERN STATES: 9.4</b></p>
		<p><b>NON-SOUTHERN STATES: 14.9</b></p>
<p><b>GENERAL HOSPITAL BEDS Per 1,000 people 1940</b></p> <p><small>Source: Journal American Medical Association, March, 1942</small></p>		<p><b>13 SOUTHERN STATES: 2.2</b></p>
		<p><b>NON-SOUTHERN STATES: 3.9</b></p>



had 70 or more tuberculosis deaths per 100,000. Every State in the region had 3 or more of these counties and of the 110 counties in the region, Tennessee had 51.

The death rates for influenza and pneumonia were 70.3 per 100,000 for the Nation, and 90 in the Nation's warmest climate, the Southeast.

Pellagra, a disease caused usually by lack of proper food, was responsible for 1.6 deaths per 100,000 in the Nation in 1940, but in the Southeast the rate was 400 percent higher, or 6.5. In 35 counties, there were pellagra mortality rates of 20 or higher per 100,000, and this includes over 10 percent of the counties in Georgia.

Venereal disease, one of the most important causes for rejection of draftees, shows perhaps the sharpest contrast between the South and the Nation. Syphilis accounted for 9.4 of every 100 men rejected before draft boards and induction centers throughout the country; but in the 13 Southern States, 16.1 of these 100 men were rejected because of syphilis. This disease was especially prevalent among Negro youth, but not exclusively by any means. Eleven of the 13 Southern States had higher syphilis rejection rates among white youth alone than the national average for white youth.

Syphilis mortality rates in parts of the Southeast are dangerously high. In 12.3 percent of the counties in the region, there were death rates of 30 or more per 100,000, compared to the national average in 1940 of 14.4.

Malaria, which caused only 1.1 of 100,000 deaths in the United States accounted for 4.5 in the Southeast.

#### THE SYMPTOMS

Unnecessary death, misery and ill health are shown in their clearest and grimmest form in the infant and maternal mortality rates in the South.

That good medical care could have prevented a substantial percentage of the South's infant deaths and stillbirths is proved by the fact that in 1940 the number of infant deaths and stillbirths per thousand in South Carolina (110) was more than twice the number in the States of Washington (51), Connecticut (53), Oregon (53), and Minnesota (54).

The reason that eight of the nine States with the highest maternal death rate were Southern States is easily understood by a glance at the chart on the *right*, which indicates that only 3 of every 10 southern mothers are able to have the protection they need in childbirth, compared to almost 8 out of 10 outside the South.

Lack of hospital facilities is probably the most important factor, not only behind the high child and maternal mortality rates but underlying the whole southern health picture. For although the South has 29.5 percent of the Nation's population, it has only 18.8 percent of its general hospital beds, 18.1 percent of its tuberculosis hospital beds, and 18.3 percent of its mental hospital beds.

The 10 States with least number of hospital beds per 10,000 people in 1940 were all southern. Mississippi is at the bottom with 15 beds per 10,000, compared to Nevada with more than 4 times that amount (62). The minimum necessity is considered to be 4 beds per 1,000 people, but the Southern States had an average of only 2.2 beds in 1940. No Southern State was up to the minimum, although Louisiana, Florida, and Virginia were considerably ahead of the rest of the South, with 3.7, 3.3, and 3.1, respectively.

The shortage of hospital beds available for care of Negroes who are sick or injured is particularly acute. Note the following figures:

Arkansas: 0.9 bed per thousand for Negroes; 1.4 beds per thousand for entire population.

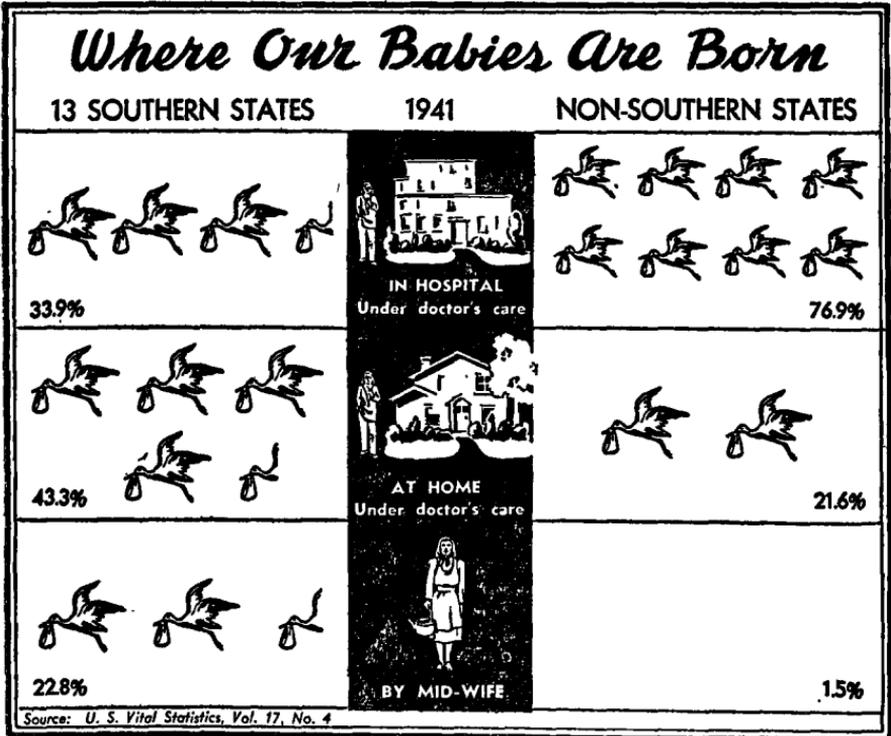
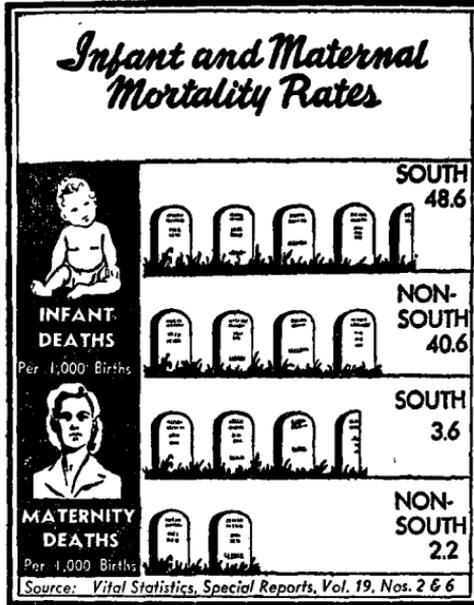
Mississippi: 0.7 bed per thousand for Negroes; 1.3 beds per thousand for entire population.

South Carolina: 0.9 bed per thousand for Negroes; 1.7 beds per thousand for entire population.

This was reflected in the mortality rate of Negro mothers, which in 1942 was 5.5 per thousand live births, compared to approximately 2 for white mothers.

Another vital health facility is the local health department. Yet 38.9 percent of the counties in the South (529 counties) are not served by a local health unit. Of the 832 counties with health departments, most are inadequately staffed. The minimum number of personnel for efficient operation is 4 per 10,000 population, but 66 of the 67 counties in Alabama, for example, had in their health departments 3 or less employees per 10,000 people.

Several other factors need to be mentioned to complete the southern health picture. One is the sanitation needs of the South. According to a study of



sanitation facilities in the Public Health Reports, of 5½ million rural homes in the Southern States, less than 3 million have a water supply within 50 feet; 657,799 have no toilet or privy; and 4 million dwelling units have only outside toilet or privy.

From the same source, we find that of the 4,933 incorporated communities in the South, 1,928 or 39½ percent need a public water supply; 47.2 percent need a sewage system with treatment; 36.8 percent need extensions to existing sewer systems and 15 percent need new sewage-treatment plants.

These mortality rates alone are frightening; but they do not begin to reveal the over-all effect of poor health on the South. For example, the presence of malaria, which in 1937 was estimated to infect annually more than 2,000,000 people, is estimated to have reduced the industrial output of the South by one-third.

One of the most striking examples of the effect of malaria on industry was revealed by the Public Health Service in studies among employees of a cotton mill in eastern North Carolina. Before the attempts to control malaria, the records of the mill one month showed 66 looms were idle as a result of ill health. After completion of control work, no looms were idle for that reason. Before control work, 238,046 pounds of cloth were manufactured in 1 month. After completion of the work, production rose to 316,804 pounds in 1 month—an increase of 33½ percent.

Control work of this sort, however, is but an isolated phenomenon. In fact, in wide areas of the South, even the most elementary health and medical facilities and personnel are lacking.

In 15 counties in the South—counties with a population of 3,000 or over—there were in 1944 no active physicians whatever. In 15 more southern counties, in the same year, there were over 10,000 people per active physician. In 78 counties, there were 5,000 to 10,000 people per doctor.

The seriousness of these figures can be seen if one realizes that the minimum ratio for safety is 1 doctor per 1,000 population. In 1940, there was a national ratio of 1.25 doctors per 1,000 population.

Yet, in 1944, 63.4 percent of the counties in South Carolina had over 3,000 people per active physician; 44.8 percent of Florida counties; 40 percent in Virginia; 39.2 percent in Georgia, and 38.8 percent in Alabama.

This drastic situation was aggravated by the national shortage of doctors during wartime. But conditions were little better in 1940, when there were only 9.4 doctors per 10,000 people in the Southern States compared to 14.9 doctors in the rest of the Nation.

A special shortage exists with regard to Negro doctors. In the State of Mississippi, for example, there were only 58 Negro doctors in 1942 to serve a Negro population of well over 1,000,000. In the South as a whole, there were 4,913 Negroes per Negro doctor in 1942. And there has been a 12.1 percent drop in the 10-year period 1932-42 in the number of Negro doctors in the South.

Another special physician shortage is in the rural areas. In North Carolina, for example, only 31 percent of the doctors are in rural areas, where 73 percent of the people live. Here, too, there has been a serious decline in the past few years.

A similarly serious shortage exists with regard to dentists and nurses. In 1940, there were 27.3 male dentists per 100,000 people in the Southern States, compared to an average of 64.1 in the rest of the country. In the same year, there were over twice as many trained nurses and student nurses per 100,000 population in the non-Southern States as in the Southern States: 156 in the South and an average of 315.8 outside the South.

#### ONE-FOURTH OF OUR PEOPLE

(From a speech by Dr. Paul B. Cornely, Howard University, Washington, D. C.)

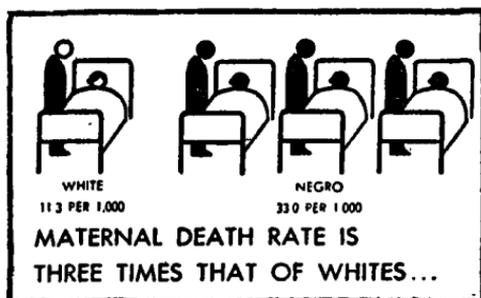
There is no such thing as Negro health—just as there is no Chinese or Irish health. Rather, Negro health problems cannot be isolated from the health problems of the whole community. Negro health conditions affect the welfare of the community and the Nation as a whole, and thus, if for no other reason, are the responsibility of the entire Nation. This is easy to prove: the sick Negro who cannot work in the groves of Florida curtails to some extent the supply of oranges for the breakfast of a white worker in Connecticut; the physically defective Negro who cannot be accepted in the armed forces affects adversely the successful defense of our country.

Here Negro health problems, their causes and suggested solutions, are discussed in terms of the total Negro population, since the problems of the almost 10,000,000 Negroes in the South, while more acute, are not different from those of the group as a whole.

#### FACTS OF NEGRO LIFE AND DEATH

The general Negro mortality rate is 30 to 40 percent higher than the rate for whites.

Negro life expectancy is 10 to 12 years shorter than that of the white group. Between the ages of 20 and 24, three times as many Negro as white women die.



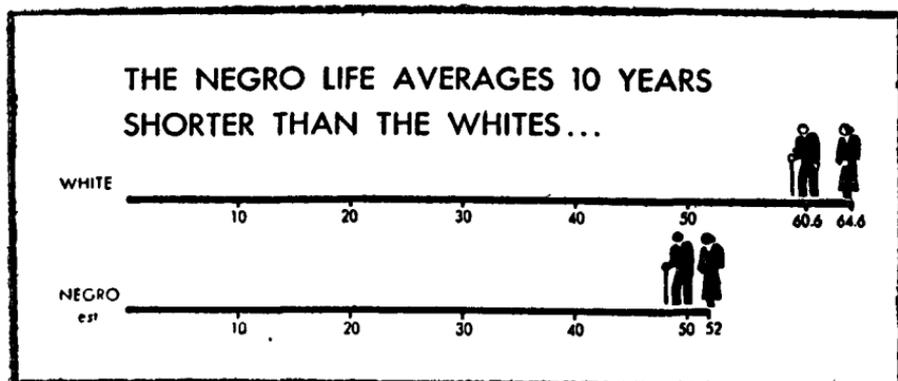
In 1942, three times as many Negroes as whites died of tuberculosis. And in certain cities and age groups, this disproportion has reached levels of 8 to 1.

Veneral disease is from 10 to 12 times more prevalent in Negro than in young white men.

In spite of the fact that utilization of sulfa drugs has cut fatalities tremendously, pneumonia and influenza still kill, proportionately, twice as many Negroes as whites.

#### CAUSES

Three major factors determine to a great extent the health status of any group: Socio-economic level, educational level, and availability of health and medical care. In each of these categories, Negroes are literally "at the bottom of the pile."



The low economic stratum of the Negro is well illustrated by his per capita income, the housing facilities available to him, and the nutritional level at which he must exist. In the field of housing, for instance, the National Health Survey in 1935-36 found that in the South 21.2 percent of Negro households had more than 1½ persons per room as compared to 8.3 percent of white households in that area.

The low educational level of the Negro is shown in the fact that up to January 1, 1945, 32 percent of Negro rejectees examined under selective service were disqualified because of educational deficiency. It is not difficult to explain

this educational deficiency when it is recalled that in 1935-36 10 Southern States spent almost \$50 for each white child as compared to \$17 for each Negro. In States like Mississippi and Georgia, a Negro child was allotted \$9 for a year's education as compared to \$45 for a white youngster. The resulting low educational level is an effective deterrent in the development of interest, awareness, and alertness in matters which pertain to health, in terms of himself and his community.

The third factor, lack of health and medical facilities, can be illustrated in many ways. The availability of Negro physicians to serve the Negro population is extremely important. Yet in the decade 1932-42, the number of Negro physicians in the Nation as a whole decreased 5 percent, in the South 12 percent, while the total number of physicians in the Nation increased 12 percent. The South with 10,000,000 Negroes had few more than 2,000 Negro physicians. Mississippi employed five Negro public health nurses for a Negro population of 1,000,000. Negro dentists were even scarcer.

General hospital beds are woefully lacking in the South. Hospital bed facilities for specific diseases are similarly inadequate. Finally, care available to Negro mothers and infants leaves much to be desired. In 1942, 45.7 percent of Negro live births were delivered by midwives. The situation in some States was even worse, as seen in the following table, which shows percentages of births attended by midwives:

	<i>White</i>	<i>Negro</i>
South Carolina-----	5.4	77.2
Mississippi-----	4.9	80.0
Arkansas-----	4.6	71.6
Georgia-----	6.7	69.5

#### PROBLEMS CAN BE SOLVED

In any attempt to solve the problems of Negro health, it should be borne in mind that they are merely exaggerations of the picture of the community as a whole. Thus any program which meets the needs of the community needs only to be intensified or extended to meet the problems of Negro health. However, certain specific suggestions can be made:

1. Abandonment of the quota system in allocating health facilities to the Negro. It seems elemental that health services must be furnished in relation to the needs of any group, rather than on a basis of its ratio in the population. Similarly, the second-hand approach—the feeling that Negroes can get along with less than whites, and therefore can use to advantage what has been found inadequate for the white community.

2. Development of a generalized health program, which adds to its emphasis on specific diseases an interest in nutrition, sanitation, protection in industry and on the farm.

3. Extension of educational opportunity to young Negroes, whereby they may secure training in medicine, dentistry, nursing, and allied fields.

4. Development of a hospitalization program, especially in the South. If the Hill-Burton bill, S. 191, is passed (see p. 7), it is hoped that the new facilities will be developed in terms of the needs of the community as a whole.

5. A compulsory medical care program, whether financed by Government or private funds, could ease the impact of illness on all individuals.

#### THE DIAGNOSIS

The poverty of the South is the basic cause of the ill health of the South. The southern people are sick because they are poor—poorly fed, poorly clad, poorly housed—unable to afford medical care, their poor communities unable to afford adequate medical facilities.

Per capita income, the clearest index of a region's wealth, correlates with surprising accuracy with almost any selected index of a region's health. The accompanying chart shows a comparison of per capita income with the number of doctors per 100,000 population for the various regions of the United States. The same almost exact relationship would be reflected if the ratio of hospital beds to population had been chosen—for wealth means health, as surely as health means wealth.

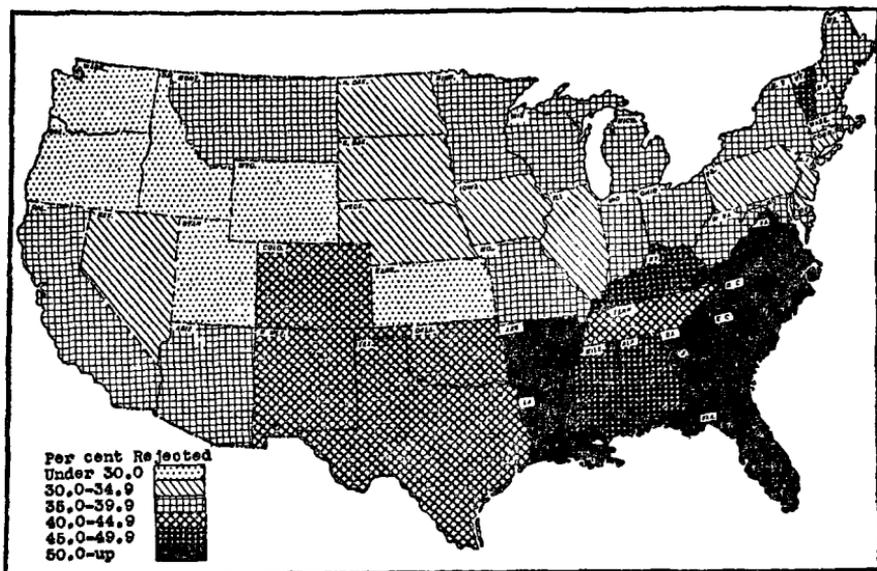
#### POORLY FED AND HOUSED

A Department of Agriculture study proves in cold statistics what southerners know well from experience—that the overwhelming number of southern people have less healthful diets than their fellow countrymen, because they are in

lower income groups. The southern diets were particularly deficient in vitamins A, B, C, and G.

The homes of the southern people, too, reflect their poverty. The 1940 United States Census of Housing, which classifies the average value of occupied dwelling units, shows that the average value of a home in the Southern States is \$1,363, compared to \$2,503 in the Nation as a whole. Of the 10 States with poorest homes, 9 are southern. The farm homes in the South are even poorer, averaging in value only \$644. One of the main reasons many homes are valued so low, of course, is because they have dangerously inadequate sanitation systems, breeders of disease.

#### STATE HEALTH EXPENDITURES PER CAPITA



Yet, ironically enough, the medical attention needed most by the southern people, whose poor living conditions mark them as targets of disease, is not available to them. They cannot afford a doctor's service, nor can many doctors afford to practice in their poor communities. Why the acute shortage of doctors in the South? Because doctors are attracted to those places where:

- (1) There are modern hospital facilities;
- (2) There are assurances of income;
- (3) There are opportunities for research.

The lack of these facilities, especially in the largely agricultural South, makes rural practice particularly unattractive to young physicians. Yet it is in the rural areas that they are most crucially needed.

#### WHY SO FEW HOSPITALS?

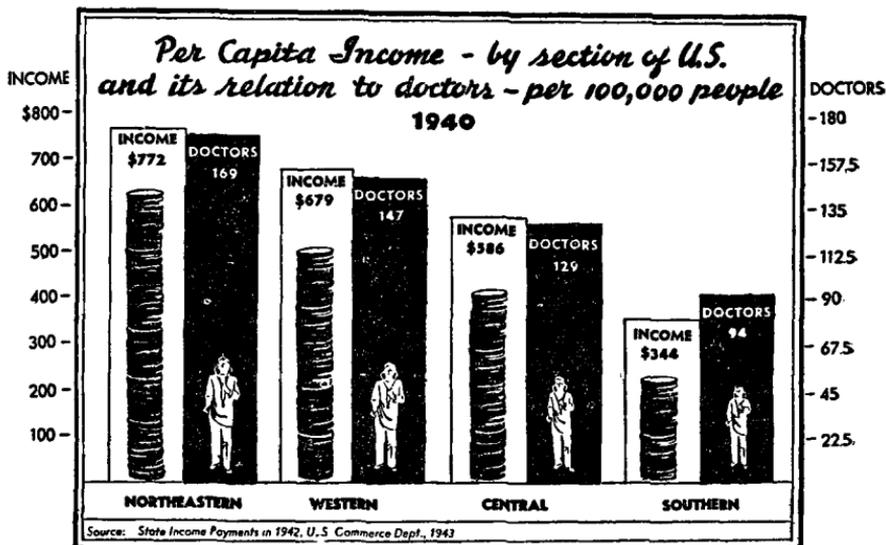
The lack of hospitals and diagnostic facilities is probably the most important factor in keeping doctors away from rural practice. In fact, the presence of hospital facilities alone, independent of such factors as community wealth and size of population, appears to attract physicians. This is suggested by a United States Public Health Service study which shows that among counties with per capita income of less than \$300, those with no general hospital beds had 60 percent fewer doctors in proportion to population than did those with 250 or more general hospital beds.

The absence of modern hospitals in so many southern areas is again the result of the low income of its people. Rural areas lack the corporate and individual wealth that provides ample tax funds, generous endowments, and full payment of fees and charges.

As seen in the chart below, the South's per capita health expenditure is as great as that of the rest of the Nation. However, this per capita allotment is totally inadequate to meet the region's desperate needs, and the States cannot allocate more money. The citizens of those States simply do not have the wealth.

The South's wealth through the years has been sucked out of the region to outside financial interests. In 1935, for example, the assessed value of taxable property in the South averaged only \$463 per person, while in nine Northeastern States it amounted to \$1,370.

It is thus clear that the South is unable to meet its health problems alone and without Federal assistance.



THE PATIENT IS IMPROVING

The South is getting healthier. Over the past few years, great progress has been made in lowering the death rates for many diseases, in developing a wide public health program, and in bringing medical care for the first time to many thousands of people.

Perhaps the greatest stride forward in the past few decades is the work of increased and extended public health units in Southern States and counties. In 1942, 66.9 percent of the counties in the Southeast were covered. A map prepared just a few years ago would have been far blacker.

WORK OF PUBLIC HEALTH MEN

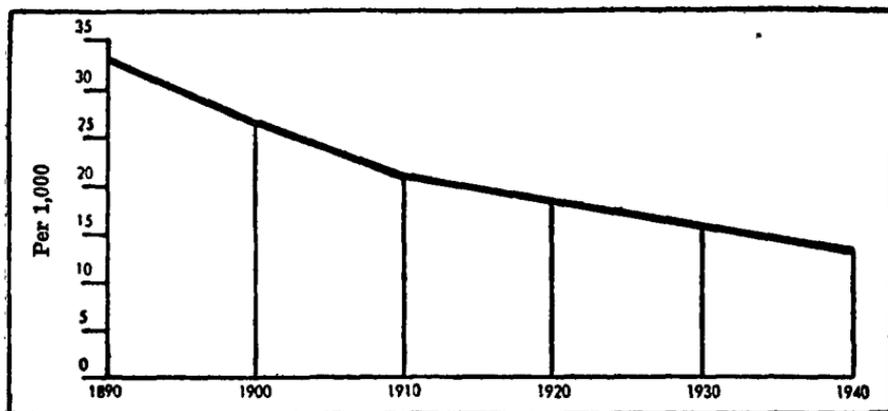
These public health departments do varying work in the different States, but in general, the role of public health is to organize the medical forces of a region for the conservation of the people's health. The program of health departments includes sanitation of water supplies and sewage disposal, milk inspection, immunization, physical examinations in public schools, maternal and child health clinics, nutritional clinics, venereal disease control, acute communicable disease control, malaria control, tuberculosis control, supervision of hotels and restaurants, prevention and care of blindness, dental services, laboratory service, and health education.

Federal aid financed much of this activity. 36.8 percent of the almost \$13,000,000 spent in the seven Southeastern States in 1940-41 was from the National Treasury, allotted through the Social Security Act.

MEDICAL CARE FOR THE FARMERS

Funds from another Federal agency, the Farm Security Administration, have been used to set up a health service program of great significance, especially in

southern rural areas. When the F. S. A. was established in 1936 in the effort to rehabilitate low-income farm families, it immediately became clear that the ill health of these rural people must be tackled as an initial step. It also soon became evident that granting of individual loans to pay for emergency sickness bills was insufficient, for like the risk of fire, the risk of illness could not be effectively budgeted on an individual basis. So a series of group health plans were developed which now cover F. S. A. borrowers in one-third of the counties in the United States, and in 1943 included over 360,000 rural southerners.



Under these medical service-plans, organized under a basic working agreement with State and local medical associations, a farm family voluntarily pays an annual fee to cover emergency medical and hospital care under a physician of their own choice. The plans vary from county to county in services offered and prepayment fees, but the latter are usually based on the size of family, average income and care provided, and range from \$15 or \$20 per family in low income areas to as much as \$40 or more in high income areas. Services offered vary according to need, ability of the group to pay, and facilities already available, but they usually include physician's service, both home and office calls, obstetrical care, emergency surgery and hospitalization, and in some cases, dental care. In 1942, 55.3 percent of all eligible F. S. A. families had taken advantage of the opportunity to join plans.

#### STAR-SPANGLED BABIES

Yet another valuable Federal project is the emergency maternal and infant care program for wives and infants of servicemen, providing free medical, nursing and hospital care for prospective mothers during pregnancy and child birth, as well as infant care. This program, operated by State Health Departments, has been of especial benefit in southern rural areas where such care was not generally available in the past, and by July of last year had been used by over 100,000 southern mothers.

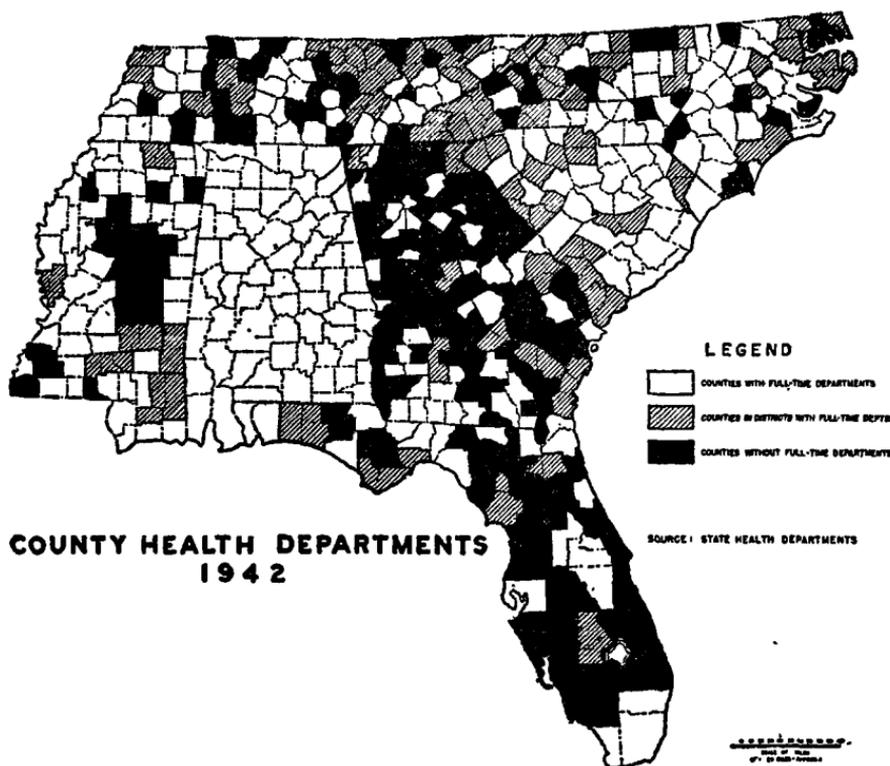
These are some of the reasons southern death rates have dropped so sharply and gratifyingly—but the great differences still evident between these rates in and out of the South point to still urgent unmet needs.

#### SOME PRESCRIPTIONS . . .

That the Southern States alone cannot afford the comprehensive program necessary to restore good health to their people is universally recognized. If education of the child is the Federal government's responsibility, then surely too is the health of the child. But what kind of Federal aid is needed?

The South's two leading Senators, farsighted Claude Pepper of Florida and Lister Hill of Alabama, have both given much study to this problem, Senator Pepper as chairman of the Senate's Subcommittee on Wartime Health and Education, and Senator Hill as author of the Hospital Construction Act. Both have concluded that the first need is a hospital and health center planning and construction program to cover the whole nation.

The Pepper committee has proposed networks of medical facilities on a regional or State basis, to make high quality medical care available to every citizen



regardless of where he may live. This recommendation has been embodied in a bill, S. 191, introduced jointly by Senators Hill and Burton.

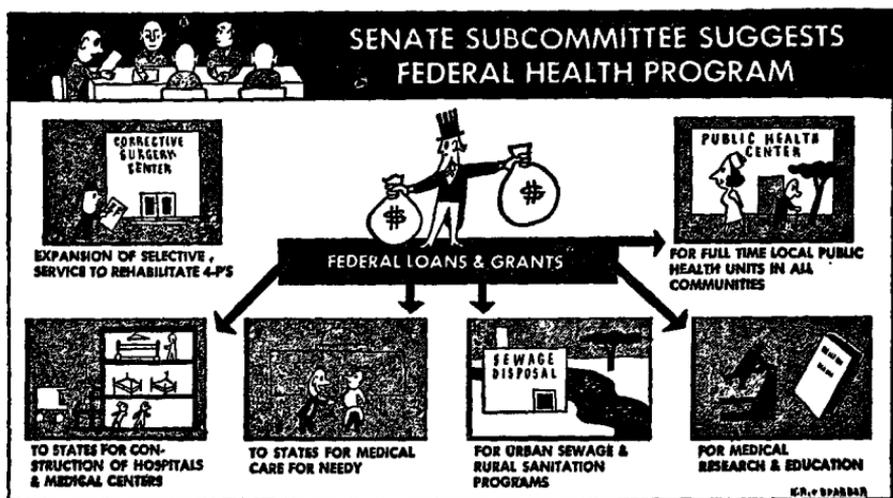
The Hill-Burton bill authorizes Federal aid to the States for three purposes: (1) to assist the States in making a careful survey of the hospitals and health facilities in the State to determine what is needed to bring health services to all; (2) to assist States, counties, cities and communities to provide for themselves modern hospital and health centers, and (3) to assist the States to correlate and integrate their hospital and public health services and to plan additional facilities when and where needed.

The bill provides an initial \$5,000,000 for planning and \$100,000,000 for building new facilities, with additional appropriations to be made available from year to year.

The Pepper committee, on the basis of its comprehensive survey of the nation's health needs, has outlined a model plan for such State health services—"A medical center which combines and coordinates the three major aspects of modern medical care: the preventative, the diagnostic and the therapeutic service." It proposes the development of a coordinated network of small neighborhood and community health centers, rural and district hospitals, around a large base hospital.

But facilities alone, vital though they are, are not enough. The people must be able to afford to use them. Authoritative and conservative estimates show that the average cost of good medical care today is about \$150 per family per year. That would be 5 percent of the income of a family that receives \$3,000 a year. Seventy percent of the families in the United States, however, have incomes of less than \$3,000, and 50 percent have less than \$2,000. Even if we leave out of consideration entirely the fact that many families have need of medical services costing much more than the average figure of \$150 a year, it is evident that majority of the population cannot meet the costs of proper medical attention.

Clearly, the only solution of this problem is a method of payment by which the risks may be distributed among a substantial proportion of the people and the costs of illness over a long period of time. There is considerable agreement that some method of prepayment is the answer, but considerable disagreement over whether it should be voluntary or compulsory. The Pepper committee is



still studying the question, and to date, has recommended only certain conditions that any such program must meet.

They recommend, first, that the medical care given must be complete care—that is, including hospitalization, general medical care, including all modern diagnostic and preventive services and dental care. Insurance against so-called catastrophic illness, or a portion of the medical bill, is not enough. Second, the cost of the service must be low enough so that most of the people can be included in the system, which will require governmental subsidies.

Many feel that an extension of the social-security benefits to include complete medical care is the answer. This program of cradle to the grave security as proposed in the Murray-Wagner-Dingell bill introduced in the last session of Congress provides complete protection—medical and hospital care as well as maternity benefits, old-age benefits, and unemployment compensation for virtually the entire population. It is financed through employer and employee pay roll tax of 6 percent each on wages up to \$3,000 per year. A new and improved bill, to be introduced soon in this session of Congress, is expected to reduce the tax to 4 percent each. This type of program, endorsed by all the labor organizations and many groups in the medical field, is similar to Britain's postwar health insurance program and according to a poll of the National Opinion Research Center is favored by 68 percent of the American people.

#### THE CURE IS UP TO US

Critical though the case of the South may be, lacking though the facilities are, difficult though the prescription is to fill, the cure is possible. And the treatment is in our hands.

What can we do?

1. We must enlist the interest of our whole community in these problems. Health is one issue upon which agreement can be reached among all groups in the population. It is our responsibility to bring about such agreement—to form community councils on health representing business, farm organizations, labor unions, parents and teachers, women and civic groups, the church, Negro organizations—as well as the medical profession and public health representatives.

2. These councils must study the community health problems, and plan a program to meet local needs. They must work with other such groups in the State and present their proposals to the governor or appropriate State agencies, urging legislation and other necessary steps to implement them.

#### NORTH CAROLINA SETS THE PACE

North Carolina presents a splendid example to the South. There, Governor Broughton appointed a commission on hospital and medical care which, on the basis of an exhaustive and careful survey of medical care service in the State, prepared a series of recommendations. These include:

(a) The expansion of the 2-year medical school at the university to a 4-year school with a central hospital of 600 beds; with scholarships for promising youth; the establishment in cooperation with neighboring States of a regional medical school for Negroes;

(b) The appropriation of \$5,000,000 to aid communities and counties to build new hospitals and health centers and to expand present facilities;

(c) Encouraging the development of health insurance and group medical care plans;

(d) Expansion of public-health program, including the general examination of all school children with treatment of remedial defects and an adequate program of disease prevention;

(e) Hospital aid for low income groups.

The public interest and effort that produced this program in North Carolina must be duplicated in all Southern States.

#### PENDING LEGISLATION IN WASHINGTON

3. Community groups must study and lend active support to Federal health legislation that offers Federal financial aid to implement local programs. First in immediate importance is the Hill-Burton hospital construction bill. Southern Congressmen, especially, must be urged to lend Senator Lister Hill their support in pushing through this bill, which will cover the South with desperately needed health facilities. The provisions of the new Murray-Wagner-Dingell bill, shortly to be introduced, must be brought to public attention.

We know that the South is in ill health because the South is poor. It is clear then that the problem of health cannot be solved as an isolated problem. The South's future—in wealth and health—lies down the road of industrialization—toward an expanding economy and full employment.

Our goal must be to secure what Franklin D. Roosevelt outlined in his economic bill of rights:

"The right to adequate medical care and the opportunity to achieve and enjoy good health"—for every person in the South, regardless of where he may live, regardless of his ability to pay, regardless of his color.

The South needs the full strength of all its citizens in the days ahead—in the fight to build a happy, prosperous and democratic South, in a peaceful and secure family of nations.

Senator DONNELL. Pardon me, this newspaper is published by the Southern Conference for Human Welfare?

Dr. FOREMAN. Yes, sir.

The Southern States had a 40 percent higher selective-service rejection rate than the rest of the Nation. Our rejection rate was 50.4 percent, while that of the rest of the country was 35 percent. Yet we have a warm climate, most of our people live in the fresh air of the countryside, and we have certain other natural advantages that might be expected to make our population healthier.

Pellagra, due to severe food deficiency, and malaria death rates are 400 percent higher in the South than elsewhere in the country. Syphilis mortality is far above the national average. Even tuberculosis, influenza, and pneumonia rates are higher than elsewhere, even though our warm climate should certainly give us a natural advantage in the respiratory group of diseases.

Our maternal mortality rate is 3.6 deaths per thousand; that of the rest of the country 2.2, or 40 percent less. Our infant death rate is 48.6; that of the non-South, 40.6.

These are a few statistics. Most of us know the tragedy and suffering they illustrate and the regional backwardness they foster.

#### THE CAUSES

The two main sources of this misery are clear, namely, poverty and inadequate medical services. The two main sources of this misery are

clear, namely, poverty and inadequate medical services. The two are interconnected; but we have learned that attention must be paid to both, that there is nothing completely automatic about improvement in one improving the other and, conversely; that we do not have to wait for improvement in one to begin improvement in the other.

We certainly abhor our poverty. As individuals and through organizations such as the Southern Conference for Human Welfare, we are fighting to overcome the economic backwardness of the South, to take it out of its feudal past into a prosperous free future.

What are the inadequacies of our health service? Our sanitation is miserable. According to the United States Public Health Service, 657,799 southern rural homes have not so much as an outdoor privy, much less an indoor toilet.

Our shortage in hospitals, doctors, dentists, and nurses is severe. We have over 40 percent fewer hospital beds and doctors per person than the rest of the country; yet we certainly need them as much or more because of our high sickness rates. But we do not even utilize fully those facilities and that personnel we do have. Our hospital occupancy rates, despite the vast need, are actually lower than those elsewhere. Why? Because of inability to pay. The economic aspect, the financial barrier to medical care, the lack of medical purchasing power; these are the root causes.

#### VOLUNTARY HEALTH INSURANCE NOT THE ANSWER

Does private or voluntary health insurance offer us the way out? We do not think so. The private medical insurance we can get now is far too expensive and does not meet our health needs. The commercial policies sold provide small amounts of cash, not medical care, in the event of disabling illness; but they have such a huge overhead that only 40 percent of the premiums paid in comes back as benefits. The rest goes for company administrative costs, profits, commission, and the like.

Blue Cross hospitalization is good as far as it goes, but it does not go very far. If one belongs to an eligible group, it costs a family about \$24 a year, but covers only the hospital bill. Yet doctor services alone take three times as much in the average medical dollar. Most incomes are so low, such an outlay is too much.

How can a farm family netting only a few hundred dollars a year afford to belong? This is the usual average of rural annual income in the South. Not for just a few families, mind you, but the average. So the answer is—they do not join. I do not know the figures on Blue Cross membership in the rural South, but I doubt that it exceeds the national figure of less than 2 percent of all rural families. We have heard a lot of exaggerated claims about Blue Cross, but it offers little prospect of meeting our needs.

There are some medical society plans available but they offer even less. They cost about as much as Blue Cross, and cover only the surgical or obstetrical fees. They do not cover preventive, diagnostic, or home and office care.

Much of the best we have now comes from Government-sponsored voluntary prepayment plans under the Department of Agriculture; but even these suffer from the inherent defects of voluntary medical insurance. The Farm Security Administration has been able to work

wonders in assisting half a million low-income farmers to form voluntary health associations for prepaid medical care. The associations have improved the health of these families considerably, but they are not enough.

Adequate medical care costs \$100 a year, according to experts, and poor families cannot raise such amounts, no matter how they pool their resources. Further, turn-over in membership, low percentage of eligibles joining, and other problems have beset these organizations.

Much the same has been true of the Department of Agriculture's experimental tax-assisted voluntary plans in five southern counties. These are open to all farm families, and were described by Senator Claude Pepper, chairman of your Health Subcommittee, in his testimony before this committee on April 2.

Thus, despite all the belated and extravagant claims of the American Medical Association (which in 1932 through its spokesman, Dr. Morris Fishbein, branded voluntary prepayment medical service plans "socialism and communism, inciting to revolution"), we see no evidence that private medical insurance alone, or tax-subsidized, can do the job.

#### NATIONAL HEALTH INSURANCE IS ESSENTIAL

A national health program, as recommended by President Truman in his health message of November 1945, is necessary if we are to get more hospitals, public-health services, doctors, dentists, and nurses, and to be able to go to them when we need medical care. We want to pay for our own doctor and hospital care, but through a national health insurance system whereby we will pay small sums in advance to obtain such care.

Specifically, our organization wants to see the Wagner-Murray-Dingell national health bill, S. 1606, become law. All the provisions of this bill would be of value to us, but perhaps the health-insurance section needs the greatest emphasis, since that is the most controversial part.

Under title II, a fund would be created which would pay for doctor and hospital services. Wage earners, we understand, would pay about 1½ percent of their incomes to cover themselves and their families; an equal amount would be paid in by the employer. Self-employed farmers, shopkeepers, or small businessmen for example, would pay about 3 percent of their incomes under \$3,600 a year. We, that is the people of the United States, pay 4 to 5 percent of our incomes now, on the average, so this would not be more, and in most cases less, than we are spending as individuals at present. The average farmer in the South pays from 8 to 10 percent of his income. For those families that are hit hard and have to pay 10, 20, 50, or more percent of their income for medical care, it would make all the difference between catastrophe and security.

We expect to be entitled to go to our family doctor or any other doctor participating in the system, and most will participate, though they will not be forced to. Instead of putting our money on the line at the time we receive the care, or paying the bill later, we will go to the doctor or hospital when we need to. They will collect the money for the service rendered by a suitable arrangement with the insurance fund. There would be no direct financial dealings between doctor

and patient. Instead there would be, as there ought to be, a strictly professional relationship. Doctors will not have to spend so much of their time and energy trying to collect bills, and we will not have to hold back on going to doctors because we cannot afford the cost. The same goes for the hospital.

With insurance, we could get modern medical care when we need it, including regular health examinations and preventive care. This will prevent some critical illnesses which would not be allowed to drag on until it is too late for the doctor to do anything about them.

#### MEDICAL ADVISORY COUNCIL

We attach the greatest importance to the Federal and State Advisory Policy Council created under title II of the bill. We would emphasize the part lay groups, the consumer of medical care, must play in such councils.

The public is best qualified to know how things work out and to set broad policy. On such a medical policy council should be representatives of the Negro people, the sharecropper, the industrial worker and other groups especially interested in this bill. Probably no set formula can be written into the legislation to assure this, but a very clear policy in favor of such participation, as part of the legislative history of this measure, is vitally necessary.

The South can afford its part in a national health program. It cannot afford to do without such a program. The need for it is now. We therefore urge speedy passage of this bill.

The CHAIRMAN. Thank you, Mr. Foreman. Have you studied the bill in detail, the various provisions of it?

Dr. FOREMAN. Senator, I have studied some of the provisions of it in detail. I have read the President's message, and I have gone into certain aspects of it, but I have not studied the whole bill, item by item.

The CHAIRMAN. You would not be prepared, then, to analyze the various provisions of it, but you are here just giving us your over-all views of the need of such a system in the South, and the provisions that would put that into effect would be a matter for technical action on the part of men who would be capable of putting it in the proper phraseology.

Dr. FOREMAN. My object in coming here was to say for the southern people how greatly they need health insurance, and the details, as you say, I am perfectly willing to be left up to people who know the situation more expertly than I.

The CHAIRMAN. I am sure that the statement that you make here this morning is not in the least bit exaggerated, because we have had hearings before on this subject, and we have had representatives from the various States of the South appear here and testify with reference to the great need of medical care in that section of the country.

Senator, do you wish to ask some questions?

Senator DONNELL. I would like to ask the Doctor some questions. Now, Dr. Foreman, are you a physician?

Dr. FOREMAN. No, sir.

Senator DONNELL. You hold a degree of what?

Dr. FOREMAN. Doctor of philosophy.

Senator DONNELL. Would you mind, for our record here, to tell us briefly your educational background?

Dr. FOREMAN. I would not mind at all. I am a graduate of the public schools of Atlanta, Ga., and of the University of Georgia, where I received an A. B. degree in 1921, and I then studied a year at Harvard University and a year at the London School of Economics, and then I got my M. A. and Ph. D. degree in Columbia University in the faculty of political science.

The CHAIRMAN. I am called away to another meeting, and I will have to ask you to carry on the meeting until I return.

(At this point Senator Donnell assumed the chair.)

Senator DONNELL. So that your degree is along the line of political science, I believe you said.

Dr. FOREMAN. Yes, sir.

#### THE SOUTHERN CONFERENCE FOR HUMAN WELFARE

Senator DONNELL. Doctor, the organization, the Southern Conference for Human Welfare, is how large an organization, and how is it constituted?

Dr. FOREMAN. It is composed of some six or seven thousand people who are voluntary joiners of it. Those in the South are members, and people outside of the South who care to join, may do so as associate members.

Senator DONNELL. Does the conference hold stated meetings from time to time?

Dr. FOREMAN. It does, sir.

Senator DONNELL. Go ahead.

Dr. FOREMAN. It holds, according to our bylaws, prescribed biennial conferences which are open to the entire membership.

Senator DONNELL. And when was the last biennial conference held?

Dr. FOREMAN. The last meeting of the membership was held in Raleigh, N. C., in February of this year.

Senator DONNELL. Did the meeting at Raleigh adopt any resolutions?

Dr. FOREMAN. Excuse me, it was Durham.

Senator DONNELL. Did the meeting at Durham adopt any resolutions in which it mentioned this bill, S. 1606?

Dr. FOREMAN. The meeting of the membership in Durham, sir, was just for the purpose of reorganizing our bylaws. It was purely a business meeting. The board of the Southern Conference is left to its discretion on this, and the president in the absence of the board.

Senator DONNELL. So that the meeting held in Durham did not pass upon S. 1606?

Dr. FOREMAN. No, sir.

Senator DONNELL. Now, the board itself is composed of how many persons?

Dr. FOREMAN. The board itself is composed, I feel sure, it is 26.

Senator DONNELL. That is 26 on the board?

Dr. FOREMAN. Yes.

Senator DONNELL. This meeting at Durham was attended by approximately how many persons?

Dr. FOREMAN. About 400 people.

Senator DONNELL. And were they entirely from the Southern States?

Dr. FOREMAN. Well, there may have been some who came from outside, but I think it was almost exclusively from the South.

Senator DONNELL. Now, there are 26 members of the board, and you call it the board of directors?

Dr. FOREMAN. The board of representatives it is called.

Senator DONNELL. Now, has the board of representatives passed upon and adopted any resolutions with respect to this bill, S. 1606?

Dr. FOREMAN. No, sir.

Senator DONNELL. When was the most recent meeting of the board of representatives held?

Dr. FOREMAN. The most recent was just following that meeting in Durham.

Senator DONNELL. That was February of 1946?

Dr. FOREMAN. That is right.

Senator DONNELL. Now, had either the membership at any meeting held by it, or the board of representatives at any meeting held by it, prior to the meeting held in Durham, passed any resolutions with respect to S. 1606?

Dr. FOREMAN. Not with respect to this particular bill. We have, however, gone on record repeatedly as in favor of Federal aid to health and education, and this is so completely in line with the policies of the membership and the board of the Southern Conference for Human Welfare throughout its history that I, as president, feel perfectly qualified to take the responsibility of committing the board and the membership on it.

Senator DONNELL. Has either the membership or the board of representatives ever gone on record specifically with respect to compulsory health insurance?

Dr. FOREMAN. I am inclined to think that they have not.

Senator DONNELL. That is your present best recollection?

Dr. FOREMAN. That is right.

Senator DONNELL. Now, Doctor, then you have undertaken as I understand it, expressing what you deem to be the sentiment of the organization, to come here today to speak on behalf of the Southern Conference.

Dr. FOREMAN. That is right.

Senator DONNELL. But neither the board nor the membership has, itself, passed specifically upon this bill, S. 1606?

Dr. FOREMAN. That is right.

Senator DONNELL. How widely scattered are these 26 members of the board?

Dr. FOREMAN. Throughout the South.

Senator DONNELL. Does that board hold meetings from time to time?

Dr. FOREMAN. It does, sir.

Senator DONNELL. How does it happen that this S. 1606 has not been called to the attention of that board, so that it might pass upon the matter specifically?

Dr. FOREMAN. Because the bill, itself, has not been submitted to them, but they have, as I said, endorsed the idea of Federal aid to health, and they specifically empowered me to act for the board on particular measures as they come up.

Senator DONNELL. Of course, there is quite a distinction possibly, is there not, between the general authorization to express views on Federal aid for health and a compulsory health insurance program?

Dr. FOREMAN. Yes, but, Senator, I am an elected officer of the Southern Conference, and as you will understand, an elected officer has to take a certain amount of discretion in these things. I am perfectly willing to risk my position as an elected officer in this interpretation of the Southern Conference's position.

Senator DONNELL. The point I desire to make, Doctor, in interrogating you, is that this organization composed of six to seven thousand people, has never specifically passed upon Federal compulsory health insurance, nor has the board of 26 members which is located, as you have indicated, in the South, passed specifically upon Federal compulsory health insurance; and it is you, one individual, even though you are the president, who is undertaking to express here the opinion of this great organization of six to seven thousand people, is that correct?

Dr. FOREMAN. That is correct, but what I want to repeat is that I am fully authorized to do so.

Senator DONNELL. I am not questioning that.

Dr. FOREMAN. That is what I am expected to do by the conference.

Senator DONNELL. Has the conference authorized you, or has the conference directed you to come here and state to this committee that the conference unequivocally endorses S. 1606, the Wagner-Murray-Dingell national health bill? Has either the conference of the membership or the board of representatives passed any specific resolution stating that your organization endorses unequivocally S. 1606?

Dr. FOREMAN. The board has so authorized me.

Senator DONNELL. Now, just how was that authorization conferred?

Dr. FOREMAN. As far as my recollection serves me, sir, we had a discussion of the question of Federal aid to health and the board asked that I participate and do whatever I could to carry out the wishes of the board in that respect.

Senator DONNELL. In regard to Federal aid to health?

Dr. FOREMAN. Yes.

Senator DONNELL. But I still understand from you that the board did not pass any resolution with respect to this particular bill, S. 1606, is that correct?

Dr. FOREMAN. Senator, that is correct, but if it would strengthen the case of Federal aid to health, I will be very glad to get a resolution passed by the board at its next meeting which I expect to be very soon.

Senator DONNELL. That is assuming that the 26 members of that board will do as you think that they will do.

Dr. FOREMAN. That is right.

Senator DONNELL. You have interpreted, in the absence of any resolution by the board and of the membership, what you think is the opinion of that board.

Dr. FOREMAN. I feel fully confident.

Senator DONNELL. That is what you feel, but the board has never expressed itself, nor has the membership, on this specific problem.

Dr. FOREMAN. On the specific wording of this bill.

Senator DONNELL. Or the specific provisions of compulsory health insurance.

Dr. FOREMAN. I am not sure whether the compulsory health insurance aspect of Federal aid to health was raised or not.

Senator DONNELL. You have no present recollection of any affirmative action being passed by either the membership or the board, affirming their being in favor of compulsory health insurance, am I correct?

Dr. FOREMAN. I think that you are correct.

Senator DONNELL. Now, Doctor, you state in your statement here, in one place, quoting, "We unequivocally endorse the President's national health program and S. 1606, the Wagner-Murray-Dingell national health bill, the main measure to carry it out." And yet, I understood you to testify that you have not studied all of this bill, is that correct?

Dr. FOREMAN. I have studied the President's message.

Senator DONNELL. But I am talking about S. 1606, which you designate here as the main measure to carry out the President's national health program, and which measure you state that you "unequivocally endorse."

Dr. FOREMAN. That is right.

Senator DONNELL. Have you read all of that bill?

Dr. FOREMAN. No, sir.

Senator DONNELL. What portion of it have you read?

Dr. FOREMAN. I am not able to give you the fractions, Senator, but I feel that I have gone through it sufficiently to understand its content and its meaning, and I am perfectly willing to take the President's own analysis of it as adequate.

Senator DONNELL. Doctor, would you say that you have read half of the bill?

Dr. FOREMAN. Yes, sir.

Senator DONNELL. Have you read three quarters of it?

Dr. FOREMAN. I probably have read three quarters of it.

Senator DONNELL. How about the first part of the bill?

Dr. FOREMAN. I skimmed through the first part of the bill which I understand is not controversial, I understand that even you are not opposing that.

Senator DONNELL. You centered upon the second part of the bill?

Dr. FOREMAN. That is right.

Senator DONNELL. You have centered your attention on that?

Dr. FOREMAN. Yes, sir.

Senator DONNELL. Have you read all of that?

Dr. FOREMAN. I think that I have, yes, sir; I think that I have read, as far as I can remember, I have read practically all of that.

Senator DONNELL. I understand that you are not undertaking here today to testify as to the details of the bill; you feel that is a matter to be left to persons who are technically acquainted with the subject matter?

Dr. FOREMAN. It depends on what you mean by "details." I do not pretend to be an expert, I am not a medical doctor, nor am I a public health expert, but there are certain things that you might call details which I would not.

Senator DONNELL. You are not undertaking to discuss all of the features of title II of this bill, am I correct in that?

Dr. FOREMAN. I am perfectly prepared to be asked any questions on title II.

## ATTITUDE OF THE AMERICAN MEDICAL ASSOCIATION

Senator DONNELL. I want to ask you a few in a few minutes. Now, Doctor, you refer on page 5 of your mimeographed statement from which you have read, to what you call the "belated and extravagant claims of the American Medical Association."

Dr. FOREMAN. Yes, sir.

Senator DONNELL. Have you ever attended a meeting of the American Medical Association?

Dr. FOREMAN. I have discussed in great deal with a representative of the American Medical Association, their belated and extravagant claims.

Senator DONNELL. What do you mean by "belated"?

Dr. FOREMAN. I mean by that, about 10 years ago they claimed that voluntary medical assistance even was communistic and socialistic and inciting to revolution.

Senator DONNELL. I am not clear as to what you mean by the term "belated."

Dr. FOREMAN. I mean that it is only now that they are even coming to the point of advocating voluntary health insurance. Ten years ago they thought it was communism.

Senator DONNELL. You know today the American Medical Association oppose very vigorously compulsory health insurance.

Dr. FOREMAN. I know that they do just as vigorously as 10 years ago they opposed voluntary methods.

Senator DONNELL. And you also know that the American Medical Association is the largest single association of practicing physicians in the United States?

Dr. FOREMAN. That is right, even monopolistic, I would call it.

Senator DONNELL. Just what do you mean by that?

Dr. FOREMAN. I mean in the District of Columbia they attempted to insist on their rights as a monopoly and to break up at that time, which was about 10 years ago, a voluntary medical association here in the District of Columbia.

Senator DONNELL. The American Medical Association does, however, include many thousands of the leading or at least of certain of the leading physicians of the United States.

Dr. FOREMAN. That is right.

Senator DONNELL. And you know that its position is diametrically opposed to compulsory health insurance?

Dr. FOREMAN. That is correct.

Senator DONNELL. Now Doctor, you say on page 6 of your statement that doctors under this proposed bill, S. 1606, will not have to spend so much of their time and energy to collect bills. Do you regard this expenditure of time and energy which prevails under the present system in trying to collect bills as seriously impeding the efficiency of the physicians of this country?

Dr. FOREMAN. I do. I think that the medical profession is torn now in a dilemma between being a profession and being a business. I think the reason that the American Medical Association is opposed to this is because too many of its members, or too many of the people who are controlling its policy, are thinking in terms of their business rather than their profession.

Senator DONNELL. You mean to say that you think the members of the American Medical Association in large part are opposing S. 1606, because they think it will be financially injurious to the physicians, is that correct?

Dr. FOREMAN. Not because it will be, but because they think it will be.

Senator DONNELL. That is your judgment, that they think that.

Dr. FOREMAN. Not that they think it will be financially injurious to the physicians as a whole, but to them as individuals.

Senator DONNELL. That is to the members of the American Medical Association as individuals?

Dr. FOREMAN. The few people who are determining this policy.

Senator DONNELL. The American Medical Association has house of delegates, does it not?

Dr. FOREMAN. Yes.

Senator DONNELL. And the house of delegates of the American Medical Association is the governing body of that organization?

Dr. FOREMAN. That is right.

Senator DONNELL. And that consists of members selected from throughout the United States?

Dr. FOREMAN. Yes.

Senator DONNELL. There is quite a large membership in the house of delegates, is there not?

Dr. FOREMAN. Yes.

Senator DONNELL. And it is considered to be at least fairly representative of the entire medical association, is it not?

Dr. FOREMAN. Well, I think it is representative, in one sense they represent the others, and on the other hand they are not a fair sample.

Senator DONNELL. Is it likely, Doctor, in your opinion, that the members of the American Medical Association would select as members in the house of delegates persons who are not fairly representative of the American Medical Association?

Dr. FOREMAN. Well, again it depends on what you mean by "representative." If you mean they are a fair sample of the medical profession of this country, I would not agree. If you mean that they are the chosen representatives of the medical associations, that is a fact.

Senator DONNELL. At any rate, for some reason the physicians in this country who constitute the American Medical Association have designated as their representatives and governing body the persons who compose that body.

Dr. FOREMAN. I think that those chosen representatives are more influenced in their thinking by the business aspects of the medical business than the professional aspect of it.

Senator DONNELL. Now, Doctor, have you made an investigation as to the motives behind the American Medical Association, have you taken a poll of them to find their reasons, or anything of that sort?

Dr. FOREMAN. No.

Senator DONNELL. What is the basis on which you draw this conclusion in regard to the motives behind the American Medical Association?

Dr. FOREMAN. Because so far as the study that I have made of the health situation, it is so completely contrary to the facts.

Senator DONNELL. Have you studied the motives and beliefs of any considerable number of the members of the American Medical Association?

Dr. FOREMAN. Well, you say "considerable."

Senator DONNELL. I will ask you, have you inquired of as many as 500 members of the American Medical Association, the reasons underlying their opinions with respect to compulsory health insurance?

Dr. FOREMAN. I have not.

Senator DONNELL. As a matter of fact, is it fair to say that you have not talked with as many as 100 members of the American Medical Association as to the reasons for their opposition to compulsory health insurance?

Dr. FOREMAN. I would say this, that I have talked to representatives of groups of much more than a hundred, the Physician Forum. As you recognize, the Physicians Forum is a group of doctors who very much favor this bill.

Senator DONNELL. The Physicians Forum, it has been testified to here before the committee, as I recall, consists of about 2,000 members.

Dr. FOREMAN. Yes.

Senator DONNELL. Do you know what the membership of the American Medical Association is?

Dr. FOREMAN. No, sir.

Senator DONNELL. You know that it is many times that number?

Dr. FOREMAN. I was just talking about the numbers, you mentioned 200 and 500. I am saying that the Physicians Forum with whom I have discussed this matter, represents more than that.

Senator DONNELL. Do you know whether the members of the Physicians Forum are likewise members in large part of the American Medical Association?

Dr. FOREMAN. I think that they are.

Senator DONNELL. You think that they are?

Dr. FOREMAN. Yes.

Senator DONNELL. And your conversations have been with the members of the Physicians Forum?

Dr. FOREMAN. Not exclusively.

Senator DONNELL. Primarily?

Dr. FOREMAN. Not even primarily.

Senator DONNELL. What proportion of the doctors that you have talked with are members of the American Medical Association but not members of the Physicians Forum?

Dr. FOREMAN. Senator, I have been interested in this question for some years, and I have repeatedly discussed it with doctors, with representatives of doctors, with medical associations, and so forth. But I have not made any what I would consider scientific study of the motives, I am merely expressing my opinion.

Senator DONNELL. And you would not undertake to tell the committee that you can accurately state what are the motives behind the American Medical Association?

Dr. FOREMAN. Nor anybody else.

Senator DONNELL. Now, Doctor, I take it that you agree that there is a presumption that arises that a great organization such as the American Medical Association is speaking out of what it considers to be honest motives?

Dr. FOREMAN. Yes.

Senator DONNELL. And the members of the American Medical Association are at least in large part composed of leading physicians, that is true?

Dr. FOREMAN. I did not intend to imply that business is necessarily dishonest.

Senator DONNELL. But you say, or you and I would agree, that the American Medical Association does consist in very large part of leading members of the medical profession?

Dr. FOREMAN. That is correct.

#### FINANCING NATIONAL HEALTH INSURANCE

Senator DONNELL. Now, Doctor, on page 6, you give your understanding here as to how this proposed compulsory health insurance would be financed, namely, 1½ percent of the incomes of wage-earners, to cover themselves and their families, and an equal amount would be paid in by the employer, and the self-employed would pay about 3 percent of their incomes under \$3,600 a year. Where do you get the information that that is the method by which this plan of health insurance is to be financed?

Dr. FOREMAN. From title II.

Senator DONNELL. Now just where is that in title II, is there anything about that?

Dr. FOREMAN. I will be glad to find it.

Senator DONNELL. If you will just find that, I would like to see it. Title II begins on page 35.

Dr. FOREMAN. The fund will be set up, as I understand it—

Senator DONNELL. We will come to specific sections if you will call my attention to it, to where it is from title II that you derive this understanding as to how this proposition is to be financed, by payments by the wage-earners of about 1½ percent of their incomes and so forth.

Dr. FOREMAN. I am not sure that I can put my finger on it right away, I will be glad to supply that reference.

Senator DONNELL. I think, perhaps, we might pause on that and just see where it is in here, in title II.

Dr. FOREMAN. Does the Senator challenge this fact?

Senator DONNELL. Yes, I do. I want to call your attention to section 212 (b) and ask you if that is what you have in mind? Is that the section on which you have based your conclusion, Doctor, with reference to the method of financing?

Dr. FOREMAN. I regret that I cannot point that out at this time exactly, Senator.

Senator DONNELL. Well, Doctor, I think that I am correct in this statement, that with the exception of section 212 (b), and I may be in error, but with the exception of 212 (b) which reads:

From such appropriations, the Secretary of the Treasury shall credit quarterly to the account amounts equivalent to 3 percentum of the wages as defined in section 217 (a), paid after June 30, 1946, with respect to employment, as defined in section 217 (b) after such date.

I say with the exception of that section, I do not think that you will find anything in here which even remotely undertakes to express how it is that this plan is to be financed. I think, Doctor, perhaps you have confused your recollection of title II with some part of S. 1050

which is a much larger bill, which is also pending before the Senate at this time. Do you know of any other provision in title II, other than the one that I have cited, that even remotely refers to anything about a 3 percent aggregate of wages?

Dr. FOREMAN. I am afraid that I do not, I am not able to put my fingers on it, Senator.

Senator DONNELL. Now, Doctor, you referred to this bill, S. 1606, as the main measure to carry out the program of the President. You are aware, are you not, that S. 1606 was taken in largest part directly from S. 1050?

Dr. FOREMAN. I know that.

Senator DONNELL. And you know, do you not, that generally speaking, 1606 is but one link in the chain of the large program contemplated by 1050.

Dr. FOREMAN. In my opinion, the health insurance is the main link, though.

Senator DONNELL. You think that that is the main link?

Dr. FOREMAN. Yes, sir.

Senator DONNELL. Now, Doctor, on page 4 of your statement from which you read, in line 1, you state, referring to commercial policies, that only 40 percent of the premiums paid in come back as benefits. Could you tell us what the figure is in Blue Cross and other voluntary plans, with respect to the administrative and acquisition costs?

Dr. FOREMAN. I got that figure from some published data of the Department of Agriculture, and I will be very glad to get it and submit it for the record.

Senator DONNELL. The figure which you have given of 40 percent refers to private companies, which are issuing policies of health insurance, does it not?

Dr. FOREMAN. Yes.

Senator DONNELL. And in other words, 60 percent of the premiums paid into private companies, according to your statement do not come back as benefits, but you are not undertaking to say that any such ratio prevails in connection with Blue Cross enterprises, are you?

Dr. FOREMAN. I am not implying that that is the same.

Senator DONNELL. Do you know, Doctor, whether or not the figure of from 12½ to 15 percent as regards administrative and acquisition costs under Blue Cross plans is approximately the experience that we have had thus far? Do you know that to be true or not?

Dr. FOREMAN. Senator, I would hesitate to say that because I cannot give that with any accuracy.

Senator DONNELL. Going back for a moment to the method of financing of this type proposition, and referring particularly to the section to which I called your attention, in title II, you will observe there that the only reference to the 3 percent is to the fact, and that is on page 61, that there should be credited from appropriations made by Congress to the public health services' account, amounts equivalent to 3 percent of the wages paid after June 30, 1946, and so forth, and that is all that that provides.

Dr. FOREMAN. Yes.

Senator DONNELL. You do not find anything indicating where these funds "equivalent to 3 percent" are to come from, whether they are to come from taxes upon employers and employees or not, do you?

Dr. FOREMAN. Well, it calls for the definition over here in 217 (a), I was looking to see that.

Senator DONNELL. That is 217 (a) and (b).

Dr. FOREMAN. Yes, it means all remuneration.

Senator DONNELL. And 217 (b) defines the term "employment." There is nothing in either of these sections 212 or 227 that states from what source the amounts equivalent to 3 percent of the wages shall be derived, whether those amounts shall come from pay-roll taxes or whether they shall come from especially earmarked income taxes, or other sources, is there?

Dr. FOREMAN. I am not able to put my finger on it; it was my definite impression that half of the employees was to be furnished by the employer.

Senator DONNELL. Doctor, just how thoroughly would you say that you have studied this title II, have you gone through it with the utmost care?

Dr. FOREMAN. Senator, I have a great many other things that I am doing, and it was several weeks ago when I went through it, and so I have not got it at my finger tips as perhaps I should have. I did not realize that I was going to be questioned on the bill.

Senator DONNELL. You realize in coming before our committee, that you did so with this quotation, "We unequivocally endorse the Wagner-Murray-Dingell National Health Bill, the main measure to carry it out"? You understood, Doctor, that you were going to come here and discuss this bill?

Dr. FOREMAN. I am prepared to stand behind that statement.

Senator DONNELL. And furthermore, on page 5 of your statement, you say:

Specifically, our organization wants to see the Wagner-Murray-Dingell National Health Bill, S. 1606, become law.

Dr. FOREMAN. That is right.

Senator DONNELL. And as you have indicated, your conclusion to that effect has not been based on resolutions adopted by either the membership or by resolutions adopted by the board of directors or representatives of your organization, is that correct?

Dr. FOREMAN. Well, resolutions specifically referring to this bill?

Senator DONNELL. Or to compulsory health insurance?

Dr. FOREMAN. There were resolutions authorizing me.

Senator DONNELL. There is no resolution to which you have called attention this morning of either your membership or of your board of representatives which endorses specifically compulsory Federal health insurance, am I correct in that?

Dr. FOREMAN. I think that you are.

Senator DONNELL. Now, Doctor, on page 4 of this statement, at line 7, you say:

Yet doctors' services alone take three times as much in the average medical dollar.

I do not understand the meaning of that sentence. Would you kindly elucidate that?

Dr. FOREMAN. The average dollar spent for medical service is what I meant by the medical dollar.

Senator DONNELL. Now, just what do you mean by saying that doctors' services alone take three times as much in the average medical dollar?

Dr. FOREMAN. If you begin at the beginning of that paragraph:

Blue Cross hospitalization is good as far as it goes, but it does not go very far. If one belongs to an eligible group, it costs a family about \$24 a year, but covers only the hospital bill.

In other words, the Blue Cross does not give the service for the medical care, but just for the hospital bill, and yet doctors' services alone take three times as much in the average medical dollar. In other words, the services part of the average dollar spent for medical costs, altogether, doctors' and hospital services, the medical care, the doctor's part is three times as much as the hospital part.

Senator DONNELL. I think that you have clearly explained that. I did not understand it, and I understand what you mean. Doctor, what is the authority that you have by way of statistical information that justifies that statement?

Dr. FOREMAN. The studies put out by the various organizations, including particularly the bureau of the Department of Agriculture studies on human nutrition.

Senator DONNELL. How recently have those studies been made?

Dr. FOREMAN. My understanding is in the last year or so, I will be glad to present them for the record.

Senator DONNELL. Would you present those and file them for the record?

Dr. FOREMAN. I will be very glad to.

Senator DONNELL. Is it not a fact, Doctor, that in large part the documentation of your statement here, so far as statistics are concerned, is based on the report of the committee having to do with the costs of medical care, published in 1935?

Dr. FOREMAN. Not by any means.

Senator DONNELL. Have you seen that publication?

Dr. FOREMAN. Yes.

Senator DONNELL. That is one of the leading publications on that subject?

Dr. FOREMAN. Yes.

Senator DONNELL. And is there anything any more modern on that, that involves a general compilation of statistics on that subject?

Dr. FOREMAN. Well, the costs of medical care, of course, are being worked on, and Dr. Michael Davis, who is an old friend of mine, has been working on this for years, as you know, and he is bringing out regular publications, and whether they are compiled in as complete a document as that since then, I have not seen it; but I am sure that more and more figures are being brought out all of the time, which I have seen.

Senator DONNELL. It is a fact, however, is it not, Doctor, that in considerable part the figures which you have used in your statement are based on this publication issued in 1935?

Dr. FOREMAN. That is one of the publications.

Senator DONNELL. And I am not asking you at this moment, unless you care to, to indicate which particular portions of your statement are based on that, and which are based on more modern statistics.

Dr. FOREMAN. I will be glad to file that with the committee.

Senator DONNELL. Would you do that, that is very fine.

Referring to that statement that you have given us this morning, you mentioned that you have not examined S. 1606 for several weeks.

Dr. FOREMAN. That is correct.

Senator DONNELL. Did you come here from Georgia to testify on this matter?

Dr. FOREMAN. No, sir.

Senator DONNELL. Are you located here in Washington, D. C.?

Dr. FOREMAN. Yes, sir.

Senator DONNELL. And you did not in the last few days, then, study 1606?

Dr. FOREMAN. I did not go back to the original bill, Senator. I did go over the President's statement and over certain other things.

Senator DONNELL. How recently was the statement which you have presented this morning prepared?

Dr. FOREMAN. In the last week.

Senator DONNELL. In the last week?

Dr. FOREMAN. Yes, sir.

Senator DONNELL. Were you assisted in the preparation of that statement?

Dr. FOREMAN. Yes, sir.

Senator DONNELL. Would you mind telling us who assisted you?

Dr. FOREMAN. We have a research division in our Washington office, and we have some volunteers in the Washington Committee, and the Washington Committee is composed of 400-odd people, and that volunteer group with our paid services in the office gets it up. Miss Peggy Hobbs is in charge of our legislative research, and she was responsible for getting this up for me.

Senator DONNELL. Did you personally prepare any part of this statement, Doctor?

Dr. FOREMAN. I went over it, and it was brought to me in draft, and I went over it and changed it according to my ideas of what I wanted to say. I did not do it originally, the original work on it.

Senator DONNELL. Does the document as it now stands and as you read it, in substance, in the major points at any rate, stand precisely as it was when it was brought to you?

Dr. FOREMAN. In substance it stands as it was brought to me.

Senator DONNELL. And you had not personally prepared it at that time?

Dr. FOREMAN. I did not.

Senator DONNELL. Now, Doctor, was there any portion of this document that was prepared by or under the auspices of any United States Government agency?

Dr. FOREMAN. Not so far as I know, as I say, Miss Hobbs is responsible for getting it up and so far as I know she had the work done in the office and with whatever voluntary help she could get at home.

Senator DONNELL. Would you mind telling us who Miss Hobbs is and what her training is?

Dr. FOREMAN. Miss Hobbs is a woman who is a college graduate, who comes into our office and works on legislative work in the afternoon and works at home in the morning and in the evening.

Senator DONNELL. Does she have the background of educational experience in college or university?

Dr. FOREMAN. She does.

Senator DONNELL. Has she had social-service work that she has been engaged in?

Dr. FOREMAN. To a certain extent; yes, sir.

Senator DONNELL. Would you mind telling us just briefly what her experience is?

Dr. FOREMAN. Her experience since she left college has been work as a writer and a certain amount of social service, I think; I am not absolutely certain how much she has done in social service, but she is a very intelligent girl who knows how to get the facts out in a certain case. We have to appear on a number of bills, of which this is one, and her job is to get together the facts for me on any particular bill as it comes up. So when I asked her to do this, she got in touch with the people among our membership who were willing to help her, and I do not know who those were.

Senator DONNELL. It is Mrs. Hobbs, is it not?

Dr. FOREMAN. Yes.

Senator DONNELL. What was her maiden name, Stein?

Dr. FOREMAN. No.

Senator DONNELL. What was her maiden name?

Dr. FOREMAN. I regret to say that I do not know. She was married since I have known her.

Senator DONNELL. Was she with the Department of Agriculture at one time?

Dr. FOREMAN. I feel perfectly sure she was not.

Senator DONNELL. You are quite sure she was not?

Dr. FOREMAN. That is right.

Senator DONNELL. Now, Doctor, do you know what educational institutions she attended?

Dr. FOREMAN. Bennington College.

Senator DONNELL. Where is that located?

Dr. FOREMAN. In Vermont.

Senator DONNELL. Is that a senior college or is it a junior college?

Dr. FOREMAN. It is a full college.

Senator DONNELL. What degree did she receive from it?

Dr. FOREMAN. A. B., I think.

Senator DONNELL. Has she received any subsequent degrees?

Dr. FOREMAN. No.

Senator DONNELL. What is her age, if you know?

Dr. FOREMAN. I do not know, Senator, but I think it is in the thirties.

Senator DONNELL. Do you know how many years of experience she has had since she left the college?

Dr. FOREMAN. You mean how long she has been out of college, I should say about 10 years, but I would like to point out that she was not alone involved in preparing this, but was merely to get together whatever authorities and research she could and work with me on getting it ready.

Senator DONNELL. She prepared the assembling of the data from other persons in your organization, and you were not one of the persons in the organization who participated in the assembling of it as it was presented to you by Mrs. Hobbs, is that correct?

Dr. FOREMAN. It was discussed with me, in advance, as to the kind of testimony I wanted to present.

Senator DONNELL. And you wanted to present this?

Dr. FOREMAN. This is not the first time I have discussed this bill, I have been in a joint debate with the American Medical Association on the bill previously.

Senator DONNELL. Now, Doctor, this is not said critically but merely as a matter of information; you realize, of course, that this is a highly important measure, and in fact you characterize it as the main measure to carry it out, and you have come before the United States Senate Committee to give us the benefit of your views, and yet several weeks have elapsed since you have examined this document, S. 1606, and you are unable to state with any certainty where you derived the information as to the method of financing that was proposed. Am I correct in those statements?

Dr. FOREMAN. You mean that I cannot now give you the reference for all of the figures here?

Senator DONNELL. I am talking about the financing of the health insurance program, as to how that is to be done.

Dr. FOREMAN. Well, I cannot now put my hands on it; no, sir. This 3 percent is the figure that I have been going on, that I felt and I still feel that I can verify the fact that one-half of it comes from the employer and one-half from the employee.

Senator DONNELL. I think that you will fail to find that in this title II. I may be in error in it, and if I am I stand corrected, but I do not think that you will find that. I think that you will find it in S. 1050.

Dr. FOREMAN. It is possible that I and my assistant have been confused on that.

Senator DONNELL. I think that that is all, Doctor.

Senator SMITH. Just one question, if I may. Doctor, what do you estimate would be the over-all cost of the compulsory health program? Have you made estimates on that?

Dr. FOREMAN. No, sir; I have not. I will be very glad to get up a figure.

Senator SMITH. I have heard such strange figures, and I would like to know what the estimates are. It goes up as high as 3 billion or 4 billion dollars, and it is something that we ought to consider in relating it to our whole social program.

Dr. FOREMAN. What I have heard, and I cannot myself vouch for, is that it would be less than, or I think the cost would be very little more, if any, in total than the amount that is now being paid for all medical and health work, but because it would be for everybody and would be prepaid, the total medical bill would be lowered. In other words, as I understand it, the theory, and as I say this is hearsay, Senator, and I am not prepared to give you the figures on it, was because we would have general coverage, with preventive care for all of the people, that the total medical bill of the country would be considerably lower than it is at the present time; and since it seems to me that we can think of it as a national problem, that would seem to me to answer the fundamental part of your question as to whether the country can afford health insurance.

Senator SMITH. Then you suggest as the philosophy behind the bill, that everybody should stop paying their doctors and go into this plan and get their health taken care of by the over-all Government program, that is your theory?

Dr. FOREMAN. My theory is, if the bill is passed practically everybody will take advantage of the bill, including practically all of the doctors.

Senator SMITH. So that the doctor would no longer have the personal relationship with the patient as to his fees and so on, and there would be no difference in skills as far as the patient is concerned?

Dr. FOREMAN. I would say because the doctor does not have to deal with his patients on the fees, there would be a more personal relationship with the patient. The doctor would be assured of his money and therefore would think of his patient only in a professional capacity.

Senator SMITH. Well, would that apply to any professional job? You might say that the lawyers do not have any fees in a law case. Why not put them on a basis of a nice, pleasant relationship, where you just call your lawyer and the Government pays him? I am trying to get the philosophy of this bill.

Dr. FOREMAN. The Senator has given me caution, and I am not prepared to answer the legal question.

Senator SMITH. Well, we will leave that out.

Dr. FOREMAN. But as far as the medical is concerned, I am absolutely convinced that the people would get better medical care under this bill, and that it would be of great benefit to the people in this country, particularly the southern people.

Senator SMITH. That is all I have.

Senator DONNELL. Doctor, may I ask you, for a moment, do you know a lady named Peggy Stein?

Dr. FOREMAN. Yes.

Senator DONNELL. Connected with the Department of Agriculture?

Dr. FOREMAN. I know her casually.

Senator DONNELL. Is she here today at the hearing?

Dr. FOREMAN. No, I do not think she is.

Senator DONNELL. Did she participate at all in the preparation of this document from which you have testified?

Dr. FOREMAN. So far as I know she did not.

#### BILL COLLECTING UNDER EXISTING SYSTEM

Senator DONNELL. Doctor, referring just for a moment to one statement concerning which I asked you a question before, you state in your statement on page 6:

Doctors will not have to spend so much of their time and energy trying to collect bills.

Is that one of the major points you are emphasizing here in advocacy of the Federal compulsory health insurance as distinguished from the present plan?

Dr. FOREMAN. No.

Senator DONNELL. You do not regard that as particularly serious, nor do you think that doctors seriously interfere with their efficiency by trying to collect bills under the present system?

Dr. FOREMAN. I would say from my experience with doctors that they do have very great difficulty in getting payment of bills.

Senator DONNELL. Yes.

Dr. FOREMAN. There is considerable loss by doctors, and that represents a problem for doctors in maintaining a professional attitude to-

ward the patient, if at the same time he has to be dunning the patient for money, and the patient is again coming to the doctor with an unpaid bill, that is apt to cause him some embarrassment.

Senator DONNELL. Again, I can understand your point that doctors have had in many instances difficulty in collecting bills, but do you not join with me in expressing the experience that many doctors have been unjust to themselves, in that they have failed to try to collect the bills and have put forth the time and energy and have charitably and generously permitted patients to receive services without being compensated therefor?

Dr. FOREMAN. There is no question but that there are a great many fine and philanthropic people in the medical profession.

Senator DONNELL. And you will not say to this committee that you are urging as an important reason in favor of compulsory health insurance that doctors at the present "spend so much of their time and energy trying to collect bills"?

Dr. FOREMAN. I think the medical profession should be relieved of that. I think they would be better doctors if they did not have to worry about the bills.

Senator DONNELL. But that still does not answer my question. You are not trying to assert to the committee that doctors today, instead of treating patients, spend so much of their time and energy trying to collect bills?

Dr. FOREMAN. I do not want to quibble on the question, but I think in terms of getting medical care to the people of the South, and to get some doctors giving some care, the question of whether a doctor spends one-fifth or one-half of his time in collecting bills is a relatively unimportant thing, but nevertheless when you have to take up the question of medical care by the medical profession on these things we have to say they will be relieved of that.

Senator DONNELL. Going back again, Doctor, would you tell the committee that you know of your own knowledge of any doctor who is putting in one-fifth to one-half of his time in trying to collect his bills?

Dr. FOREMAN. I was using that figuratively.

Senator DONNELL. Do you know of any doctor whom you think actually impedes his usefulness by spending time trying to collect bills?

Dr. FOREMAN. If you take the psychological aspect of this situation, a doctor might be impeded by the feeling, when a patient presents himself, "Is that patient going to pay his bill?"

Senator DONNELL. I am asking you the question, do you know of any doctor of your own knowledge who spends so much time and energy trying to collect bills that he impairs his efficiency?

Dr. FOREMAN. I have known doctors, whose names I will not give, whom I think have been sufficiently worried about whether or not they are going to be paid as to impair their medical activities.

Senator DONNELL. That still did not answer my question, Doctor. I will ask it this one more time: do you know of any doctor of your own knowledge that has used so much of his time and energy in trying to collect bills as to impair his usefulness in his profession?

Dr. FOREMAN. Not completely. What do you mean by "impairing"?

Senator DONNELL. To any material extent.

Dr. FOREMAN. I would say "Yes."

Senator DONNELL. You know of doctors who have spent so much of their time and energy trying to collect bills that they have impaired their usefulness to a material extent?

Dr. FOREMAN. I have known doctors whom I thought impaired their therapeutic work, so to speak, because of their anxiety for the remuneration, for the patient's fees.

Senator DONNELL. But not because of the time and energy spent in trying to collect bills?

Dr. FOREMAN. I was trying to explain that psychological anxiety is just as much impairment as the time of writing out the bills.

Senator DONNELL. You make the statement here that:

Doctors will not have to spend so much of their time and energy trying to collect bills.

Dr. FOREMAN. I mean the psychological aspect of this question.

Senator DONNELL. I am not talking about psychology. I am talking about the time and energy. Do you know of any doctor, to your knowledge, who has devoted so much time and energy to collecting his bills—so much time in hours and so much energy—as to interfere with his efficiency to any material extent?

Dr. FOREMAN. "Any material extent" is a subjective judgment, and I would say "Yes".

Senator DONNELL. You think you have known some?

Dr. FOREMAN. I do, sir.

Senator DONNELL. Would you mind telling us whether you know a considerable number of doctors who have devoted so much time and energy to the collection of bills that they have interfered with their efficiency?

Dr. FOREMAN. I can only make the basis on the doctors I have known intimately, because doctors do not generally discuss this and any casual discussion with a doctor would not bring out their anxiety about the collection of that bill.

Senator DONNELL. Doctor, you do not mean to tell us that you have observed personally any considerable number of doctors that have been devoting such an amount of time and energy to the collection of bills as to interfere materially in your judgment with their efficiency? I am correct in that, am I not?

Dr. FOREMAN. Senator, you pin me down to the point where I hesitate to answer. All I can say is that my best judgment and belief is that many doctors are sufficiently disturbed about the difficulties of collecting their fees that it does interfere with their medical activities. That I am prepared to stand by.

Senator DONNELL. I am still saying, doctor, that you are not answering my question as to whether doctors devote so much time and energy to collecting their bills as to interfere with their efficiency. They may be worried, but you have not yet, except in your answer that you gave a while ago, indicated that you know of doctors actually using so much time and energy in the collection of their bills as to interfere with their efficiency.

Dr. FOREMAN. I just say, in my own best judgment what I have said here is correct.

Senator DONNELL. Very well.

Senator SMITH. Mr. Chairman, I would like to interrupt for the record to interpose an experience.

Senator DONNELL. Yes, sir.

Senator SMITH. I assume I was raised from the atmosphere of the medical men. I think there is no greater profession than the profession of medicine. I think the witness would agree.

Dr. FOREMAN. I would.

Senator SMITH. I never knew of one in all my years ever concerned with the financial side of his practice. The way they are, they do not give enough attention to it.

Senator DONNELL. That has been my experience.

Senator SMITH. Lots of them make personal sacrifices and pay no regard whatsoever to the question of collecting the fee. They were interested in the body and spirit of the patient. My father was like that. I would like to say, Senator, there may be a few exceptions, but the general experience of the medical profession has been so high that I am unwilling to have the statement made here and let it go unchallenged that doctors are thinking in terms of dollars and cents.

Senator DONNELL. I would like to be recorded also as sharing your opinion, not from personal knowledge, because I have never been in a physician's family, but my experience has been that the medical profession has been extremely unjust to itself in that it has not given as much interest to collecting fees as it should have done. I think it is to be commended for that; and I would not share in the view that doctors have devoted so much time and energy to collecting their bills that they have impaired their efficiency.

I want to say this in fairness to Doctor Foreman, that he does not say that in so many words. I want to read the sentence. He says:

Doctors will not have to spend so much of their time and energy trying to collect bills, and we will not have to hold back on going to doctors because we cannot afford the cost.

That is the statement he made, but I certainly do not concur in the view that I have ever known any doctor whom I thought devoted so much time and energy going out collecting bills that he could not give attention to his patients.

Dr. FOREMAN. I think unquestionably some of the great philanthropists of the human race are in the medical profession, but I think also that doctors are human beings.

I would like to give one instance in my own experience with the medical system of Atlanta, Ga., which has regular meetings—or did have at the time this happened. I am not sure whether the custom persists today. They excluded from these meetings all Negro doctors in Atlanta, Ga., and I, in my concern for the health of the people of Atlanta, including the Negro people, went before that body and appealed to them to allow the Negro doctors to sit in and hear their discussions once a month of current medical problems, so that the Negro doctors of the city of Atlanta would be able to keep abreast of medical information and carry that to their people. In doing so I did it with the encouragement and blessing of some of the finest doctors of Atlanta, I want to make that clear. All we were asking for at that time was that the Negro doctors be allowed to sit in and hear, so that they could keep current with the discussion; and that was turned down by this medical society, and as it was explained to me by the doctors in

Atlanta, the reason for turning it down was that so many of the doctors there did not want the Negro doctors to keep abreast of the situation because they did not want to lose their clients, or patients, to the Negro doctors.

Now, that seems to me to indicate that there are a number of the members of the medical profession very much concerned about collecting their bills.

Senator DONNELL. Doctor, may I ask one more question.

Dr. FOREMAN. Yes, sir.

Senator DONNELL. In your statement you emphasize the great importance of the Federal and State advisory policy councils created under title II of the bill. Do you recall how large a membership that Council has under the terms of the bill?

Dr. FOREMAN. As I remember it, that Council is selected by the Surgeon General from a panel submitted to him, but the number at the moment I do not have.

Senator DONNELL. Do you recall approximately the number?

Dr. FOREMAN. My memory is that it is about 20, but I am not certain.

Senator DONNELL. You are very close to it. It consists of the Surgeon General and 16 members to be appointed by the Surgeon General with the approval of the Federal Security Administrator.

Dr. FOREMAN. Yes.

Senator DONNELL. Are you favorable to that plan of the selection of the Council, so that ultimately the approval is of the Federal Security Administrator rather than the untrammelled judgment of the Surgeon General; that that shall be requisite to the selection of the members of the Council?

Dr. FOREMAN. It follows the pattern of having a civilian Secretary of War.

Senator DONNELL. Do you favor that plan of leaving it to the Federal Security Administrator rather than to what I might say was the untrammelled confidence in the Surgeon General?

Dr. FOREMAN. I do. I have great confidence in the present Surgeon General, and I have no reason to think that the future Surgeon General will be unwise in the selection of an advisory group, but this group is to represent not only the medical profession, but the public at large, so that the patients may be protected. Therefore, it seems wise for the collaboration in this.

Senator DONNELL. You understand that under section 204 of the bill the ultimate power resides in the Federal Security Administrator to determine who shall or shall not go on that Council?

Dr. FOREMAN. Just like Federal appointments with the confirmation of the Senate. It requires collaboration.

Senator DONNELL. You realize that to be the situation under the bill?

Dr. FOREMAN. I do.

Senator DONNELL. In that connection you mentioned—and I am not questioning your statement—you suggest that on such a medical policy Council there should be representatives of the Negro people, sharecroppers, and other workers especially interested in this bill?

Dr. FOREMAN. I do.

Senator DONNELL. Do you regard this Council sufficiently large in number to have those members representative of as many groups as you contemplate in this statement?

Dr. FOREMAN. I think so.

Senator DONNELL. It could be done?

Dr. FOREMAN. It could be done. The main thing is to get that in the public represented, to get these groups of the people represented.

Senator DONNELL. May I ask you one other question along this line. If this plan of the 1½ percent pay-roll tax against employees and 1½ percent against employers should be adopted it would, of course, be obligatory upon every individual who comes within the class. Do you see any injustice in applying such a tax, in view of the fact that at least some of our population, notably the members of the Christian Science organization, do not believe, as I understand it, in the medical treatment for individuals? Do you think it is proper to impose that tax in view of the fact that there is at least one segment of our population, and perhaps others, who do not agree with the wisdom of such type of treatment.

Dr. FOREMAN. My answer to that, Senator, is that in my opinion health is at least as fundamental as education, and we do not hesitate to tax all groups of people regardless of whether or not they believe in public education for our public education system; and that the same thing holds true for health.

Senator DONNELL. Doctor, I have not interrogated you, and shall not, in regard to some of the details of this bill taken up with some of the other witnesses, notably the question of freedom of choice, whether or not it exists under the bill.

Dr. FOREMAN. I would be glad to give my answer.

Senator DONNELL. I think it would be tedious to go into that.

Dr. FOREMAN. I would like to say, Senator, that freedom of choice does not exist at the present time in the South, in the rural districts of the South, where you are very lucky to have any doctor, much less freedom of choice.

Senator DONNELL. Because of the fact that there are so few doctors there?

Dr. FOREMAN. Because of the fact that there are so few doctors there, and because the doctors under the present plan cannot make a living in the rural South.

Senator DONNELL. May I ask you why you think the American Medical Association is opposed to this compulsory health insurance?

Dr. FOREMAN. I think that the American Medical Association, or some members of the American Medical Association, are opposed to this because they feel that under it those members who are opposed will get less income than they do at present. I am not at all sure that that is the case. I feel that by and large the medical profession will be better compensated under this than it was before, and that it will be possible for doctors to go into places such as the rural South where they cannot now operate profitably.

Senator DONNELL. You think that the judgment of those members of the American Medical Association who feel this bill would injuriously affect them financially is not correct?

Dr. FOREMAN. As a profession I think it is not correct.

Senator DONNELL. Of course, as you have indicated, you are not a physician and have never practiced medicine, have you, doctor?

Dr. FOREMAN. No.

Senator DONNELL. And these men are all members in the medical profession; that is correct, is it not?

Dr. FOREMAN. I think it is.

Senator DONNELL. Very largely they are actual practitioners; that is correct, is it not?

Dr. FOREMAN. But not infallible.

Senator DONNELL. None of us are infallible, but they are practicing physicians?

Dr. FOREMAN. Yes.

Senator DONNELL. And would have the opportunity, perhaps, to judge better than some of us not physicians as to the operation of this bill?

Dr. FOREMAN. That I would not agree to. I think that the layman is much more in a position to say what is the best kind of service than the doctor.

Senator DONNELL. I am talking about the financial effect on the doctors. Do you think that the doctor or the average layman is better qualified to judge the financial effect?

Dr. FOREMAN. No; because I would not deny that certain experts would get less under this than they would at the present time. If they decided to stay out, they might continue to get as much, but I do feel that by and large the medical profession would be better compensated under this national health bill than it is at present.

Senator DONNELL. Doctor, is it not a fact, or do you know, that regardless of whether this bill would better compensate them, that there is a very large segment of the medical practitioners in this country that regard this bill as unsound in principle even though it would give each man more money than he would get under present conditions; and that the opposition, at least in large part, is based on the principle of Government insurance compulsorily applied, regardless of the effect it may have had on the individual practitioner?

Dr. FOREMAN. That is not a medical question.

Senator DONNELL. You know that to be a fact?

Dr. FOREMAN. I know that doctors have based objections to this on completely nonmedical grounds.

Senator DONNELL. Yes.

Dr. FOREMAN. They feel it is too much Federal control, but that is just as if doctors were opposed to income tax.

Senator DONNELL. Is that not one of the important bases of the opposition of the American Medical Association, that they do not favor the federalization of control of the American Government of patients and doctors; is that not one of the important bases of the opposition?

Dr. FOREMAN. I do not think it is; no.

Senator DONNELL. You do not think it is.

Dr. FOREMAN. No. There is no Federal control of the relation of doctor over patient in this bill.

Senator DONNELL. I think we might disagree on that, but I shall not go into this point with you.

Is there anything further, Senator Smith?

Senator SMITH. No.

Senator DONNELL. Thank you, doctor, for coming. Pardon me, I did not know Senator Aiken was here.

Senator AIKEN. I had another committee hearing.

## THE PROBLEM OF THE SOUTH

I was just wondering, Doctor Foreman, in the southern conditions, what progress has been made in the South in improving health and providing medical care in the last few years?

Dr. FOREMAN. I think the greatest has been done through the supplemental work of the Farm Security Administration, Senator. And we have had a chance to get medical care on a much more basic plan than ever before, although even that is selective.

Senator AIKEN. You say the syphilis mortality is above the national average; and the tuberculosis, influenza, and pneumonia rates are higher than elsewhere. How do the percentages of illness and death compare with what it was 10 or 20 years ago?

Dr. FOREMAN. It is less, Senator, but it is still far higher than the rest of the country.

Senator AIKEN. There is some improvement?

Dr. FOREMAN. There is some improvement; yes.

Senator AIKEN. What is that due to? You say the Farm Security Administration, in some cases. What other factors would tend toward improving health conditions in the South?

Dr. FOREMAN. The Public Health Service, standard of public health, sanitary facilities, economic position of the people.

Senator AIKEN. Higher earning power?

Dr. FOREMAN. Higher earning power. Still we are the poorest part of the country; have the largest number of midwives; the greatest consumers of patent medicines.

Senator AIKEN. The fewest doctors?

Dr. FOREMAN. The fewest doctors, the fewest hospitals, the fewest nurses. And I do not believe that there is any real hope for getting good health conditions in the South except on a national basis, on the basis of Federal aid, through such a plan as this.

Senator AIKEN. Or an increased earning capacity. Your shortage of doctors is due to the fact that people cannot afford doctors?

Dr. FOREMAN. One of the factors in their not being able to afford it is that there is so much illness. I can supply the Senator with the amount of time lost by the workers of the South from the industries of the South because of illness, which exceeds by far that of any other part of the country.

The whole question of pellagra and malaria, and so forth, which are peculiar diseases to the South, have greatly impeded our economic development; and I would say definitely it is a national question, because one of our greatest exports in the South is uneducated people whom we send constantly to the North and West out of the South.

Senator AIKEN. Are they coming back from the North in anywhere near the same numbers as they went into the North?

Dr. FOREMAN. As I remember the figures, the South had fewer returning veterans coming back to the South than any other part of the country. I think on the one hand it is dissatisfaction with the poor conditions of the South, and on the other hand I think it is the economic opportunities that exist in the North, and there is a constant migration of people from the Southern States to the North; and I think that the whole country suffers when those people go to the North uneducated and unhealthy. You have to bear the burden of our unhealthy and uneducated people when they move north. Therefore it seems to me

to be a national problem which should be met by the Congress of the United States.

Senator DONNELL. Is there anything further, Senator Smith? [No response.]

The committee will probably not meet in this room tomorrow. We will meet, however, at 10 o'clock tomorrow morning, and the location of the meeting will be announced in the Washington Post tomorrow morning.

If there is nothing further, gentlemen, the meeting stands adjourned until tomorrow at 10 o'clock.

(Whereupon, at 11:31 a. m., Wednesday, April 10, 1946, the committee adjourned to meet again at 10 a. m., Thursday, April 11, 1946.)



# NATIONAL HEALTH PROGRAM

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THURSDAY, APRIL 11, 1946

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

The committee met at 10 a. m., pursuant to adjournment, the Honorable James E. Murray (chairman) presiding.

Present: Senators Murray, Johnston, Aiken, and Donnell.

The CHAIRMAN. The hearing will come to order.

The first witness this morning is Mr. Harold L. Ickes, the executive chairman of the Independent Citizens Committee of the Arts, Sciences, and Professions.

Mr. ICKES. I have a statement here and I am going to ask your indulgence to read it. I prefer to finish the statement before I am asked any questions, if that is agreeable.

The CHAIRMAN. That will be very satisfactory.

## STATEMENT OF HAROLD L. ICKES, EXECUTIVE CHAIRMAN OF THE INDEPENDENT CITIZENS' COMMITTEE OF THE ARTS, SCIENCES, AND PROFESSIONS

Mr. ICKES. Mr. Chairman and gentlemen, I am glad to have this opportunity to appear before this distinguished committee today in support of the purposes of the Wagner-Murray-Dingell bill. I do, however, wish to warn you that I come here not as an expert in the field of public health, although I have had some experience in the problems of that field.

### CONSERVATION OF THE NATION'S HEALTH

Most of my life has been devoted to conservation, generally the conservation of natural resources. Too many of the people of America too frequently think of our natural resources in terms of oil or coal, trees or land, or in terms of water power or national parks.

Indubitably, these are natural resources and they are worth protecting and by and large in the last generation or two this country has done a good job of protecting them. But many of us have, in the past, tended too often to overlook the fact that the people of America are its greatest natural resource. Most of us take people for granted—except, of course, at election time.

It does us no good to conserve our oil fields, to perfect new techniques for getting more miles out of a gallon of crude oil, to make new plastics out of the hydrocarbons of coal, to harness additional water power, to irrigate more arid lands or to prevent erosion if there are no people to enjoy the fruits of these advances, or if there

are few people to use them. Furthermore, there can be no real sense in attempting to conserve our natural resources if the people who are to use and enjoy these resources are ill, or weak, or sickly, or die unnecessarily.

As a matter of fact, every illness, every head cold, every case of cancer tends to deprive the people of the enjoyment and use of the great resources that we have in two ways: Illness takes out of the ranks those who may enjoy or use our natural resources. It also reduces our labor force, and thus reduces the productivity of this great country.

With the be-all and the end-all of Government the greater well-being of more people, it is plain logic to demand the removal of obstacles which stand in the way of greater production of more things for more people.

In these times when the production of goods and services was never more greatly needed in this country, it is sinful waste to permit thousands of man hours of production to be lost each year through illness that could either be prevented or readily cured. This is not to say that all illness is preventable, but it is to say that much illness and disease and physical infirmity could be prevented if adequate medical services were available at a cost within the means of those who need them.

#### SELECTIVE SERVICE REJECTIONS

The medical records of the Selective Service System, for instance, show that out of the 14,000,000 men examined during the last 6 years, nearly 4,500,000 were rejected for physical defects of one kind or another. Estimates are that one out of every six of those rejected for physical defects would have been in shape to serve his country in the Army had he, at some earlier time in his life, received adequate medical care.

I am not disposed to believe implicitly in the rigid accuracy of these figures or to infer too much from them. I am well aware that the standards of local draft boards varied from county to county and from time to time, and that some men who were rejected for physical defects might well have been accepted at a later time or in a different county. I also know that there are hundreds, perhaps even thousands, of men who, by one device or another, simulated an illness of sufficient gravity to warrant rejection by their draft board.

I am, however, conscious that thousands, and perhaps tens of thousands of men, with fairly grave physical defects were drafted into the Army when this country reached the end of its manpower resources back in 1944.

So it is my belief that while these figures from the Selective Service System may not be strictly accurate, they are probably roughly so, and to my mind they are indicative of a serious flaw in the system under which, in normal times, the medical needs of the people of this country are provided for.

#### UNITED STATES IS NOT THE HEALTHIEST NATION

There are other evidences to support the contention that medical care in this country is not what it should be. On the basis of the latest available figures there are seven other countries in the world which

have lower infant mortality rates than this one. There are eight or nine which have lower mortality rates for adolescents.

There are a score of countries which have lower mortality rates for mature men and women. Obviously, illness or disease is not the only cause of death. People fall off of brass rails or get run over by automobiles, and there are more automobiles in the United States than in other countries. Still these mortality rates are again roughly indicative of the extent to which the United States lags behind some of the other countries of the world in caring for the health of its inhabitants.

Obviously, such figures as these indicate a vital need for greater medical care for more people in this country. Not even in our biggest cities are the medical facilities—doctors, hospitals, nurses, and so forth—enough to take care of all of the men and women and children who need medical care. Nor are these facilities which exist geared to take care of that class of the population which needs medical care the most—those without the necessary funds to pay the high costs of the present day including all of the necessary scientific apparatus.

The reason for the higher incidence of death among almost all classes in this country than in many others is found, in part at least, in the tragic figures which show that, even before the war, our rural areas were but scantily supplied with doctors and nurses.

Proportionately the war made a greater drain upon the rural areas than the cities so far as doctors were concerned. The Government's own figures show that in some rural communities there is now but one doctor for every 3,000 inhabitants. Whether those physicians who return to civilian practice will want to go back to the rural areas, even if they came from them, is a question which cannot yet be answered, although some shrewd inferences might be drawn from the tendency of the many soldiers who have already been released.

But, even if there are found enough doctors who are willing to supply the medical needs of our nonurban communities, they would not be enough. Doctors alone cannot do the job. They must have access to modern medical facilities.

Undoubtedly, life in the country is generally more healthful than life in a crowded city slum. Still country life is not healthy enough so that the men and women and children of our rural areas should be denied hospitals and hospital services forever. Yet this seems to be the prospect, for about 1,200 of the counties in the United States have no general hospital facilities.

Now, I know that in some of our western States even a small hospital would house all of the inhabitants of some of the counties, but such areas are comparatively few in number, and in actuality there are a respectable number of counties in this country with several thousand residents which do not contain any hospital facilities.

I would be the last to deny that the country doctor has produced miracles in his time, but I think that the country doctor who has performed these miracles for years without adequate tools of his profession to help him deserves a better fate than to be consigned forever to caring for his patients through the media of a bag of pills and a stethoscope.

Further, I doubt whether those physicians who have spent 3 or 4 years in the Army or the Navy, where they have had access to the latest

medical equipment, will be much entranced with the prospect of settling in the country with only a fever thermometer and a roll of adhesive tape as aids to minister to the needs of the community. Nor is it right to deny to either the physician or the patient the help of X-ray machines, laboratories, and all of the modern devices which the medical profession, stimulated by the exigencies of war, has produced.

#### HOSPITAL CONSTRUCTION UNDER THE PWA

I am no Johnny-come-lately to the cause of more adequate hospital facilities for the people of this country. When President Roosevelt designated me as Public Works Administrator, I early had impressed upon me the woeful lack of modern medical facilities in the United States, and during my tenure of that office nearly 800 projects providing for new hospitals or additions and improvements to existing ones were initiated.

More than 100,000 beds were added to the Nation's supply. PWA also provided for service and utility buildings in connection with existing plants, including nurses' homes, laundries, power and light plants. In addition, PWA made allotments for the construction of medical and dental schools where medical students and graduate doctors received more adequate training. In large metropolitan areas clinics and medical centers were constructed.

All told, close to half a billion dollars were spent under my direction for the improvement of the means of taking care of the Nation's ill and diseased. And this does not include the huge sums, nearly a billion dollars, which were spent in what might be called the field of preventive medicine, for sewer and water systems, for example. My only regret is that more of the funds which were spent in those days were not put to use in permanent improvements such as the PWA built, rather than in being frittered away on programs of doubtful value.

So increasingly impressed did I become, as Public Works Administrator, that health and human life were our primary and most precious resources that, when the final appropriation was made for PWA under my administration in 1939, I seriously proposed to President Roosevelt that all of it be expended in building new hospitals and improving and expanding existing ones.

I did not see how public funds could be spent to better advantage. Generally speaking, I was in favor of at least one hospital in every county although, as I have already indicated, there were counties that were so sparsely settled that such an expenditure would not be justified. There would necessarily be also the question of upkeep. There would be no sense in building a hospital that could not be maintained.

The workingman of this country is more and more becoming aware that his social security depends not only on the money payments that he receives from or through the Government, but upon his continued good health. His concern over this is manifested again and again in negotiations with employers by union demands for medical plans or for welfare funds. The American Federation of Labor which at one time was opposed to medical care is now in favor of it.

## SPECIALIZED MEDICAL CARE BY INDUSTRY UNDESIRABLE

The latest manifestation of the desire and the need of the working-man for adequate medical care for himself and his family is to be found in the attempt by coal miners to compel the operators to pay into a welfare fund 10 cents on each ton of coal mined. I think that the need for medical care for the miners has long been proved and that there are many operators who have been remiss in their duty, and chisellers in practice, in their method of providing medical care for the men who work for them and for the families of those men.

Nevertheless, I am opposed to the proposal of providing medical care for the miners by giving what would amount to extra-governmental power of taxation to private individuals. If such a power should be granted to the coal industry, it would logically follow that there should be the same right in other industries.

My opposition to this proposal is founded on the fact that I think that the mine workers' plan is economically unsound and governmentally unwise. For instance, I cannot see why the coal miners in Fayette County, W. Va., should have a hospital built for their exclusive use or should have a staff of doctors, solely their own, when there may be others in Fayette County who may also become ill and require the services of a physician or a hospital.

If adopted by other major industries and unions in the country, the plan which has been put forth by Mr. John L. Lewis, of the United Mine Workers of America, might, if carried to its logical conclusion, result in a hospital on one side of the street devoted to treating coal miners for silicosis and a second hospital on the other side of the street devoted to treating cement-factory workers suffering from the same disease.

Personally, I do not feel that the country can afford so wasteful a duplication of medical services, nor do I feel that the health of the Nation as a whole would be benefited to any great degree under a system whereby the kind and extent of the medical care furnished to a person would depend upon the bargaining power of the union to which he belonged.

It seems to me that under such a system the great mass of the unorganized workers in this country would receive the least medical care, yet it is they who, according to competent analysts, receive the lowest wages, spend the least for medical care, and generally need it the most. It seems to me that it is economically unsound to set up hospitals or provide medical care on the basis of the occupations of the people. To my mind the only way to set up hospital facilities is on a population and a geographical basis.

I might add at this point that I am unable to see the wisdom of setting up veterans' hospitals throughout the country solely for veterans. I think that the medical problems of veterans, whether they be maimed or psychotic, are no different from the medical problems of the industrial worker who loses an arm or leg or his mind. I cannot see why the treatment should be different.

I challenge anyone to tell me why a munitions worker who lost his legs in an explosion while loading shells during the war should be treated any differently than the soldier who suffered the same injury on the battlefield. I am not proposing here that our veterans receive

anything less than the best. I am not suggesting that they be pushed out of hospitals to make room for civilians. What I am advocating is that all of us everywhere in this Nation have the benefit of competent medical and hospital facilities. Hospitals treat people, not veterans or coal miners. They treat diseases—tuberculosis, silicosis, cancer—not dock workers or musicians.

There is a second reason for opposing the kind of a welfare fund for the miners which is proposed. That reason is found in the economics of the coal industry. An increase of 10 cents a ton in the cost of each ton of coal produced would worsen the competitive condition of coal. The fact is that at this moment coal is being pushed out of market after market by a rising petroleum and natural gas industry, and the higher the miners push the price of coal the greater that unemployment will be in the coal fields.

In short, such a welfare fund as the miners propose to set up by this special tax on the coal operators would tend to cut their own throats. It would make it harder for the coal business, and it would better the chances of competitive businesses to get more of coal's customers.

What is true about the economics of the coal industry is also true about industry in general. It seems to me that an over-all, Nation-wide medical insurance plan would be better for the coal business and better for most business. At least it would put them all on even competitive basis so far as the costs of the medical care of the workers in the industries are concerned.

In summary, let me say that I believe that there is a real and vital need for more adequate medical care for more of this Nation's inhabitants. I believe something should be done about this and quickly. I do not believe that this job can be done piecemeal or by industry or labor alone. I think that the Wagner-Murray-Dingell bill provides what seems to me to be a real opportunity to achieve the end that all of us desire.

#### COMPARISON TO OLD AGE INSURANCE

As I see it, the only way that this problem can be met is the same way that we met the problem of financing old-age protection. Fifteen years ago the idea of old-age insurance was new. Yet today no one would take exception to the method of paying for old-age pensions which the Federal Government has provided. To my mind the prepayment features of old-age insurance might well be applied to the insuring of the population of this country against the worst of the illnesses which could befall the people of this Nation.

I have carefully refrained from commenting on the specific provisions of the bill. I have done this because I believe that this Committee and the Congress are fully competent to draft the detailed legislative provisions which would effectuate the major aims of the bill.

I do believe that it is a major responsibility of both this committee and the Congress to adopt whatever measures may be necessary to assure adequate medical services to those who may require such services.

The primary, in fact it might be said the sole concern of government is the welfare of the people, and for my part I cannot reconcile this undoubted objective of government with an attitude that would deny doing anything which might be required to maintain and improve the health of the men, women and children who constitute America.

The CHAIRMAN. Mr. Ickes, I note that you have talked mainly of the lack of adequate modern medical care and hospitalization in this country and the need of some plan whereby more modern medical care and hospitalization shall be made available to the people of this country. Have you studied the various technical provisions of the bill, and are you prepared to discuss those provisions in regard to the effect that they will have, and the manner in which they purport to bring to the American people this modern medical care and hospitalization that we have?

Mr. ICKES. I would not be competent to discuss those, Senator, but Dr. Butler of the Harvard Medical School is here, and I understand that he will follow me as a witness, and he has forgotten more than I ever knew about such matters.

The CHAIRMAN. Your testimony, it seems to me, is very important. You have told us what has been done in this country under your administration, while you were head of the PWA. If the American medical profession and the hospital organizations of this country had been left to their own devices during the last 10 or 12 years, we would not be in a very good situation at this time with regard to giving adequate medical care and hospitalization to the American people, would we?

Mr. ICKES. I agree with that. I think one of the best performances of PWA was the money allocated for the building and improvement of hospitals, and I think the events have proved more clearly than I could possibly have anticipated, that for that last appropriation to be spent primarily and exclusively for hospitals throughout the country was a sound proposal, and would be very helpful at this very time.

The CHAIRMAN. I agree with you on that. Modern medical care and hospitalization has become so expensive that without governmental assistance of that kind, it is almost impossible to make it available to a very great section of our population.

Mr. ICKES. That is true.

The CHAIRMAN. Thank you very much for your statement, Mr. Ickes. Any questions?

Senator JOHNSTON. I notice that you speak critically of the Government taking over the medical problems of the veterans. You say that they have no more right to go into that field than they do for the medical problems of the industrial workers. Do you not think service-connected disability is quite different from the problem of someone working for a private industry?

Mr. ICKES. You misunderstood. I did not speak critically. What I intended to say and what I think I did say—may I finish my statement?

The CHAIRMAN. Yes.

Mr. ICKES. The veterans, of course, ought to have all of the medical help and attention that they need, but civilians also ought to have it.

Senator JOHNSTON. You make this statement: "I think that the medical problems of veterans, whether they be maimed, or psychotic, are no different from the medical problems of the industrial worker who loses an arm or a leg or is maimed."

You say, in a sense, that a man that is wounded on the battlefield is no different from a man that is injured in industry.

Mr. ICKES. I said no such thing, and I am not going to be drawn into a demagogic discussion.

Senator JOHNSTON. That is what you say. If anybody gets demagogic, I think, from past records and history, it might be the ex-Secretary of the Interior.

The CHAIRMAN. I do not think that will add to the studies that we are making here. It seems to me that your statement was intended to mean that the care of veterans is no different than the care of a man injured in industrial activities, that a man hurt by loading shells on trucks for use in the war has a right to the same kind of treatment that a veteran would have on the battlefield.

Mr. ICKES. That is right.

Senator JOHNSTON. I will agree with the honorable chairman, if it was making shells to be used in the war, the problem would be the same thing, but I make the distinction between an industrial worker and a man that is working in the direct line of war.

Mr. ICKES. What about a man digging coal in order to carry on the war? If you want to go down that alley, it has many ramifications.

Senator JOHNSTON. Your ideas are absolutely socialistic, to take over everything, is that true?

Mr. ICKES. Far from it.

Senator JOHNSTON. Where are you going to stop?

Mr. ICKES. Well I do not have to say where I am going to stop. I am saying where we ought to go.

Senator JOHNSTON. I will be the one to pass upon the legislation and pass it, and I want you to tell me where to stop. Where would you stop?

Mr. ICKES. The statement takes care of that.

Senator JOHNSTON. You leave it entirely up to us, but you do not say anything, your statement is only general.

Mr. ICKES. It is general.

Senator JOHNSTON. But you are willing to go all the way, are you not? What are you going to do with the doctors throughout the United States?

Mr. ICKES. I think people are entitled to more medical and hospitalization services than they are getting.

Senator JOHNSTON. Are you going to take over all of the doctors in the United States?

Mr. ICKES. I would not propose that at all.

Was Santee-Cooper Dam in your State socialization?

Senator JOHNSTON. That was you that put that down there.

Mr. ICKES. Of course, I put it there, and I did not hear any objection from you at the time either.

Senator JOHNSTON. Not a bit, not a bit, and I think it was a good thing.

Mr. ICKES. So do I.

Senator JOHNSTON. And I think it is bringing back money into the Government every day as far as that goes.

Mr. ICKES. And healthy people will bring back money.

Senator JOHNSTON. And it is bringing industries to South Carolina every day.

Mr. ICKES. Yes.

Senator JOHNSTON. Certainly I am for it.

Mr. ICKES. It is the old theory of a local benefit being accepted where a general good is called socialistic.

Senator AIKEN. I take it that you object to the 10 cent assessment on coal, because that 10 cents would be added to the price of coal, and it would constitute a tax on all of the people of the United States who use coal for the benefit of a single occupational group of around 500,000 men?

Mr. ICKES. It is the wrong approach, and it is giving the power of taxation to a nongovernmental group.

Senator AIKEN. And if that were carried far enough, you would find all union labor would be given the benefits of hospitalization and medical care, whereas the majority of the people, workmen who do not belong to unions, would be left on the outside?

Mr. ICKES. That is right.

Senator DONNELL. May I inquire of the witness, please. Mr. Ickes, I observe as you emphasized, that you have carefully refrained from commenting on the specific provisions of this bill, S. 1606.

Mr. ICKES. Yes.

Senator DONNELL. I will ask you to state whether you have read this bill, S. 1606?

Mr. ICKES. Well, I was prepared for that question, because I understand that is a customary question from the Senator. I have not.

I have read a carefully prepared digest of it, and I did not know—I have been appearing before congressional committees for some 13 years—and I did not know that it was a necessary prerequisite to have read carefully a bill, because I have appeared before so many committees the members of which had not read the bill.

The CHAIRMAN. I believe that at the commencement of these hearings it was stated that several Senators had not read the bill.

Senator DONNELL. Referring now to my question, you have not read the bill, is that correct?

Mr. ICKES. That is correct.

Senator DONNELL. Have you read any part of it?

Mr. ICKES. Yes, sir.

Senator DONNELL. Which part of S. 1606 have you read?

Mr. ICKES. Oh, well, I read the parts that I wanted to read.

Senator DONNELL. Which was that part?

Mr. ICKES. I am not prepared to say.

Senator DONNELL. How recently have you read this bill, or the part of it?

Mr. ICKES. During the last 2 or 3 days.

Senator DONNELL. And you are still not prepared to say what parts of it you have read, is that right?

Mr. ICKES. I think it would be by way of supererogation. I do not think that the question is pertinent, if I may say so, and I do not think that any good would result from my entering into a detailed statement of what I have read.

Senator DONNELL. The point that I am making is that you have not read all of the bill.

Mr. ICKES. I said that.

Senator DONNELL. And you are at this time unable to state to us what part you have read?

Mr. ICKES. I have said that two or three times.

Senator DONNELL. I would like to ask you to answer it again. You have not read all of this bill and you are unable to state what parts of the bill you have read, is that right?

Mr. ICKES. For the third time, no; and for the fourth time, in anticipation; no.

Senator DONNELL. Well, make it the fiftieth time and say "No" again.

Mr. ICKES. That is right.

Senator DONNELL. Now, Mr. Ickes, you were emphasizing, as I understood in your testimony, what you regarded as the purposes of the bill, that is what you came here to testify about primarily.

Mr. ICKES. I was talking, if the Senator will do me the honor to follow me, about the general subject matter of public health, and I was not discussing any particular bill, and I said very clearly and definitely that the committee and the Congress were better prepared than I to agree upon the terms of the bill.

Senator DONNELL. Mr. Ickes, I do not think that there is any disposition here to argue with you in regard to your right to come before the committee to give your views as to the general purposes, but as I understand it, so that we may have it perfectly clear—

Mr. ICKES. The answer is "No."

Senator DONNELL. Inasmuch as I had not submitted the question, perhaps you might find that your answer was "Yes" to this question.

Mr. ICKES. Perhaps it might be.

Senator DONNELL. The question that I was asking you, or was going to ask you, in substance was whether or not you were coming here as you state in the opening statement—your first sentence—in support of the purposes of the Wagner-Murray-Dingell bill?

Mr. ICKES. The purposes?

Senator DONNELL. Your answer is "No" to that or "Yes"?

Mr. ICKES. I came here in support of the purposes.

Senator DONNELL. That is what I understood. Now, I understood, also, that you did not come here to testify as to the details of the bill.

Mr. ICKES. As to the principles of the bill.

Senator DONNELL. In other words, we will start with that, that you came here to testify as to the, first, principles, without regard to going into the various details of the bill, which you have fully and completely and repeatedly stated you have not examined, that is correct, is it not?

Mr. ICKES. That is quite correct.

Senator DONNELL. Now, having passed that, let me ask you first, before we go into these further matters, I observe that you—

Mr. ICKES. You know, if I may interrupt, a man could be in favor of taking care of an illness, where the illness might be taken care of, without the man being a doctor or knowing anything about it.

Senator DONNELL. That is true, and we have a right to express our opinions, there is not a man sitting here on this committee who is a physician. Now, Mr. Ickes, you are described here at the outset as being the executive chairman of the Independent Citizens Committee of the Arts, Sciences, and Professions.

Mr. ICKES. That is correct.

Senator DONNELL. Would you tell us, please, what is that committee and what is its composition and membership?

Mr. ICKES. Yes. The national officers and board of directors are Jo Davidson, national chairman, Harold L. Ickes, executive chairman, Frederic March, treasurer, Herman Shumlin, secretary, and James Roosevelt, national director of political organization.

The vice chairmen are Col. Evans F. Carlson, Norman Corwin, Joseph E. Davies, Dr. Reuben G. Gustavson, Fiorello H. LaGuardia, Archibald MacLeish, Dr. J. Robert Oppenheimer, Paul Robeson, Dr. Harlow Shapley, and Frank Sinatra.

The national board of directors is composed of William Rose Benet, Leonard Bernstein, Walter Bernstein, Charles Boyer. In this connection I would like to say that we are now voting on additional membership to the board of directors, but the ballots have not been counted. Others on the board of directors are Henrietta Buckmaster, Eddie Cantor, Duke Ellington, Howard Fast, Jose Ferrer, Dr. Channing Frothingham, Ben Grauer, Marion Hargrove, Moss Hart, Lillian Hellman, John Hersey, Walter Huston, Crockett Johnson, Gene Kelly, Richard Lauterbach, Eugene List, John McManus, Florence Eldridge March, Bill Mauldin, Dorothy Maynor, Stanley Moss, Dr. Walter Rautenstrauch, Quentin Reynolds, Hazel Scott, Orson Wells, and Langston Hughes.

Senator DONNELL. How large a membership does the committee have?

Mr. ICKES. Ten or twelve thousand.

Senator DONNELL. Are you appearing here on behalf of the committee or as an individual this morning?

Mr. ICKES. On behalf of the committee. May I submit for the record data on the meeting at which I was selected to appear?

(The data referred to is as follows:)

MINUTES, EXECUTIVE COMMITTEE MEETING, INDEPENDENT CITIZENS' COMMITTEE OF THE ARTS, SCIENCES, AND PROFESSIONS, THURSDAY, MARCH 21, 1946

Attending:

Jo Davidson	Peter Lyon
Henry Billings	Hazel Scott
Howard Fast	William Rose Benet
Dr. Walter Rautenstrauch	Carl Van Doren
Stanley Moss	Henrietta Buckmaster
Samuel L. M. Barlow	Ben Grauer
Lillian Hellman	Hannah Dorner
Florence Eldridge March	

Discussion: \* \* \* Wagner-Murray-Dingell bill comes up for hearing within a few weeks. Miss Dorner suggested that Mr. Ickes testify at the hearings for the ICCASP and that if he can't make it, that Mr. LaGuardia who is an expert on medical care appear and also Dr. Allan Butler, who is a member of our Medical Advisory Council.

Motion: That Mr. Ickes or Mr. LaGuardia appear before the hearings on the Wagner-Murray-Dingell bill.

M/S/C: Carl Van Doren, William Rose Benet.

Senator DONNELL. Has the committee been polled in any way, Mr. Ickes, with respect to this bill, S. 1606?

Mr. ICKES. I can even answer that question.

Senator DONNELL. Will you tell us, please, about the poll?

Mr. ICKES. The national membership meeting on February 10, at the Alvin Theater in New York.

Senator DONNELL. That is, S. 1606 was endorsed?

Mr. ICKES. That is correct.

Senator DONNELL. Do you have a copy there of the resolution or endorsement?

Mr. ICKES. No. It has also been endorsed by the national board of directors, and the board of directors of each chapter.

Senator DONNELL. How large a meeting was there in New York when this endorsement was made?

Mr. ICKES. I was not there, I do not know.

Senator DONNELL. Now, Mr. Ickes, how recently has this committee been formed?

Mr. ICKES. Which committee?

Senator DONNELL. The Independent Citizens Committee of the Arts, Sciences, and Professions?

Mr. ICKES. I first knew of it during the 1944 campaign, and I think it was organized along about that time.

Senator DONNELL. I wonder, Mr. Ickes, if you recall specifically whether this resolution that you refer to, of endorsement, at New York, specifically mentioned S. 1606?

Mr. ICKES. That is what I said.

Senator DONNELL. It did?

Mr. ICKES. Yes.

Senator DONNELL. Would you find it convenient to furnish to our committee a copy of that resolution for its files?

Mr. ICKES. Yes, sir.

(The information is as follows:)

EXTRACT—MINUTES OF THE ANNUAL MEMBERSHIP MEETING OF THE INDEPENDENT CITIZENS' COMMITTEE OF THE ARTS, SCIENCES AND PROFESSIONS, ALVIN THEATER IN NEW YORK, SUNDAY, FEBRUARY 10, 1946

Mr. CORWIN. I have been asked by the platform and program committee to read its program and platform for 1946, subject to your approval.

There is need for the Independent Citizens' Committee of the Arts, Sciences and Professions, as it begins its second year, to emphasize again the responsibility of forward-looking members of the arts, sciences, and professions in their role as independent citizens, to work for the realization of a prosperous peace for our world community.

In this year, we recognize that there have been laid the foundations for world peace; here at home the issues of reconversion, full employment, and the emergence of a prosperous America, are yet to be resolved. To all of these, the Independent Citizens' Committee of the Arts, Sciences and Professions must give its full energy, because upon how these issues are resolved depends whether the American people have won or lost the peace. Also, during 1946, we face an election campaign which will send to Washington one-third of the Senate and the entire House of Representatives. In this campaign, the Independent Citizens' Committee will lend its support or try to defeat candidates regardless of party labels, and only with respect to the position they take on domestic or foreign policy positions, which we regard as of continuing and urgent importance.

Insofar as foreign policy is concerned, the Independent Citizens' Committee reaffirms its support of the United Nations Organization, and pledges its continued efforts toward strengthening this most specific apparatus for world peace and international unity. To this end, we support the principle of unanimity in the Security Council. The problems posed by atomic fission become graver in direct proportion as any country attempts to make of atomic energy a "big stick" in the arena of diplomacy.

As the organization which played a vital part in helping to form the Federation of Atomic Scientists, the Independent Citizens' Committee calls for the free international exchange of all scientific information, from all nations, to all nations, for the benefit of all mankind. [Applause.] We urge the international custodianship and development of atomic energy for the uses only of peace.

As in the past, we support the growth of democracy, the growth of progressive self-government, throughout the world. The struggles of colonial and semi-colonial people toward independence warrants our support. Also, as in the past, we call on our Government to oppose sharply as possible the Fascist or proto-Fascist governments of Spain and Argentina [loud applause], and, more generally, such states and governments as are inimical to progress and freedom.

Still as regards foreign policy, we go on record as being eager to cooperate with organizations of similar character and aims in our own and other countries. In this connection, we will support the broad aims of UNESCO, and seek to implement its work as far as possible.

Insofar as domestic policy is concerned, we are on record as supporting organized labor's fight to maintain the national pay envelope and employment rolls. Further, we believe that this can be accomplished only by holding the price line. [Applause.] During 1946, we will do everything within our power to fight inflation and achieve the continuance of OPA. We will continue to urge the fullest possible extension of the franchise, and specifically the repeal of the poll tax [Applause]; and we reaffirm our support of the Fair Employment Practices Committee. [Applause.]

In summary, here is the specific legislative goal for 1946:

Full-employment bill.

Unemployment compensation bill.

Sixty-five-cent minimum-wage bill.

Ellender-Taft-Wagner house bill.

Kilgore Federal house bill.

Murray-Wagner-Dingell health bill.

Missouri Valley Authority.

Permanent FEPC.

Repeal of poll tax. [Applause.]

Bill to abolish the House Committee on Un-American Activities. [Applause.]

Bill to establish a National Science Foundation.

McMahon bill for domestic regulation of atomic energy under the heading of "Legislation to be introduced" come: Extension of Social Security, fine arts bill, liberalization of income tax, extension of price control.

I have been requested to ask all you members to adopt the program for 1946 by a formal motion, subject to discussion after the motion is made. Will someone make such a motion?

MEMBERS. So move.

(Motion seconded.)

Mr. CORWIN. Is there any discussion?

Mr. HICKERSON. I didn't hear mention of Federal aid to public education.

Mr. CORWIN. I take it that is an amendment to the motion. Will some one second it?

(Motion seconded.)

Mr. CORWIN. Any discussion on either the main program or the amendment to the program?

If not, we will put the matter to a vote.

All those in favor? Opposed?

(Motion carried unanimously.)

Mr. CORWIN. That is for the main platform. Now on the amendment. All those in favor? Opposed?

(Motion carried unanimously.)

Senator DONNELL. Now, I understood, Mr. Ickes, that you were emphasizing in your testimony very largely the importance of adequate hospital facilities, is that correct?

Mr. ICKES. That is one thing.

Senator DONNELL. And then you took the view, as you have expressed it, that an over-all, Nation-wide medical insurance plan would be better for the coal business and better for most businesses, I believe that is your reference, or at least one reference, to the Nation-wide medical insurance plan.

Mr. ICKES. It should not be treated by industries at all, that is what I said.

Senator DONNELL. You think that this is a Nation-wide problem and not to be treated by industries?

Mr. ICKES. That is correct.

Senator DONNELL. Now, Mr. Ickes, you state, also, in your statement that no one would take exception to the method of paying for old-age pensions which the Federal Government has provided. Now,

as regards old-age pensions, is it not a fact that the method which the United States Government has provided is one under which the States through contributions, made both by the National Government and the State governments, administer the distribution of those old-age pensions, that is correct, is it not?

Mr. ICKES. I do not know. What I had in mind was that this plan would be a contribution, a deduction from the pay of the employee, a contribution by the employer, and that administration would be under a board, an advisory council, the head of which would be the Surgeon General of the United States.

Senator DONNELL. Now, Mr. Ickes, may I ask you, do you favor, generally speaking, a situation under which individuals may find it impossible to procure the physicians of their own choice? Do you favor that plan, generally speaking?

Mr. ICKES. No; I think that they ought to be allowed to have physicians of their own choice.

Senator DONNELL. And you are not acquainted, I take it, with the provision of S. 1606 that refers to the right of the Surgeon General to prescribe the maximum number of patients which a doctor may take in communities in which the so-called per capita basis has been adopted by the doctors? You are not familiar with that?

Mr. ICKES. I do not know anything about the details.

Senator DONNELL. I understand. Now, you also refer, Mr. Ickes, at one other point I think in here, to medical insurance. Do you have any preference between a Federal compulsory health insurance and a voluntary system of health insurance, instituted under some such plans as the Blue Cross? Do you have any personal preferences as between those two?

Mr. ICKES. I do not think that your voluntary system will get anywhere.

Senator DONNELL. You feel that that is not practicable?

Mr. ICKES. It will not do the job, if your objective is to maintain the health of our people, you have got to do it any way it can be done.

Senator DONNELL. Now, the first title of this bill—

Mr. ICKES. The right to insure, although fine in theory, is like the right to vote, which may be cut off entirely by a poll tax—inability to pay.

Senator DONNELL. I get your point. Your point, as I understand it, is that although in theory, voluntary insurance under the Blue Cross is desirable, you do not think that the people will find it practicable to avail themselves of it, or will avail themselves of it Nation-wide; is that correct?

Mr. ICKES. That is correct.

Senator DONNELL. And you think, therefore, that Nationwide compulsory health insurance is desirable in view of that fact; is that correct?

Mr. ICKES. Something of that sort.

Senator DONNELL. Now, may I ask you, Mr. Ickes, have you examined S. 1606 to a sufficient extent to recall that title I is based on the theory of grants-in-aid to the States, and title II is based on the theory of operation by the Federal Government? Have you examined that?

Mr. ICKES. I am not prepared to discuss the draftsmanship or the final form the bill should take.

Senator DONNELL. I was not referring to the draftsmanship, I was referring to the two major portions of the bill.

Mr. ICKES. I am just expressing, as a general principle, my belief that the primary concern of the country ought to be the health and well-being of the people.

Senator DONNELL. I think, Mr. Ickes, there would be no dispute upon that question, they are all agreed as to that, and it is simply a question of means.

Mr. ICKES. No one would dare to dispute it, but would only run it down blind alleys.

Senator DONNELL. Now, you also mentioned, Mr. Ickes, in the course of your discussion, the fact that hospital facilities are not adequately provided in some sections of the country, and you refer to that in general terms.

Mr. ICKES. That is right.

Senator DONNELL. Are you familiar with the bill recently passed by Congress having to do with this hospital problem?

Mr. ICKES. No.

Senator DONNELL. You do not know how adequately, if at all, that bill provides for the solution of that problem?

Mr. ICKES. No; but my guess would be that it would not be adequate.

Senator DONNELL. But have you examined that bill?

Mr. ICKES. No.

Senator DONNELL. Then you are proceeding merely on your impression as to what that bill probably is; is that right?

Mr. ICKES. No; I am not taking that bill into account at all.

Senator DONNELL. You are not taking it into account at all. You do know that such a bill was passed?

Mr. ICKES. I know the general situation, which I became familiar with as Public Works Administrator, during which, among other things, we build some beautiful hospitals, in St. Louis and other places, in Missouri.

Senator DONNELL. You have not, however, studied the provisions of the hospital bill recently enacted by Congress just a few weeks ago?

Mr. ICKES. That is right.

Senator DONNELL. That is all, Mr. Chairman.

Senator AIKEN. You did state, Mr. Ickes, somewhere in your testimony that construction of the hospital would not suffice, unless there was some means of maintaining the operations of the hospital, which is not provided for in the hospital bill.

Mr. ICKES. I would expect that there would be a few flaws in it.

The CHAIRMAN. Thank you for your statement, Mr. Ickes.

Mr. ICKES. You are quite welcome, and it is a great pleasure. I would like to make one observation, that I do not see why the personnel of an organization should be a matter of major interest, and I do not see what bearing it has on the merits of the pending legislation.

Senator JOHNSTON. I think that is where the committee disagrees with you, and I think that I do. I think who you represent amounts to a great deal, and I think the public believes that.

Mr. ICKES. I am afraid that you have a suspicious mind.

Senator JOHNSTON. I probably do have a suspicious mind of you.

Mr. ICKES. Now, that does flatter me.

Senator DONNELL. Mr. Ickes, you mentioned, and this is said with the utmost of respect for your view, do you not think that it is of importance to know something of the background and the number of the persons who are represented by a committee, and their opportunities for knowledge of the subject concerning which they speak?

Mr. ICKES. Oh, yes. Where that relates to the merits of the bill, itself, if that is the purpose of the question, why of course it is unobjectionable.

Senator DONNELL. Of course, we are here undertaking to pass on a specific bill, that is what has been presented to this committee, Mr. Ickes.

Now, may I ask you one or two further questions about this committee, on behalf of which you speak here this morning? You were not present at the New York meeting, you say, which approved S. 1606?

Mr. ICKES. That is correct.

Senator DONNELL. Have you ever seen the copy of the resolution that was adopted at that meeting?

Mr. ICKES. No.

Senator DONNELL. Do you have any idea as to how many people were present at that meeting?

Dr. BUTLER. I was not there at that meeting. I was there at a meeting a year ago, attended by about 1,000 members of this organization, where the previous draft of the Wagner-Murray-Dingell bill was discussed.

Senator DONNELL. Was that S. 1160 or this bill?

Dr. BUTLER. I am not that good at memory, but it was a draft of the Wagner-Murray-Dingell bill that was current last spring.

Senator DONNELL. That was the large bill?

Dr. BUTLER. Yes; S. 1050.

Senator DONNELL. That was considered a year or so ago by the meeting; is that right?

Dr. BUTLER. Yes.

Senator DONNELL. Now, if I may resume questioning Mr. Ickes. Have you ever seen the resolution that was adopted this year at the New York meeting?

Mr. ICKES. No.

Senator DONNELL. When was the meeting held, as nearly as you can recall?

Mr. ICKES. I think that I gave the date.

Senator DONNELL. Possibly you did, I do not retain it.

Mr. ICKES. February 10.

Senator DONNELL. Is there a record made of the debate and the proceedings on S. 1606 at that meeting; do you know?

Dr. BUTLER. I do not know.

Senator DONNELL. I understand that Dr. Butler was not there, but if either of you gentlemen can tell us who was there at the meeting in February of this year, I would like to know.

Mr. ICKES. Approximately 900.

The CHAIRMAN. I was going to suggest that Dr. Butler will follow him on the stand.

Senator DONNELL. Now, Mr. Ickes, do you know whether or not the fact that S. 1606 was to be discussed at that meeting was included in the notice of the meeting which was sent, and whether or not the membership of this committee, some eleven or twelve thousand, have ever received a copy of S. 1606 from which to study its terms?

Mr. ICKES. No; but I must, if I may, or I may if I must, to put it the other way, express my admiration for the clean bill of health and the impeccable state of mind with which anybody apparently must approach a bill these days. I do not suppose this was any immaculate conception, Senator. It was a group of members that discussed, maybe inherently as one votes a straight ticket in an election booth, approval or disapproval of a certain measure. It is a democratic process, democratically carried on, and not subject to question, Senator, as to methods.

Senator DONNELL. Mr. Ickes, if I may be pardoned, I am not at all questioning the right of that committee to pass upon the matter, and we welcome its view, but I do think that we have a perfect right to inquire into the degree of care which that committee and its officers, including yourself, have taken for the study with respect to the study both of the principles and of the bill.

Mr. ICKES. I was not an officer at the time.

Senator DONNELL. You were not an officer at the time?

Mr. ICKES. No.

Senator DONNELL. When were you made an officer of this committee?

Mr. ICKES. Five or six weeks ago.

Senator DONNELL. Were you a member of the committee back at that time, in February?

Mr. ICKES. No.

Senator DONNELL. You have become a member of it since then?

Mr. ICKES. That is right.

Senator DONNELL. So you are not informed, I take it, of what transpired except in a very general way, like any citizen would be, in that committee or its deliberations, prior to the time you went in?

Mr. ICKES. All that I have given you is hearsay and therefore irrelevant and incompetent.

Senator DONNELL. I do not think so. We are glad to have it and it is helpful to have your views. I respect your views, and I am glad to have them.

Mr. Ickes, do you know, please, whether or not included in the membership of the Independent Citizens Committee of Arts, Sciences, and Professions there is any sizable number of physicians, and if so, I would be glad to know approximately what proportion, and perhaps Dr. Butler will know.

Dr. BUTLER. They are sizable.

Senator DONNELL. The doctor is going to be on the stand and we can find out from him. You are not informed personally?

Mr. ICKES. No.

Senator DONNELL. Let me ask you one concluding question, and that is: Have you ever examined S. 1050, namely, the bill which was approved, as I understand it from Dr. Butler, a year or so ago?

Mr. ICKES. I have not.

**STATEMENT OF DR. ALLAN M. BUTLER, ASSOCIATE PROFESSOR OF PEDIATRICS, HARVARD MEDICAL SCHOOL; CHIEF OF THE CHILDREN'S MEDICAL SERVICE, MASSACHUSETTS GENERAL HOSPITAL; AND AN EDITOR OF THE JOURNAL OF CLINICAL INVESTIGATION, JOURNAL OF PEDIATRICS, QUARTERLY REVIEW OF PEDIATRICS AND ADVANCES IN PEDIATRICS**

The CHAIRMAN. Dr. Butler, will you state your full name and give the committee some of your background, your profession, and so forth?

Dr. BUTLER. Dr. Allan M. Butler from Boston. I am here representing the Independent Citizens Committee, which has just been discussed. I am associate professor of pediatrics at the Harvard University Medical School, chief of the children's service, Massachusetts General Hospital, and an editor of five medical journals.

The CHAIRMAN. Doctor, in order to expedite the hearings, I would like to ask if it would be possible for you to file your complete statement and summarize it and allow yourself to be examined?

Dr. BUTLER. It would be possible, I think, but it would be better to read it.

The CHAIRMAN. You may proceed.

Dr. BUTLER. It will not take very long.

The CHAIRMAN. You may proceed.

Dr. BUTLER. The reason I want to read it is that I want to present it to you.

Senator DONNELL. May I interrupt for a moment?

Personally, I am very much pleased that the chairman is permitting him to do that. I think it is better to know that the witness is testifying, rather than overlook some salient features that we do not have in an incomplete statement.

The CHAIRMAN. I thank you for that comment. I believe in that myself.

Senator DONNELL. Yes, sir.

The CHAIRMAN. But we have several other witnesses. Of course, Dr. Butler is a very important witness.

Senator DONNELL. Yes, sir.

The CHAIRMAN. And I want to have his full and complete statement.

Senator DONNELL. Thank you.

Dr. BUTLER. I want to try to give you a background of why I think you have an extraordinarily important job to do; why, in doing that job, you must take measures to protect the quality of medical care; why, in doing a good job, you are going to run afoul of the opposition of a so-called medical profession; and why you must be bold in what you do.

**INEVITABLE CHANGE IN PATTERN OF MEDICAL CARE**

The legislation that this Senate committee is considering is not the product of political expediency or sentimental reformers. It is a reflection of the fact that science has forced upon us in every phase of human endeavor a new social economy that infringes upon our personal liberty while freeing us from the ruthless forces of nature and the sufferings of ill health. Music and drama have been revolutionized by projection all over the world immediately as produced, or years later as recorded. The application of science to industry,

agriculture, and transportation has produced undreamed-of results and increased society's productiveness to a point where economists are faced with problems created by abundance rather than want.

To reap the material benefit of such productiveness and to avoid unemployment and chaos, we have accepted at the expense of social independence more and more administrative control by private groups, mammoth corporations, and government.

In times of economic stress or war we have resorted to increased Government control to provide direction to this intricately inter-related and yet competitively disorganized production as will meet our needs.

And now in peace, to prevent the total destruction of ourselves and of our civilization by the latest achievements of science, can we do other than submit to the sovereignty of a world government at the expense of our national independence?

And if we do, can our finest traditions prevail in a world in which the great majority of individuals have no tradition of democracy, of freedom of speech and religion, or of justice to the individual as we know it?

On the other hand, if we declare the price of a United Nations too great, will these traditions and the material benefits of modern civilization survive the competitive struggle for national independence?

With science presenting such a dilemma, how ridiculous to argue that science must be applied to medicine without changing the pattern of medical care or the so-called independence of physicians.

In arriving at your recommendations to the Congress, will you as representatives of the people permit the guildlike interest of solo practitioners to limit the benefits of science in improving medical care? Will you in deference to such interests permit an anarchic application of science at the expense of the Nation's health?

The pertinence of these questions is supported by the 1942 report of the maternal mortality committee of the committee on maternal health of the Minnesota State Medical Association that 73 percent of the deaths were preventable, and that in 69 percent of these the physician was wholly or partially responsible. This record reflects the fact that the only standard of practice enforced by State medical societies is the standard that avoids legal malpractice.

#### IMPORTANCE OF GROUP PRACTICE

I trust that you, in considering this legislation, will accept the fact that the time-honored general practitioner, who rendered all aspects of medical care to patients, is a casualty of the progress of science. We must face the fact that the total knowledge available for the care of patients today cannot be mastered by an individual physician. Modern medical care of the sick patient requires the services of not one but many physicians, as well as highly trained technical and nursing personnel skilled in the use of complicated apparatus and delicate techniques.

The hospital's role in medicine used to be the provision of bed and operating-room facilities. Today, provision of these is no more important than the provision of the laboratory procedures and special techniques upon which proper medical diagnosis and treatment are more and more dependent.

In 1930 a committee of eminent physicians, public-health officials and laymen, called the Committee on the Cost of Medical Care, after intensive study concluded that the benefits of modern medicine are made available most readily to the public by the organization of group practices centered about hospitals.

The perspective afforded by the intervening 15 years has amply confirmed this conclusion, the conclusion which was then and still is opposed by so-called organized medicine, or the societies that defend the guild interest of sole practitioners. Yet these practitioners would not suffer from such an organization of medical services.

The family practitioner, as differentiated from the general practitioner, would be an important member of such groups. He would be the internist specially trained in the recognition of the early manifestations of disease and complications and in the treatment of those conditions which do not require the special knowledge, techniques, and hospital facilities readily provided by others in the group of which he is a part.

Whatever limitation group practice might impose on the action of an individual physician would be balanced by the group's consideration of each member's qualifications, limitations, and personal needs.

The members of a group can readily be "off call," in doctors' phraseology, for definite hours or days or for a month's vacation or post-graduate study. No member should be burdened with responsibilities for which he is inadequately prepared by training and experience.

The intellectual satisfaction and stimulus of being associated with the educational and scientific activities of his hospital group would also compensate for the loss of the odd independence of the sole practitioner—odd, because in one sense it is almost unique in our highly organized society and in another sense it is more imaginary than real. Actually, the sole practitioner must be at the beck and call, day in and day out, of his patients, lest he lose the practice he has so laboriously acquired.

#### PRESENT MEDICAL CARE TOO EXPENSIVE

It is a foregone conclusion that some method of adequately financing medical care in an orderly and predictable manner must be evolved. Modern science has made medical care extremely costly to the individual patient. Personal experience has proved this too forcefully to probably each of us. Yet science has diminished the cost of illness to society by reducing the economic loss incident to death early in life and to unemployment due to illness.

Obviously, distributing the cost of medical care over society as a whole is a logical solution of the problem created by the present inequitable distribution of the costs of illness.

The American Medical Association agrees that patients whose family income is \$3,000 per year cannot pay the costs of serious illness. Patients whose family income is \$2,500 per year are admitted to our urban hospitals as charity patients. This means that doctors whose average net income is only slightly over \$3,000 per year are called upon to render free medical care to these patients. It means that patients with incomes well above the average pertaining in these urban areas are forced, under the present system, to be charity patients.

Charity, we must remember, pays hospital costs, nursing costs, social-service costs, and laboratory costs. It does not pay physician costs. With the increase in the cost of medical care, the charity tradition is placing an impossible burden on physicians.

Doctors should not and cannot continue to carry this economic burden. No other individuals in a system of free enterprise are asked to make such a contribution.

The attempt of doctors to do so by soaking the rich is an unsatisfactory and illogical method of meeting the problem. As stated by the American Academy of Pediatrics—

the discrepancy that now exists between surgical fees on the one hand and free service to the indigent on the other has contributed in no small part to the problems of an equitable remuneration of physicians.

The conclusion is inescapable that the high costs of modern medicine must be financed by people when they are well. They cannot be financed by those who suffer the misfortunes of illness.

Much is made of the difference between the voluntary or compulsory extension of insurance as a means of distributing medical costs. This actually is of minor importance.

The important point is that the successful operation of either voluntary or legislative medical insurance on a scale that will be significant in solving the problem of cost will require reorganization of our current medical practice and development of effective administrative agencies at Federal, State, and local levels.

These agencies must not only be concerned with the efficiency in terms of cost of medical service, but with the maintenance of high standards. The Children's Bureau of the Department of Labor provides an excellent example of how a governmental administrative agency can raise standards of medical care. The contributions it has made in raising the standards of maternal, infant, and child health throughout the country are recognized by the American Pediatric Society and the American Academy of Pediatrics.

#### VOLUNTARY MEDICAL PLANS INADEQUATE

A false impression of the satisfactory expansion of voluntary medical insurance frequently results from not making a sharp distinction between hospital insurance and medical insurance, and possibly Senator Donnell's remarks to Mr. Ickes about the Blue Cross reflect this lack of distinction.

The public should understand that while hospital insurance has grown over the past 15 years so that it now covers risks for 30,000,000 people, medical insurance has grown but little and provides only a very limited type of service to some 3,000,000 persons. And that figure does not include the insurance that is paid in cash in terms of indemnity.

Thus the 30,000,000 with hospital insurance receive coverage for hospital board and lodging costs, but only a few have coverage for professional costs.

It is even more important for the public to know that no state-wide voluntary medical service has made any provision for protecting teaching services or encouraging research. Moreover, because the

guild of solo practitioners dominates these voluntary plans, there is considerable doubt as to whether they will make provision for these essential elements in the improvement of medical care.

It is imperative that any extension of insurance medicine include adequate provision for teaching and research. The bill before you does.

If adequate provision is not made, then as insured patients cared for by physicians of their own choosing replace the charity hospital patients now cared for by the specially trained personnel of well-organized teaching services, the quality of medical education will be jeopardized.

Because medical education determines what the medicine you get tomorrow will be, the preservation of teaching and clinical research units is of vital importance to the public. The point can hardly be overemphasized.

The organized hospital units of medical service teach clinical medicine not only to undergraduate and graduate students and practicing physicians, but continually introduce new knowledge and techniques to medical practice for the public's benefit.

The standards of the medical care you and I receive from any physician are, therefore, largely dependent upon these hospital services. It is of vital importance that the legislation you are considering make provision for and encourage the development of group practices centered about hospitals as a major source of medical care.

Such provision would not only solve the problem of continuing teaching units as medical insurance expands, but would provide the public with the most effective means of obtaining a high quality of medical care economically. The guild interests of organized medicine will oppose such provisions in your legislation, just as they have opposed such provisions in the New York City health-insurance plan.

Application of the insurance principle, whether on a voluntary or compulsory basis obviously is limited to individuals who can afford to pay the premiums. For those who cannot pay, legislative collection of funds seems inevitable.

The proposal to provide medical care to the needy by the expansion of voluntary medical insurance certainly does not promise much. As magnificent as the American public's response to charitable appeals for medical aid is, it meets but a small part of the present need. Despite private willingness to contribute, the situation is such that Government is already contributing \$900,000,000 per year for medical care.

As already remarked, charity contributes very little toward covering the cost of professional care now rendered the needy. Voluntary contributions are not even meeting the costs of hospital board and lodging. There is no possibility of charity's assuming the additional cost of professional care. Yet the public must.

Such legislation as you are considering is imperative if physicians and hospitals are not to suffer financial embarrassment and your medical care is not to deteriorate. The public is unaware of the bankruptcy—and I speak advisedly—bankruptcy of medical institutions which are nationally and internationally known, and to which we in this country point with pride. Doctors are strangely complacent about the inadequate financial support of the institutions that give them their stock in trade.

## PHYSICIAN SUPPORT OF THE BILL

Finally, let us remember that much of the prejudice that physicians had concerning an extension of Government's participation in medical matters has diminished very appreciably. As you are aware, the medical profession has already approved of most of the proposals of the first Wagner-Murray-Dingell bill. It has approved of a Government-supported hospital construction program, namely, S. 191, which was a part of the bill.

It has approved of Government support of medical research and education, as you can see from the Analytical Summary of Testimony, Science Legislation, Senate Subcommittee on War Mobilization, Seventy-ninth Congress, Monograph No. 5, December 1945.

It has approved of an extension of public-health activities, of maternal and child-health services, and of medical care of the needy under social-security legislation.

Such approval of a measure that was so bitterly denounced so recently augurs well for considered discussion and constructive action on the present bill.

There is abundant support for title I of the present bill as a result of the excellent jobs done by the United States Public Health Service in the field of public health, and by the Children's Bureau in the field of maternal and child health. The specific modifications to both title I and title II as recommended by the Committee of Physicians for the Improvement of Medical Care in its report on S. 1606 should be incorporated in your final legislation.

I endorse those specific rules, and a member of that committee is to appear before you and will undoubtedly present that to you.

Senator DONNELL. Who is that, Doctor?

Dr. BUTLER. I think Dr. John P. Peters will be the member who appears before you, representing that committee.

Senator DONNELL. Thank you.

Dr. BUTLER. I think, but I am not sure.

There is much opposition to title II, which pertains to prepaid personal health service benefits. Most of the opposition originates in the well-organized propaganda agencies directed by the bureaucracy that dominates the opinion expressed by so-called organized medicine.

The manner in which this group has resisted the free discussion of the problems before you reflects an intolerance that discredits the profession. Their guild interests have prescribed a resistance to changes in the pattern of medical care which would permit greater benefit to the public by more effective application of science to medicine.

The record of leadership of organized medicine is unbelievably reactionary. Indisputable evidence is presented in a paper in the New England Journal of Medicine, February 21, 1946, which I would like to submit to this committee.

Senator DONNELL. Pardon me, if I may ask, for the purposes of identification, would you be kind enough to give us the name of that particular paper? I think there were other papers in that particular issue.

Dr. BUTLER. Senator Murray has the only copy I had.

Senator DONNELL. Minority Views on Improving Medical Care. It is by yourself.

Dr. BUTLER. By myself.

Senator DONNELL. Under the heading. "Symposium on Medical Sociology."

Dr. BUTLER. Yes.

These reactionaries, in arguing that attention should be paid to the solution of the general problems of housing, food, unemployment, and poverty, rather than to improving medical care, are again displaying a lack of responsible leadership in the field that is their business, and in which wise direction of effort will bring results beneficial to public and doctors alike.

#### PROMPT ACTION IS IMPERATIVE

Positive action should be taken on the legislation before you at this session of Congress. Restriction of this legislation to the provision of certain aspects of medical care to the needy with an inadequate budgetary appropriation may place Government medical care in the category of our inadequately financed charity medicine. This could be disastrous to American medicine, because it might establish a cheap scale for both hospital and physician remuneration.

If American medicine is to be good, it will be expensive. It will cost billions. Cheap medicine will mean poor medicine, and that, in the long run, will be expensive to the public.

Though I appreciate the magnitude of the task of establishing a program of prepaid personal health service benefits, the establishment of such a program appears the surest way to avoid Government medicine's being "charity" medicine.

Therefore, I earnestly hope you will struggle with the inclusive program that is the need.

However, provision for the gradual introduction and expansion of the total program is essential. The public is not prepared and the administrative personnel is not available for more. As I see it, your task requires imagination and boldness in the creation of a comprehensive program, but conservatism in putting that program into operation.

Just as we stand to lose much and yet gain more in resorting to a United Nations, so we will lose certain desirable things in changing our pattern of medical care. But what is lost will be but a fraction of what may be gained by such a national health program as should be devised with the constructive cooperation of physicians and the many others who are authorities in the administration and provision of medical service.

You can be confident that legislation that embodies boldness of program and conservatism in execution and expansion will receive the enthusiastic support of a large part of the medical profession.

The CHAIRMAN. Any questions?

Senator DONNELL. I would like to ask a few, Mr. Chairman.

I would like to state, Mr. Chairman, that I am sure we have all been impressed by the thoughtful and able presentation made by Dr. Butler, which is very thought provoking indeed.

I should like to ask a few questions, however.

In the first place, he makes a statement on page 2 of the mimeographed copy that is rather startling, at least to a person not a member of the profession of medicine. At the end of the first full paragraph, the sentence reads:

This record—

and I assume he is referring to the Minnesota record—

Dr. BUTLER. Yes.

Senator DONNELL (reading):

—reflects the fact that the only standard of practice enforced by State medical societies is the standard that avoids legal malpractice.

I would like to ask the doctor, Is it not a fact, Doctor, that codes of ethics have been adopted by many State societies, and the American Medical Association, which go far beyond the mere standard of avoidance of legal malpractice? Am I not correct on that? I may say, that is an assumption.

Dr. BUTLER. No, no; you are dead right. They have so-called codes of ethics.

Senator DONNELL. Yes.

Dr. BUTLER. Those codes of ethics, Senator, are not enforceable in terms of maintaining a quality of medical service, and I used the word "enforced" in the sentence you quoted.

Senator DONNELL. May I ask you, also, Doctor, Is it or is it not a fact that medical societies are attempting constantly to raise the ideals of the professional ethics among the members?

Dr. BUTLER. We must keep two things clear. If we are going to talk about professional ethics in terms of standards of medicine, we had better define what is included in professional ethics. As professional ethics are discussed in most medical societies and attempted to be maintained in most medical societies, they have very little to do with the quality of medical services.

Senator DONNELL. Doctor, I am not competent to argue that question with you, but it is a fact, is it not, that the medical societies taken by and large are attempting to see that there is a constant observance of the highest moral principles between physician and patient and the highest conceptions, not merely going back to what as I recall was the old Hippocratic oath, but with modern-day developments to insure a high professional standard of ethics between the physician and patient.

Dr. BUTLER. They try to insure a pretty good standard of ethics between physician and patient, but again, Senator, that does not mean they are asserting very effective effort in seeing to it that the doctor renders to that patient a high quality of medical services.

Senator DONNELL. Are there instances in recent years of State medical societies expelling members of the profession for unprofessional conduct?

Dr. BUTLER. Only malpractice.

Senator DONNELL. Only malpractice?

Dr. BUTLER. Yes.

## INDEPENDENT CITIZENS COMMITTEE OF THE ARTS, SCIENCES, AND PROFESSIONS

Senator DONNELL. Now, Doctor, again I am going back to, for just a moment, one matter which you gave us information on before you were on the stand, and that is in regard to this committee of which Mr. Ickes is a representative.

I understood you to say you were not present at the meeting in February of this year.

Dr. BUTLER. No.

Senator DONNELL. Are you a member of that organization yourself?

Dr. BUTLER. I am a member of that organization myself, and I am on a medical advisory committee of that organization.

Senator DONNELL. I understood him to say, as I recall, that the committee consists of eleven or twelve thousand members over the United States. Is that your understanding?

Dr. BUTLER. I have never checked the total membership of the committee.

Senator DONNELL. Do you know approximately how many physicians and surgeons are members, or, what percentage of the membership is composed of physicians and surgeons?

Dr. BUTLER. I have no idea. I only know there are many, because I happened last spring or last summer—or was it the summer before last?—I cannot remember even that date, but I happened to address a section meeting at the time of the annual meeting of this organization, and that room was full of doctors who were members of this organization.

Senator DONNELL. That was about a year or so ago?

Dr. BUTLER. I cannot remember it was last August or a year ago.

Senator DONNELL. It was some time ago?

Dr. BUTLER. Yes.

Senator JOHNSTON. What are the main objectives of the organization?

Dr. BUTLER. I really do not know, in terms of the charter of whatever they have in writing, what they are. I see them as a very intelligent group trying to keep abreast of the current issues and express intelligent opinion concerning these issues.

Senator JOHNSTON. They must have had some objective when they organized. I want to know what that objective was.

Dr. BUTLER. I think the objective was merely to arouse citizens to a considered discussion and awareness of the current issues.

Senator DONNELL. Who was the president before Mr. Ickes attained to that position?

Dr. BUTLER. I do not know. I just do not know.

Senator DONNELL. Have you been active in the organization over a period of years?

Dr. BUTLER. No; only active in the organization during the past year, and only active in the organization in terms of special advisory capacity in medicine over the past 2 months.

Senator DONNELL. So you are not acquainted with what I may term the historical objectives of the committee?

Dr. BUTLER. No. I think I am acquainted with the general objective, which I think I have defined.

Senator DONNELL. Have you seen any constitutional provision which sets forth its proposition or determination of how the composition of its membership is obtained?

Dr. BUTLER. No. I have only seen the statements that the organization periodically publishes and prints, and those statements are extraordinarily informative statements.

Senator JOHNSTON. How do they collect the money that backs it and where do they get the backing? Sometimes you can tell by that.

Dr. BUTLER. I think my membership in that organization allows me to pay either \$1 a year, \$5 a year, or something more.

Senator JOHNSTON. Something more. How much more do some people pay?

Dr. BUTLER. I think I pay \$1. I do not know. No; I have no idea.

The CHAIRMAN. Doctor, can you furnish the committee with a constitution or charter or bylaws or any other material which would indicate the aims?

Dr. BUTLER. I am sure I can, if when I leave here I do not forget to do so.

The CHAIRMAN. If you can give us the name, we can write in for it.

Dr. BUTLER. I think there is a representative in this room.

A VOICE. I will send it.

The CHAIRMAN. You will send that?

The VOICE. Yes.

The CHAIRMAN. Thank you.

(The information is as follows:)

BYLAWS OF INDEPENDENT CITIZENS' COMMITTEE OF THE ARTS, SCIENCES AND PROFESSIONS, INC.

ARTICLE 1. ORGANIZATION

(1) The name of this organization shall be Independent Citizens' Committee of the Arts, Sciences and Professions, Inc.

(2) The organization shall have a seal which shall be in the following form:

[Seal]

(3) The organization may at its pleasure by a majority vote of the membership body change its name.

ARTICLE 2. PURPOSES

The following are the purposes for which this organization has been organized: Through a program of enlightenment, to promote and cultivate the continuance and extension of the democratic way of life in the United States; to combat all retrogressive and reactionary forces and tendencies calculated to circumscribe or limit in any way the continuance and extension of the democratic way of life in the United States; to promote and cultivate the continuance and extension of democracy among all peoples of the world and to combat every influence and tendency in world affairs calculated to circumscribe or limit the same; to promote a speedy and complete victory over the enemies of the United States in the present war; to insure that the peace is just and enduring so that all nations, large and small, may be free to pursue the democratic way of life without wars or upheavals in the foreseeable future; to promote a postwar era in the United States in which the resources of the Nation shall be organized so that employment and a decent standard of living for all will be provided; to increase public interest in problems of national and international affairs; to enlighten its members and the public on matters relating to social, economic, and political policies of the United States; to encourage research activities on questions of national and international policy; to disseminate among the people of the United States knowledge and information which shall inculcate in them an understanding of the necessity and desirability for attaining the foregoing objectives.

## ARTICLE 3. MEMBERSHIP

Membership in this organization shall be open to all who are engaged in the arts, sciences, or professions.

Associate membership in this organization shall be open to the general public, but such associate membership shall not carry any voting rights.

## ARTICLE 4. MEETINGS

The annual membership meeting of this organization shall be held on the 11th day of February each and every year except if such day be a legal holiday then and in that event the board of directors shall fix the day but it shall not be more than 2 weeks from the date fixed by these bylaws. The secretary shall cause to be mailed to every member in good standing at his address as it appears in the membership roll book of this organization a notice telling the time and place of such annual meeting.

The presence of not less than 50 members shall constitute a quorum and shall be necessary to conduct the business of this organization; but a lesser number may adjourn the meeting for a period of not more than 2 weeks from the date scheduled by these bylaws and the secretary shall cause a notice of this scheduled meeting to be sent to all those members who were not present at the meeting originally called. Any number present shall constitute a quorum at the second meeting and all business transacted be binding upon the organization.

Special meetings of this organization may be called by the chairman when he deems it for the best interest of the organization. Notices of such meeting shall be mailed to all members at their addresses as they appear in the membership roll book at least 10 but not more than 20 days before the scheduled date set for such special meeting. Such notice shall state the reasons that such meeting has been called, the business to be transacted at such meeting and by whom called.

At the request of one-third of the members of the board of directors or one-third of the voting members of the organization the chairman shall cause a special meeting to be called but such request must be made in writing at least 30 days before the requested scheduled date.

No other business but that specified in the notice may be transacted at such special meeting without the unanimous consent of all present at such meeting.

## ARTICLE 5. VOTING

At all meetings, except for the election of officers and directors, all votes shall be viva voce, except that for election of officers ballots shall be provided and there shall not appear any place on such ballot any mark or marking that might tend to indicate the person who cast such ballot.

At any regular or special meeting if a majority so requires any question may be voted upon in the manner and style provided for election of officers and directors.

At all votes by ballot the chairman of such meeting shall immediately prior to the commencement of balloting appoint a committee of two who shall act as inspectors of election and who shall at the conclusion of such balloting certify in writing to the chairman the results and the certified copy shall be physically affixed in the minute book to the minutes of that meeting.

## ARTICLE 6. ORDER OF BUSINESS

1. Roll call.
2. Reading of the minutes of the preceding meeting.
3. Reports of committees.
4. Reports of officers.
5. Old and unfinished business.
6. New business.
7. Good and welfare.
8. Adjournments.

## ARTICLE 7. BOARD OF DIRECTORS

The The business of this organization shall be managed by a board of directors consisting of 55 members together with the officers of this organization. At least one of the directors elected shall be a resident of the Sate of New York and all of the directors shall be citizens of the United States.

Thirty-two directors shall be chosen for the ensuing year at the annual meeting of this organization in the same manner and style as the chairman of this organization and they shall serve for a term of 1 year.

The remaining 23 directors shall be nominated by the 32 directors chosen at the annual meeting and elected by mail referendum of the membership and shall serve until the next annual meeting of this organization.

The board of directors shall have the control and management of the affairs and business of this organization. Such board of directors shall only act in the name of the organization when it shall be regularly convened by its chairman after due notice to all the directors of such meeting.

Ten of the members of the board of directors shall constitute a quorum and the meetings of the board of directors shall be held regularly on the sixth day of February and quarter annually thereafter.

Each director shall have one vote and such voting may not be done by proxy.

The board of directors may make such rules and regulations covering its meetings as it may in its discretion determine necessary.

Vacancies in the said board of directors shall be filled by a vote of the majority of the remaining members of the board of directors for the balance of the year.

The chairman of the organization by virtue of his office shall be chairman of the board of directors. The board of directors shall select from one of their number a secretary.

A director may be removed when sufficient cause exists for such removal. The board of directors may entertain charges against any director. A director may be represented by counsel upon any removal hearing. The board of directors shall adopt such rules as it may in its discretion consider necessary for the best interests of the organization for this hearing.

The board of directors may select from among its members an executive committee which shall function between the quarter annual meetings of the board of directors and shall carry out the policies and directives of the board of directors.

The board of directors shall be composed of at least two representatives of each of the permanent committees of the organization. These permanent committees shall represent each of the fields covered by the arts, sciences, and professions.

The permanent committees will have a chairman and five or six cochairmen elected by the membership of each permanent committee.

The board of directors will appoint at its first meeting an executive council which will be responsible for carrying out the program set forth by the board. This executive council will have representation from each of the subdivisions in the committee. The membership of each subdivision shall recommend to the board of directors one representative and one alternate to serve on the executive council.

#### ARTICLE 8. OFFICERS

The officers of the organization shall be as follows: Chairman, 10 vice chairmen, secretary, and treasurer.

The chairman shall preside at all membership meetings.

He shall by virtue of his office be chairman of the board of directors.

He shall present at each annual meeting of the organization an annual report of the work of the organization.

He shall appoint all committees, temporary or permanent.

He shall see all books, reports, and certificates as required by law are properly kept or filed.

He shall be one of the officers who may sign the checks or drafts of the organization.

He shall have such powers as may be reasonably construed as belonging to the chief executive of any organization.

If at any membership meeting less than 10 vice chairmen have been elected, the chairman shall be empowered to appoint additional vice chairmen, so that the total shall not exceed 10, and said appointees shall serve as vice chairmen until the next annual election.

The vice chairman shall in the event of the absence or inability of the chairman to exercise his office become acting president of the organization with all the rights, privileges, and powers as if he had been the duly elected chairman.

The secretary shall keep the minutes and records of the organization in appropriate books.

It shall be his duty to file any certificate required by any statute, Federal or State.

He shall give and serve all notices to members of this organization. 4

He shall be the official custodian of the records and seal of this organization.

He may be one of the officers required to sign the checks and drafts of the organization.

He shall present to the membership at any meetings any communication addressed to him as secretary of the organization.

He shall submit to the board of directors any communications which shall be addressed to him as secretary of the organization.

He shall attend to all correspondence of the organization and shall exercise all duties incident to the office of Secretary.

The treasurer shall have the care and custody of all monies belonging to the organization and shall be solely responsible for such moneys or securities of the organization.

He shall render at stated periods as the board of directors shall determine a written account of the finances of the organization and such report shall be physically affixed to the minutes of the board of directors of such meeting.

He shall exercise all duties incident to the office of treasurer.

Officers shall by virtue of their office be members of the board of directors.

No officer shall for reason of his office be entitled to receive any salary or compensation, but nothing herein shall be construed to prevent an officer or director from receiving any compensation from the organization for duties other than as a director or officer.

#### ARTICLE 9. SALARIES

The board of directors shall hire and fix the compensation of any and all employees which they in their discretion may determine to be necessary in the conduct of the business of the organization.

#### ARTICLE 10. COMMITTEES

All committees of this organization shall be appointed by the chairman and their term of office shall be for a period of 1 year or less if sooner terminated by the action of the chairman.

The permanent committees shall be as indicated: Theater; radio; literature; films; art; science and technology; music; educators; medicine; dentistry; journalism; advertising, book; and publishing.

#### ARTICLE 11. DUES

The dues of this organization shall be \$3 per annum for general members and associate members, \$10 per annum for contributing members, and \$50 per annum for sustaining members.

The dues of founding members shall be \$100 per annum.

#### ARTICLE 12. AMENDMENTS

These bylaws may be altered, amended, repealed, or added to by an affirmative vote of not less than two-thirds of the members.

#### ARTICLE 13

The board of directors may associate, affiliate, or make any other working arrangement with other working organizations having similar purposes, on any terms or conditions that board of directors in its discretion may deem advisable.  
[SEAL.]

Senator DONNELL. Doctor, I understand you voiced your opinion with respect to what you consider a lack of progressive approach to these problems by the American Medical Association.

Dr. BUTLER. Yes. I am a member of that Association.

Senator DONNELL. Yes. I may repeat again, this is no flattery; I think every man is impressed with the thought and care you have given these problems.

Dr. BUTLER. Thank you.

## THE AMA BUREAUCRACY

Senator DONNELL. Doctor, you refer in your statement to the bureaucracy that dominates the opinion expressed by the so-called organized medicine. Do you mean by that bureaucracy an inner circle within organized medicine, or do you mean the association, as such?

Dr. BUTLER. I mean the inner circle.

Senator DONNELL. The inner circle.

Dr. BUTLER. In any organization as big as the thing like the American Medical Association and with the huge income of the American Medical Association, there unfortunately develops a group whose livelihood depends upon continuing to receive the full time relatively large salaries that are paid by the organization for maintaining the administrative end of their show.

Senator DONNELL. And that group is the group to which you refer as the "bureaucracy"?

Dr. BUTLER. That is right.

The CHAIRMAN. Let me ask a question there. What is the official position of Dr. Fishbein?

Dr. BUTLER. I do not know whether I should mention this, because I am not well informed, but I have inquired, and I have been told that Dr. Fishbein's official position in the American Medical Association is editor of the Journal of the American Medical Association and I think one or two other journals that are published by that association.

The CHAIRMAN. He is not actively engaged in practicing medicine?

Dr. BUTLER. He is not actively engaged in practicing medicine, and, Senator, I would like to take this opportunity to state that unfortunately Dr. Fishbein, including a great many of the people who speak concerning medical matters for the American Medical Association, have rarely if ever practiced medicine, and certainly for years have not been engaged in the practice of medicine.

Senator DONNELL. Doctor, may I ask you, you are in the Harvard medical faculty?

Dr. BUTLER. I am.

Senator DONNELL. And you have practiced medicine to some extent?

Dr. BUTLER. Every day and almost every night.

Senator DONNELL. You are engaged in private practice as well as being on the medical faculty of the Harvard University?

Dr. BUTLER. I see private patients as well as see the public patients I am on a salary caring for.

Senator DONNELL. Doctor, do you know approximately the membership of the American Medical Association, in number?

Dr. BUTLER. Yes.

Senator DONNELL. What is it?

Dr. BUTLER. The American Medical Association never lets you forget. It is about 130,000.

Senator DONNELL. About 130,000?

Dr. BUTLER. Yes.

Senator DONNELL. Are you able to say, Doctor, approximately what proportion of the active practitioners of the United States are members of the American Medical Association?

Dr. BUTLER. Yes, roughly. I should say, roughly—I think Dr. Lawrence is here. He would know better than I would, but roughly, 90 percent.

Senator DONNELL. Roughly 90 percent of the active practitioners in the United States are members of the American Medical Association?

Dr. BUTLER. Can I tell you what that means?

Senator DONNELL. Yes.

Dr. BUTLER. I will give you my own experience. I came to Boston to practice medicine. When I was first there, for 4 years I did not join the State medical society.

Not being a member of the State medical society, I cannot be a member of the American Medical Association.

When I was practicing medicine without being a member of the State medical society, I was invited to give a lecture at the annual meeting of the American Medical Association. Before the annual meeting occurred, I was notified that they had just observed I was not a member of the American Medical Association, therefore, I could not read a paper before it; to which, of course, I replied, "That is all right by me. You asked me to read the paper, and it is really a little inconvenient, so we will call it off."

Then I discovered that I was paying more for my liability professional insurance because I was not a member of the State medical society than I would pay if I were. So I joined. This was about the time of the depression. I joined the State medical society. Immediately, I am a member of the American Medical Association.

Senator DONNELL. That is as an affiliation of the two?

Dr. BUTLER. You just become a member of the A. M. A. when you join the State medical society; and to get the lowest rate of liability insurance, you have got to be a member of the State medical society.

Senator DONNELL. Going back to the percentage, I understand you say that the percentage is about 90 percent of the members of the American Medical Association.

Dr. BUTLER. Right.

Senator DONNELL. There were, some few years ago, steps taken toward the reorganization of governmental affairs of the American Medical Association, which resulted in the creation of the house of delegates of that association. That is correct, is it not?

Dr. BUTLER. That was many, many years ago.

Senator DONNELL. Perhaps it was many years ago.

Dr. BUTLER. Yes.

Senator DONNELL. And the house of delegates consists of representatives from all parts of the United States; does it not?

Dr. BUTLER. Yes.

Senator DONNELL. Do you know approximately the size of the house of delegates?

Dr. BUTLER. No; but it is a good organization in terms of the people who come from local communities to attend the national meeting.

Senator DONNELL. Yes, sir.

Dr. BUTLER. But look over the roster and you will find the same delegates have been coming from the same State medical society for years and years and years.

And if you are really interested in what you seem to be asking me, the political organization of the American Medical Association, read a book by Mr. Garso on the political organization of the American Medical Association and you will see how in that organization there is very little opportunity for the younger members, the members who are going to practice medicine under such legislation as you are considering today, to have any expression of opinion or any authority in the determination of the policies of the American Medical Association.

Senator DONNELL. At any rate, Doctor, the house of delegates is a body composed of, would you say, several hundred members?

Dr. BUTLER. Yes.

Senator DONNELL. Who come from all sections of the United States?

Dr. BUTLER. That is correct.

Senator DONNELL. And they are the governing body and the body which presents the expression of the association which is made during sessions of the house of delegates. That is correct, is it not?

Dr. BUTLER. That is right.

Senator DONNELL. The house of delegates of the American Medical Association has expressed itself, has it not, with respect to compulsory health insurance?

Dr. BUTLER. In the course of the past 15 years since I have been interested in the improvement of medical care, the American Medical Association has expressed itself on anything that has been suggested to include medical care; and, in retrospect, they have been wrong every time they have expressed an opinion. Their record is extraordinary.

You speak of the Blue Cross and what a wonderful thing it is. In 1934, the house of delegates were against the Blue Cross. They have only begun to support it within the last 4 or 5 years.

Senator DONNELL. Doctor, you have made it clear in your testimony and from your statement which you read, your views with respect to the mistakes which the American Medical Association has made.

Dr. BUTLER. Yes.

Senator DONNELL. But the fact remains, does it not, that the house of delegates of the American Medical Association which, as you say, includes approximately 90 percent of the practitioners of this country, has gone on record as being opposed to compulsory health insurance. That is a fact, is it not?

Dr. BUTLER. That is a fact. I do not know how much that fact represents the considered opinion of a vast number of doctors or how much just saying they are opposed to compulsory health insurance, really, even represents thought concerning this legislation.

Senator DONNELL. I understand your query which you raise on that, but the point to which I am addressing your attention at the moment is the fact that the house of delegates of the American Medical Association, which association includes 90 percent of the practitioners, roughly, has gone on record as opposed to compulsory health insurance.

Dr. BUTLER. Yes.

Senator DONNELL. Yes. I understand you disagree with that conclusion. You may be right, you may be wrong; but you are entitled to your opinion.

Now, Doctor, on the first page you mention one sentence which I do not think has anything to do in particular with this bill except as an analogy. You say:

Now, in peace, to prevent the total destruction of ourselves and of our civilization by the latest achievements of science, can we do other than submit to the sovereignty of a world government at the expense of our national independence?

Dr. BUTLER. Surely.

Senator DONNELL. Do I understand from that that you favor the creation of a world government to which there shall be submitted the sovereignty of this Nation at the expense of our national independence?

Dr. BUTLER. I do not favor that at this moment. I think, almost everybody must think, that we have got to look toward that pretty rapidly, or, by golly, our science is just as likely to destroy us as health is.

Senator DONNELL. I wanted to be sure it was your understanding.

Dr. BUTLER. Yes.

Senator DONNELL. As I see it, today we have a United Nations Organization.

Dr. BUTLER. Yes.

Senator DONNELL. To which we are adherents and I take it most everybody is favorable to that adherence, but you are going beyond that, you are talking not about that, you are talking about the sovereignty of a world government to which our national independence must ultimately be submitted. That is your view, is it not?

Dr. BUTLER. I would not say that is my view. I think already in establishing a United Nations just to solve the dilemma science has given us, we are going to have to sacrifice some of our sovereignty and some of our national independence and gradually we are going to have to sacrifice more and more.

Senator DONNELL. Perhaps I am wrong, but I understand in your sentence where you say:

Can we do other than submit to the sovereignty of a world government at the expense of our national independence?

that you are referring to some subsequent step, rather than a step we have thus far taken in going into the UNO?

Dr. BUTLER. Also saying we have taken some steps now.

Senator DONNELL. You think we have taken a step in that direction and a step which, in your judgment, does involve the surrender of some of our national sovereignty?

Dr. BUTLER. Surely.

Senator DONNELL. But it is your judgment that we are going to have to go further into a world government to which there shall be submitted "sovereignty at the expense of our national independence"; that is correct, is it not?

Dr. BUTLER. That is correct. I do not say I like it. I say we are going to have to.

Senator DONNELL. You do not say you like it.

Dr. BUTLER. No.

Senator DONNELL. You are using that illustration as an analogy to the situation which we are confronted with in the medical and surgical field, that is the reason for introducing it in this statement, is it not?

Dr. BUTLER. I am using that as an illustration to show that we are

losing in all fields of endeavor so much of our independence, whether we like it or not, that the relatively little independence that any physician is going to lose under such legislation that you gentlemen will finally write, is in consequential.

Senator DONNELL. I understand that you said a moment ago that you are not saying you like the idea of surrendering ourselves to the sovereignty of a world government.

Dr. BUTLER. Yes.

Senator DONNELL. And may I draw the conclusion that you do not like the idea of the surrender of personal independence of a physician to some type of governmental compulsory insurance.

Do you carry your illustration to that extent, or not?

Dr. BUTLER. Senator, I do not think we are in the fortunate position of being able to decide what we like except in comparison to what we do not like.

Senator DONNELL. Doctor, am I correct in understanding that you do not like tendency toward surrender unto a compulsory system, but nevertheless you feel that the exigencies of the situation will require such ultimate surrender.

Is that your thought?

Dr. BUTLER. That thought, with one addition.

Senator DONNELL. Would you give us that addition?

Dr. BUTLER. And if we do a good job as we surrender some of these independences while we integrate and provide medical service, we will get benefit far more than we will lose.

Senator DONNELL. So you favor the idea of the surrender of some of our independence because of what you think will be the overbalancing gains which we will obtain by such surrender; is that right?

Dr. BUTLER. Only if you gentlemen do a good job.

Senator DONNELL. I understand.

Dr. BUTLER. If you should write a bill that would allow Senator Murray as a sick individual, to ask me, as the doctor, to take care of him at Government expense, and do not write that bill in a manner that will protect the economy of how I render my medicine to Senator Murray, and the quality of that medicine that I render, and, more important, the new knowledge that is coming into medicine today, so that we have our medicine of tomorrow better, then you will do the country a great deal of harm.

Senator JOHNSTON. So you do not want it like some of the agencies render it now?

Dr. BUTLER. That is right. I do not want a cash indemnity type of medicine paid for by Government collection and disbursal of funds. If so, God help the people.

Senator DONNELL. Doctor, is it not a much more simple operation to make mere cash distributions than it is to undertake to provide restrictions, regulations, rules, under which the intimate relationships between a physician and patient shall be determined and outlined? Is that not true?

Dr. BUTLER. It is simpler; but it would be disastrous.

Senator DONNELL. I am not arguing in favor of it, but the point I am making is this: If our agencies fail merely in the distribution of cash which can be computed and paid out in a check, is there not a greater likelihood of insurmountable problems which the Government

will not be able to solve in a system of medicine and surgery emanating from Washington under the terms of such a bill as this?

Dr. BUTLER. I do not believe so, Senator, and I do not believe so because of the record of the United States Public Health Service, because of the record of the Children's Bureau, because of the record of the Army and Navy medicine in the present war, when they were confronted with a terrific job in the midst of terrific chaos and they did a good job.

Senator DONNELL. Doctor, I observe in this article, which you were kind enough to give us, February 21, 1946, issue of the New England Journal of Medicine, which I have not had time to read yet, but which I shall endeavor to read: it is entitled "Minority Views on Improving Medical Care"—

Dr. BUTLER. That is right.

Senator DONNELL. So you did not speak of the majority from whom—I do not know what it was a minority of.

Dr. BUTLER. I can explain.

Senator DONNELL. What is it?

Dr. BUTLER. The Harvard Medical School, in order to try to educate young doctors in the problems that will confront them as practitioners tomorrow, held a symposium, and I think the symposium was composed of some nine lecturers.

The gentleman who spoke at the session before the one at which I spoke was a representative of the American Medical Association, Dr. Bauer, and he gave the American Medical Association's opinion on these matters, and I was asked by the Harvard Medical School to present the minority opinions on these matters.

Senator DONNELL. That is the meaning of this expression?

Dr. BUTLER. That is it.

Senator DONNELL. I see.

Just a few more questions, Doctor. You refer in your statement, to quote it, "the record of leadership of organized medicine is unbelievably reactionary."

I think, as a matter of fact, Doctor, that record is one that is made by an association which is constituted of 90 percent of the practitioners of this country.

Dr. BUTLER. Yes, and whose constitution is such, perhaps quite wisely such, that it cannot be other than about—well, it is according to the rapidity with which things are moving—but at least 5 or 10 years behind. It is inevitable that that association be so in terms of the manner in which its delegates are elected; the manner in which everything is referred to a special committee, which committee has members who were elected 3, 4, and 5 years ago; it is inevitable that such an association is behind the times. They have to be reactionary.

Senator DONNELL. Do you regard organized medicine's opposition to compulsory health insurance to be motivated by selfish reasons?

Dr. BUTLER. I am glad you ask me that, because I would rather not answer it unless it has been asked.

Senator DONNELL. Yes, sir.

Dr. BUTLER. You have asked it.

Senator DONNELL. Yes, sir; I would like to have your answer.

Dr. BUTLER. I think the major part of the opposition—let me put it this way: the major part of the publicity that is given the medical

profession and the lay public reflects a selfish interest in maintaining the interests of doctors who are practicing medicine as they practice it today.

Senator DONNELL. You mean the financial interest?

Dr. BUTLER. Yes, sir.

Senator DONNELL. Yet, Doctor, I observe that your conclusion is, at page 7, quoting,

Such legislation as you are considering is imperative if physicians and hospitals are not to suffer financial embarrassment.

Dr. BUTLER. That is correct.

Senator DONNELL. In other words, as I take it, your view is, and if I am wrong, please correct me, your view is that legislation such as S. 1606 will prove advantageous to the medical profession; second, that in the absence of such legislation of this type, financial embarrassment by the medical profession will generally ensue? Is that correct?

Dr. BUTLER. That is correct.

Senator DONNELL. But in your judgment the medical profession is actuated by what you think are motives of self-interest, they evidently feel the other way, and think that the present situation will prove financially more advantageous than the new system; that is correct, is it not?

Dr. BUTLER. That is correct and not contradictory.

Senator DONNELL. Doctor, may I ask you this: Is it a fact that regardless of the statistics of the number in the association or out of it, is it not your observation that, taken by and large, there is not any more generous, whole-souled, upright, and charitable segment of our citizens than the medical profession, as a general proposition? Is that not true?

Dr. BUTLER. That is true, Senator, but it is equally true that in matters that affect changing the pattern of medical care, the bureaucracy that runs the AMA does not permit free discussion.

Senator DONNELL. But the members of the organization have their house of delegates which meets periodically.

Dr. BUTLER. Yes.

Senator DONNELL. And has it within its power to express the sentiments of the association, anyway that the house may want to present; that is correct, is it not?

Dr. BUTLER. With the limitation that the boys in power, who hold the offices, dominate the committee, can, to a very considerable extent, guide the expression of opinion in the annual meetings and suppress action or opinions that they do not approve of.

Senator DONNELL. However, Doctor, regardless of the point to which you make reference, the fact is that the American Medical Association house of delegates has it within its power under the constitution of that association to make any expression that it may deem proper on any proposition which comes before it. That is correct, is it not?

Dr. BUTLER. That is correct.

Senator DONNELL. How frequently does the house of delegates meet?

Dr. BUTLER. Regularly once a year, and sometimes more often. It makes me smile. I can just imagine what Morris Fishbein will say in the AMA when he understands what I have been talking about

in the hearing on the AMA. He really will have a nice little paragraph in the Journal next week, because I admit I am not too well qualified to answer all these questions. I am trying to do so honestly and sincerely.

Senator DONNELL. You are doing so, and we are glad to have your answers on them. It is interesting.

Doctor, just one further question: The house of delegates does come together once a year and sometimes more often?

Dr. BUTLER. Yes.

Senator DONNELL. Do you know approximately the number of persons who attend those sessions on the average?

Dr. BUTLER. In my ignorance, I think the only people who attend the sessions of the house of delegates are the delegates.

Senator DONNELL. Yes.

Dr. BUTLER. They hold the meeting at the time when they hold the so-called annual scientific meetings of the American Medical Association.

Senator DONNELL. Yes.

Dr. BUTLER. Thousands of people attend those meetings, at which scientific papers are read, you see.

Senator DONNELL. Yes.

Dr. BUTLER. Only a fraction of the total people attending the annual meeting actually participate in the meeting of the house of delegates.

Senator DONNELL. Of course, that is true, because the house of delegates is a smaller body.

Dr. BUTLER. Surely.

Senator DONNELL. But do you know approximately how many people do participate?

Dr. BUTLER. No, I do not.

Senator DONNELL. Is it in the hundreds?

Dr. BUTLER. I think so.

Senator DONNELL. A few hundreds, at any rate, people participate in the meetings of the house of delegates.

Dr. BUTLER. That is right.

Senator DONNELL. And they are widely scattered all over the United States?

Dr. BUTLER. Yes, sir.

Senator DONNELL. And they meet at the time and place at which the scientific association is attended by thousands of doctors?

Dr. BUTLER. That is right.

Senator DONNELL. Doctor, is it not true in your judgment and observation that with thousands of doctors reading papers, listening to papers, discussing professional matters in the same city and perhaps in the same hotels and auditoriums, that there is bound to be an influence on the house of delegates of a professional nature emanating from these thousands of physicians reading their statements, et cetera?

Dr. BUTLER. That is true. And that meeting will have a little effect. It will perhaps have an effect at the meeting which takes place next year or the year after. That is why I say such an organization as the AMA perhaps quite rightly is a very conservative, reac-

tionary organization. It takes years for the opinion of the membership to be expressed by the house of delegates.

Senator DONNELL. There never has been, as far as you know, a meeting of the house of delegates of the American Medical Association to which there has been expressed approval of a compulsory Federal health insurance plan? I am correct in that, am I not?

Dr. BUTLER. You certainly are.

Senator DONNELL. Yes. I think that is all.

#### INCOME OF THE AMERICAN MEDICAL ASSOCIATION

The CHAIRMAN. Doctor, you referred, during your testimony, to the large income of the American Medical Association. Have you any knowledge as to the spending of the funds by the American Medical Association in supplying literature regarding this problem that we are discussing here this morning to the members of their organization in the country?

Dr. BUTLER. Yes; I think I have.

The CHAIRMAN. Do you know anything about the physicians' committee?

Dr. BUTLER. Yes; I do.

The CHAIRMAN. Will you explain what is the physicians' committee?

Dr. BUTLER. Can I answer the first question you asked first?

The CHAIRMAN. Yes.

Dr. BUTLER. The American Medical Association has a large income. That income, in my ignorance, I believe is derived from the payments that each of its members make annually, from the subscriptions to the Journal, which do not amount to very much, but also from the advertisement in the journals published by the American Medical Association.

And the total income is really very great. That income, I think, is expended very wisely and very honestly and very effectively in improving medical care through publication of good journals, through financing its committee that looks into all new drugs, financing committees that have to do with certifying and approval of hospitals, et cetera, I think they do a good job with the expenditure of the money collected.

It is sad, however, that the mere fact that the AMA is so successful as a business in obtaining money from manufacturers almost limits its usefulness to the profession.

They become a vested interest. The people holding the jobs have vested interest in doing what pleases the manufacturer. That is where they get their money, and what pleases the average member of the society and the average member of the society gets his information—it is a sort of vicious circle—from the people who dominate this little bureaucracy in Chicago.

One of the serious things about medical professional opinion is that the journals dominated by the AMA and the State medical society have not allowed free discussion of these subjects which must be wisely discussed if you gentlemen are to arrive at good legislation.

Now, we will take up the second question, shall I?

The CHAIRMAN. Yes.

## THE NATIONAL PHYSICIANS COMMITTEE

Dr. BUTLER. The National Physicians Committee is an organization which was created in order to be the source of propaganda agency of certain groups of doctors—and that group of doctors all being pretty closely associated with the hierarchy of the AMA without in any way involving the AMA in the propaganda. They spent, and have over the last several years, somewhere in the neighborhood of \$200,000 to \$300,000 on propaganda resisting any extension of Government medicine.

The CHAIRMAN. And that propaganda goes to the medical profession in various parts of the country?

Dr. BUTLER. It not only goes to the medical profession. I get a pamphlet once a month—an outrageous, dishonest pamphlet.

But if you buy a drug in a drug store, you will either notice a little pamphlet on the counter, or maybe it will be included in your bill. And the drug companies contribute very heavily to the National Physicians Committee which disseminates that propaganda.

The CHAIRMAN. Well, then, as the result of this propaganda, many members of the medical profession in the country are deceived with reference to these problems and have not been able to make the correct decision.

Dr. BUTLER. They are not so much deceived, in a way, as they are bewildered by it. There is hardly a day goes by that some doctor does not stop me and say, "Put me straight on this that I received this morning in the mail. Is this an organization to whom I should send \$25 in response to this appeal, or is it one of the organizations putting out this terrible propaganda?" About your bill.

The CHAIRMAN. The National Physicians Committee have put out a pamphlet, and I do not remember the title of it now, but it refers to this bill as "political" medicine or "socialized medicine," or something of that kind and those pamphlets were received by the medical profession in various parts of the country. And they rely on it.

I remember appearing before a committee of physicians in this country some time ago, at which the head of the system undertook to make an address and as he opened his address, I recognized some of the language as coming from this pamphlet. I had a pamphlet with me and followed it in the pamphlet, and his speech followed exactly and precisely the words of the pamphlet all the way through.

I did not make any reference to it, because I was a very close friend of the doctor who read the speech, and I did not like to embarrass him, so I dropped it there.

Now, I am satisfied that in every part of the country the medical profession has become aroused by this alleged socialistic program, and are utterly deceived by the propaganda which has come to them from the National Physicians Committee. I do not think there is any doubt about that.

Senator DONNELL. May I ask a few more questions?

The CHAIRMAN. Yes.

Senator DONNELL. Doctor, did you say the National Physicians Committee is connected with the American Medical Association?

Dr. BUTLER. No, I did not.

Senator DONNELL. It is not associated with it directly or indirectly, as far as you know?

Dr. BUTLER. No.

Senator DONNELL. It is financed by manufacturers very largely, is that it?

Dr. BUTLER. I have not seen the recent statement. It is financed both by the contributions of individuals who respond to solicitation, some of them do it voluntarily, and by contributions made by commercial organizations.

Senator DONNELL. Yes.

Dr. BUTLER. May I call your attention to one thing?

Senator DONNELL. Yes, sir.

Dr. BUTLER. I have not seen the propaganda put out this year by that organization, but in previous years they have stated in their appeals for funds that the contributions could be deducted from income tax. That I presented to some people as probably not correct. The director of the National Physicians Committee was written to—

Senator DONNELL. Who was that director?

Dr. BUTLER. A Mr. Pratt.

Senator DONNELL. Where does he live?

Dr. BUTLER. I suppose now in Chicago. He used to be the publicity agent of Mr. Gannett.

Senator DONNELL. Of the Gannett newspaper chain?

Dr. BUTLER. Yes; Gannett newspapers.

Senator DONNELL. I see.

Dr. BUTLER. Before the letter was written to Mr. Pratt, a letter was sent to the Treasury, Was such a contribution deductible? The Treasury quoted the law and said "No," it was not. The Treasury's decision was sent to Mr. Pratt, and the letter said "What do you think about continuing to put on your pamphlet the fact that contributions are deductible?"

Mr. Pratt wrote back and said, "Oh, that does not matter. The Treasury boys will not ever check up on that."

Senator DONNELL. At any rate, Doctor, as I understood you to say, the National Physicians Committee is not connected directly or indirectly, so far as you know, with the American Medical Association?

Dr. BUTLER. No; it is not officially connected.

Senator DONNELL. Is it connected in any way, so far as you know?

Dr. BUTLER. Not in any official organization.

Senator DONNELL. You know of no connection yourself, of any connection between those two bodies, do you?

Dr. BUTLER. Only the connection of the personnel that run the two organizations as independent citizens.

Senator DONNELL. Well, do you mean to say that the president of the American Medical Association is an officer in the National Physicians Committee, or is he? I do not know.

Dr. BUTLER. Obviously not, Senator.

Senator DONNELL. Well, Doctor, you know of no actual connection of the two organizations, do you?

Dr. BUTLER. I know that the personnel that is active in the National Physicians Committee and hold the positions on the boards, are personnel that are very active in the group that controls the policies of the American Medical Association.

Senator DONNELL. Have you completed your answer?

Dr. BUTLER. Yes.

Senator DONNELL. I understood you to say a few minutes ago, in substance, that the American Medical Association, in the expenditures of its moneys, is doing a good piece of work or trying to do a good piece of work.

Dr. BUTLER. A very good piece of work.

Senator DONNELL. A very good piece of work. And it is of advantage to the people of the Nation and to the physicians and surgeons.

Dr. BUTLER. In publishing the journals, the publications, and financing the committees it finances, they are concerned with hospitals, drugs, medical education, and so on.

Senator DONNELL. And those matters are of great importance to the people at large, are they not?

Dr. BUTLER. Of very great importance.

Senator DONNELL. And you say the American Medical Association—at the expense of repetition, I want this to be clear—is doing a very—and you underscored “very” in your language—good piece of work.

Dr. BUTLER. A very good piece of work in those respects.

Senator DONNELL. Yes, sir.

Dr. BUTLER. And now I would like to make that statement clear in terms of any insinuation.

Senator DONNELL. Yes, sir.

Dr. BUTLER. I think the American Medical Association, while it is doing an excellent job in those respects, is involved with a philosophy of medicine. It is involved with propagating a philosophy and continuing a philosophy in medicine, which is one of the serious impediments to improving medical care.

Senator DONNELL. And, Doctor, you regard that as a reactionary characteristic of the association?

Dr. BUTLER. Yes; almost inevitable.

Senator DONNELL. I noted with much interest a little while ago in one sentence you used the two terms “conservative” and “reactionary.” It is true, is it not, that there is a tendency to think we are conservative and the other fellow reactionary?

Dr. BUTLER. Surely.

Senator DONNELL. You mean that in your judgment the American Medical Association has not kept pace with progress?

That is what your thought is?

Dr. BUTLER. Yes.

Senator DONNELL. And yet you do concede by the use of the words “very good” and “excellent” that they are at least trying to do an excellent piece of work along the lines of medical information to the members of the association through the journals and information they disseminate; that is correct?

Dr. BUTLER. That is correct. A good job in terms of medical science and medical knowledge; a poor job in terms of medical sociology and medical economics.

Senator DONNELL. That is your honest opinion?

Dr. BUTLER. Just my opinion.

Senator DONNELL. And there are others who disagree with you?

Dr. BUTLER. Yes.

Senator DONNELL. Just one further question. I notice in your reference at the bottom of this article in the *New England Journal*

of Medicine, there is a paragraph, or an article by I. S. Falk. Is that Mr. Falk who was present here yesterday in the hearing?

Dr. BUTLER. That is the same Mr. Falk.

Senator DONNELL. What is his official connection with the United States Government, if you know?

Dr. BUTLER. I do not know if I know.

Senator DONNELL. If you do not know that is all right.

Dr. BUTLER. But he is a statistician and an economist, I think, in the—I always have to get the two organizations straight—in the Social Security Board, not Administration. Is that correct?

Senator DONNELL. That is the Social Security Agency.

Dr. BUTLER. Not the top one, the one under Mr. Altmeyer.

Senator DONNELL. In other words, it is the Social Security Board.

The CHAIRMAN. I might say, right there, he is Chief of the Bureau of Research and Statistics.

Dr. BUTLER. May I also say that I quoted Mr. Falk in an article that was published in the New England Journal of Medicine.

Senator DONNELL. You quoted him in this article, *Minority Views on Improving Medical Care*, quoted here at page 264.

Dr. BUTLER. But the quote that I have taken is from an article published in the *Medical Journal*.

Senator DONNELL. I see. Just one other question, and that is this, Doctor: Did you personally collaborate in the preparation of S. 1606?

Dr. BUTLER. No; I do not think by any stretch of the imagination I could say that I personally collaborated.

I can say that the committee of which I am a member, namely, the committee of physicians for the improvement of medical care, has, with the first Wagner-Murray-Dingell bill, made a study of all such legislation and published statements criticizing all such legislation.

Senator DONNELL. That committee of which you are a member, that is a committee under what organization?

Dr. BUTLER. Under its own organization.

Senator DONNELL. A separate committee?

Dr. BUTLER. A separate committee.

Senator DONNELL. How many persons constitute that committee?

Dr. BUTLER. Well, it is an odd committee. It is a committee that has an executive committee of about thirty-some people.

Senator DONNELL. Yes.

Dr. BUTLER. And then a very loose association through a mailing list and through requests to be kept informed of the committee's action of about, I imagine, 2,000 people.

Senator DONNELL. Widely scattered throughout the Nation?

Dr. BUTLER. Yes.

Senator DONNELL. That is not the Physicians Forum?

Dr. BUTLER. No; that is another organization.

Senator DONNELL. Let us see, there is the Physicians Forum, and your organization. Am I correct in understanding that those are the only two organizations of physicians who have advocated compulsory health insurance administered by the Federal government? Am I right in that, so far as you know?

Dr. BUTLER. Well, I doubt whether they are the only ones, and I am wondering, for instance, whether the United States Public Health

Association, composed largely of physicians, has not advocated compulsory health insurance.

The CHAIRMAN. But many individual members of the profession throughout the country have advocated it.

You say that the American Medical Association has made very good use of its funds in its publications and so forth. What have you to say as to the use of the funds by the National Physicians Committee? Has their use of the funds been good or bad?

Dr. BUTLER. In my opinion, the material whose publication has been financed by those funds, has muddled the consideration of the problems concerning improvement of medical care. The propaganda is emotional. The propaganda is prejudiced. I think the propaganda is even intellectually dishonest. The problem of improving medical care is a serious problem that should be considered rationally, tolerantly, and intelligently. I do not think the National Physicians Committee has contributed to such consideration of this important problem.

The CHAIRMAN. And the propaganda has succeeded in confusing the minds of many members of the medical profession as well as individual citizens?

Dr. BUTLER. Yes.

The CHAIRMAN. Thank, you, Doctor.

Senator JOHNSTON. Doctor, do you think this bill ought to take care of the osteopaths and chiropractors?

Dr. BUTLER. I think the best way to handle that is almost to leave it alone. I, as a physician, have refused to pay any attention to the arguments pro and con of osteopaths and chiropractors.

In a democracy we have to be tolerant. We have to permit people to do what they want to do as long as they do not transgress our laws. In doing so, we sometimes benefit, we sometimes suffer.

I just would rather avoid any questions on osteopaths and chiropractors.

Senator JOHNSTON. You think they do good, do you not?

Dr. BUTLER. I would rather not answer that question, because to answer it, you would have to define when they did good, possibly, and when they did harm. It is awfully hard for somebody to live in this world and not do some good some time.

Senator JOHNSTON. The same is true in the medical profession, sometimes they do good and sometimes they do harm?

Dr. BUTLER. That is right.

It is all a relative matter.

The CHAIRMAN. Thank you very much for your able statement here this morning, Doctor; we thank you.

The next witness will be Rev. Francis W. McPeck.

#### STATEMENT OF REV. FRANCIS W. McPEEK, CHAIRMAN, LEGISLATIVE COMMITTEE, COUNCIL FOR SOCIAL ACTION, CONGREGATIONAL-CHRISTIAN CHURCHES

The CHAIRMAN. Reverend, will you state your full name for the committee, and also what organization you represent and what your official position is?

Reverend McPEEK. Mr. Chairman and gentlemen, I am the Reverend Francis W. McPeck, chairman of the legislative committee of the council for social action, Congregational-Christian Churches.

With your permission I should like to take a moment to explain by what authority I appear here this morning in order to give support to the national health program outlined in this bill.

#### THE CONGREGATIONAL-CHRISTIAN CHURCHES

Membership in the Congregational-Christian Churches is at present slightly in excess of 1,000,000 persons. We lay great emphasis on our traditional policy of congregational autonomy; that is to say, a policy under which each congregation reserves to itself the right to manage its own affairs. Individual churches, however, are joined together in both regional associations and a national body.

Each congregation also reserves to itself the right of formulating its own opinions on social questions. Denominational pronouncements are not binding on individual churches, nor are the declarations of any other bodies established by the general council of the denomination.

Created by action of the general council is an official organization known as the council for social action of the Congregational-Christian Churches. Its 18 members, whose names and occupations are appended, are elected by the general council in its regular sessions. Their duty is to make a study of important moral or social questions, to determine Christian action in light of the social teachings of our church, and to inform member churches of their judgments. They are also empowered to represent themselves on these questions in such places and at such times as seem appropriate to them. Our witness this morning is a member of the council for social action, and, as such, is thoroughly familiar with the attitude of his colleagues.

The legislative committee of the C. S. A., of which I have been chairman for several years, has been established for the special purposes of advising our fellow church members and other church groups of legislative issues significant to the welfare of the Nation. Although our staff spends virtually all of its time in research and in preparation and dispatch of educational materials, we are authorized, too, to express an opinion as a committee whenever we are unanimous, or nearly so.

I am afraid, Mr. Chairman, that I have been a bit tedious in explaining these matters, but I do so wish to make it clear that we have no mandate from the denomination as a whole. We could not have, short of an action by the general council. Nonetheless, we are giving the informed judgments to your committee of those members of our church who have been authorized to act in the ways I have described, and who have been at great pains to study the facts of America's health and the remedial proposals in this legislation. The 31 church members we represent have all considered the matter in detail and I think it not too much to say that we are about to offer testimony to which the majority of our denomination would freely subscribe.

For several years we of the legislative committee—and of the council for social action—have held firmly to a conviction that the existing plan of social security should be expanded and implemented. I shall not read the various sections of this policy statement, but shall mention only the paragraph most relevant to the matter at hand.

4. We hold that sickness and accidents cause social losses which can best be paid by a sound plan of public insurance. We believe that health and disability

insurance can be provided on a democratic basis with full consideration for the rights of doctors and private hospitals.

Under such a declaration we have published our support to S. 1050 in principle—the Wagner-Murray-Dingell bill—and to S. 1606, the national health insurance plan, introduced by the same distinguished Members of the Congress.

#### ENDORSEMENT OF S. 1606

This morning we direct our attention to the latter bill in particular.

In general, we believe that the compulsory health tax plan outlined therein is eminently fair to all citizens, as it is to all physicians. Under its several features, we believe that America's health gains in the last 10 years especially, would be conserved, and that our present distressing marks of ill health, so incontestably demonstrated by the selective-service health inventory, would tend to be much more rapidly eliminated.

As Christians, we have the duty of observing faithfully all the rules of health modern medicine devices; and in securing, in time of illness, the best kind of medical assistance available. Christian social obligation requires that we see to the health of our neighbor, first because he is our neighbor, and secondly because his health, or ill-health, directly affects us. We believe that the national health plan contains the method by which these universally admitted Christian ethical objectives may now be most effectively reached.

Having made these brief general remarks, Mr. Chairman, it is now my pleasure to introduce the distinguished physician who will speak on the particulars of the bill. A graduate of the Northwestern University School of Medicine, Dr. Theodore K. Lawless has studied not only at Talladega and the University of Kansas, but also in European schools of medicine. His residence is in Chicago, where he has an extensive practice in his field of specialization, dermatology and also syphilology. I might further add that Dr. Lawless is a member of the American Medical Association, and a member of the council for social action of the Congregational-Christian Churches, for which latter organization he appears today.

Senator DONNELL. Pardon me, Mr. Chairman, may I ask a few questions?

Reverend McPEEK. Certainly.

Senator DONNELL. I did not understand the interpolated specialist that you referred to.

Reverend McPEEK. Syphilology.

Senator DONNELL. I see. Another thing I would like to ask the witness, if I may: have you personally studied the bill, S. 1606, Reverend McPeek?

Reverend McPEEK. The legislative committee, which I am representing here this morning, has for the past 2 years held numerous discussions with experts first on the original Wagner-Murray-Dingell bill and secondly on this present bill. I do not know that all members of our committee have had the bill at hand. Our attention has particularly been paid to the digest of the provisions of it.

Senator DONNELL. Who prepared that digest, if you know?

Reverend McPEEK. I have here the papers, if you will pardon me a moment.

Senator DONNELL. Certainly.

Reverend McPEEK. I am afraid, sir, my papers are not in such order that I can produce that; but I shall be glad to do so.

Senator DONNELL. Would you be kind enough to file that for our records, together with the information as to who prepared it?

Reverend McPEEK. I would be glad to.

(The document referred to was 4781-A of the Social Security Board.)

Senator DONNELL. May I refer to the question again, have you personally studied the bill, S. 1606?

Reverend McPEEK. I have not read the bill as presented.

Senator DONNELL. You have studied the digest?

Reverend McPEEK. I have studied the digest.

Senator DONNELL. Very well.

Reverend McPEEK. And I have read in its entirety the original Murray-Wagner-Dingell bill.

Senator DONNELL. Very well.

#### STATEMENT OF DR. THEODORE K. LAWLESS, ACCOMPANIED BY REV. FRANCIS W. McPEEK

The CHAIRMAN. You may state your full name and your profession.

Dr. LAWLESS. I am Theodore K. Lawless, dermatologist and syphilologist.

The CHAIRMAN. I wish to say that we have on the list of witnesses this morning four witnesses, and the time is very short. I am wondering if it would be possible for you to file your statement and merely summarize it?

Dr. LAWLESS. Well, Senator, all we have here, practically, is a summary.

The CHAIRMAN. I see.

Dr. LAWLESS. We are not going into an extended discourse because I am representing not the medical side of this but the church side of it.

The CHAIRMAN. I see.

Dr. LAWLESS. It will take about 5 minutes or 6 minutes.

The CHAIRMAN. You may proceed to read it. I wish to say at this time I am compelled to leave, and I will ask Senator Donnell to continue the hearing.

Senator DONNELL. What is your pleasure in regard to other witnesses?

The CHAIRMAN. If we could hear them, it would be very satisfactory to me, because they perhaps would not like to be compelled to come back here again. If you could hold the hearing later in the afternoon, if you do not finish them this morning, then we could recess until next Tuesday.

Senator DONNELL. I observe on this schedule tomorrow—

The CHAIRMAN. That has been canceled. We will recess until Tuesday at 10 a. m.

Senator DONNELL. Tuesday at 10 a. m. at a place to be announced.

The CHAIRMAN. Yes.

(Whereupon the chairman retired from the committee room and Senator Donnell assumed the chair.)

Senator DONNELL. Very well; I will proceed. Doctor, may I ask you one question before you begin your statement? I am not informed as to the nature of the sciences which Reverend McPeck mentioned.

Dr. LAWLESS. Diseases of the skin, that would be dermatology; syphilology would be venereal diseases.

Senator DONNELL. Yes; I assumed it had something to do with that. Go right ahead.

#### INADEQUACY OF HEALTH CARE

Dr. LAWLESS. The Congregational Christian Churches, because of their experience gained in religious and educational work in certain sections of the country, have become acutely aware of the large amount of suffering caused by the inadequacy of medical care and the economic results of illness. Statistics released by the Selective Service System as well as data compiled by other qualified and recognized organizations and individuals, lend further support to these views.

Some indications of our health status are clearly shown from statistics of the Selective Service System. Between 30 and 40 percent of all male registrants were rejected from full military service. It must be revealed that these figures refer only to males. Inasmuch as the female rate of illness is usually higher than that of males, the figures above do not reveal the true picture. It is possible that if a complete survey of the entire Nation were made on the same basis, a much more astounding condition of health would be disclosed.

It is significant that many of the rejections were due to remedial defects and probably would not have existed had there been available the facilities which the Wagner-Murray-Dingell bill will provide. Referring to the Medical Annuals of the District of Columbia, it has been estimated that nearly 7,000,000 persons on an average are incapacitated every day.

Senator DONNELL. That is in the United States?

Dr. LAWLESS. In the United States.

Senator DONNELL. Thank you.

Dr. LAWLESS. We are also confronted with the increased span of life now being enjoyed by the peoples of this country. In 1900 17 percent of the total population were 45 years or more; in 1940, 26.5 percent are over 45 years of age. The fact is that 85 percent of our chronically ill are over 35 years of age. Thus with the increasing span of life our responsibilities for their care also increase. The passage of the national health bill would provide a ready answer for this increasing responsibility.

#### WEAKNESSES OF VOLUNTARY PLANS

The opposition point of view:

The establishment of voluntary nonprofit prepayment plans for the costs of hospitalization and voluntary nonprofit prepayment plans for medical care.

Senator DONNELL. May I interrupt? That does not seem to be a complete sentence, as I read it. Is that right?

Dr. LAWLESS. This?

Senator DONNELL. What you have quoted.

Dr. LAWLESS. I have only quoted a part of the sentence. That is that they are offering against this bill this idea.

Senator DONNELL. The thought I had difficulty getting was, what is the meaning of that sentence?

Dr. LAWLESS. That is the opposition point of view.

Senator DONNELL. And I also observe, immediately following what you have just read, that there appears in the typewritten copy which Rev. Mr. McPeck has furnished me, the words 'Against this.' I would like to understand what the proposition is, and I cannot understand incomplete sentences.

Dr. LAWLESS. The American Medical Association is, of course, in favor of establishment of voluntary nonprofit prepayment plans.

Senator DONNELL. I get your point. Thank you.

Dr. LAWLESS. Against this we offer these figures and facts:

Voluntary hospital care plans cover about 23,000,000 persons with only partial protection. Medical-care insurance covers only four to five millions.

Voluntary plans are lacking in forceful appeal to those most in need of them.

They appeal especially to the poorest risks and thereby present a cost item above the ability of the ones most in need to meet.

Neither do they fill the need of increased hospitals, laboratories and research facilities.

#### INADEQUATE LOCAL FACILITIES

The second opposition point:

The provisions of health and diagnostic centers and hospitals necessary to community needs is an essential of good medical care. Such facilities are preferably supplied by local agencies, including the community, church and trade agencies which have been responsible for the fine development of facilities for medical care in most American communities, up to this time.

May I present a picture of a community in a western State. The nearest civilian hospital 40 miles away is owned by a large mining concern, to serve its own health needs. They refuse service to many people on the grounds that space is not available and the medical staff too small, or that they lacked the necessary funds. They came to depend upon a nearby military hospital, which could only accept those who presented emergency problems, thus many waited too long and came too late. This could be magnified thousands of times.

#### THE ISSUE OF REGIMENTATION

The third opposition point is the regimentation of physicians. It is claimed by some that this regimentation of the medical profession will break the spirit of initiative of the profession. I ask you to consult the figures of the Army, which is the most highly regimented body in America, and they will reveal that a very high percentage of their medical personnel is applying for the opportunity to increase their knowledge of their chosen profession with more intensive graduate study.

#### ADVANTAGES OF THE NATIONAL HEALTH BILL, S. 1606

*Doctor-patient relationship.*—Facilitating the method of payment for medical care will improve, not hurt, this relationship. Citing a personal instance, I have at present a list of 14 cases of syphilis of the

brain whose span of productive living could be extended from 10 to 15 years. They are not receiving treatment due to lack of full facilities. Passage of the national health bill would provide for these.

*Quality of medical care.*—Not only will doctors and health services be more readily available to the public under S. 1606 than before, but the quality of medical care will be higher. Truly scientific care will be possible when patients have access to all facilities, institutional care, specialist care, laboratory procedures, et cetera.

*Health education.*—The majority of cases of venereal diseases, which could be reduced to insignificant proportions due to specific methods of treatment, was due to, among other factors, lack of proper health education. Such measures as proposed by S. 1606 will markedly reduce these diseases by increasing knowledge of the course and effect of diseases. This opinion reflects the experience of the venereal-disease control officers of the American Army.

*Medical care for minority groups.*—Compulsory health insurance will help to make medical care equally available to all. The position of the minority groups, from a health point of view, is pathetic. The wife of a minority group member who had given more than 30 years of his life as a public servant recently related to me her experience in trying to have him admitted to St. Luke's Hospital on a special service where the established rate was \$80 per week. For him they demanded \$1,500 per month.

Senator DONNELL. Doctor, by "minority group member," do you mean a member of the Negro race?

Dr. LAWLESS. Negroes, Mexicans, Japanese, Chinese.

Senator DONNELL. I meant this particular person.

Dr. LAWLESS. That is a Negro. The next one will be a Japanese.

Senator DONNELL. Very well.

Dr. LAWLESS. A doctor made all arrangements to operate on a patient in a well-known hospital, yet when she presented herself admission was refused. She was a member of a minority group.

Multiply these cases by 16,000,000 and you have a vivid picture of the plight of these minorities in more than 90 percent of American hospitals under today's plan for medical care.

The more recent advances in scientific medicine cannot reach their full advantages until all physicians are capable of applying them in practice. Under our present system, this opportunity is denied a large segment of our medical personnel either because facilities for learning are not available, or if they do exist, they are denied them, for example, medical schools, medical societies, hospitals, hospital staff meetings, clinics.

Tuskegee Institute and the National Tuberculosis Association and some of its State chapters have instituted annual postgraduate courses in an attempt to fill in the gap. Though the attempt is laudible, the results are highly disproportionate to the full needs. S. 1606 provides opportunities for graduate medical education by providing financial assistance to institutions of learning.

#### HEALTH IS A GOVERNMENT RESPONSIBILITY

The health of its nationals is a Government responsibility. When the physical and moral fibers of a people disintegrate it is reflected in

the central government. Therefore, we urge a single responsible agency, the National Public Health Service, as the agency authorized to administer this service aided by members of the professional groups—doctors, nurses, dentists, and representatives of the recipients of these services.

I am testifying in behalf of the Church whose particular interest is not political or even economic, except secondarily, but which is primarily concerned with the alleviation of human suffering. In our extensive experience in educational fields we have observed the intense suffering of masses of people in certain sections of the Nation from neglected illnesses. The communities in which these people live show an utter lack of concern for the miseries of their fellow mankind. They are apparently unaware of the simple fact of the tremendous economic loss involved or the failure of a significant potential contribution to American life. It is the duty of the central Federal Government to arouse, stimulate, and even goad these backward localities to provide the opportunities to acquire and maintain good health and the full American expectancy of life. This is the birthright of every citizen.

Senator DONNELL. Doctor, have you examined with what you consider reasonable care the specific provisions of S. 1606?

Dr. LAWLESS. The epitome edition of it, as we find in the National Health Act, 1945, Senate committee, No. 2.

Senator DONNELL. I am not familiar with that publication.

Dr. LAWLESS. That is printed for the use of the Committee on Education and Labor, United States Government Printing Office, Washington, 1945.

Senator DONNELL. Would you mind letting me see that just a moment, sir. [Witness hands document to Senator Donnell.] This relates to the National Health Act of 1945. I see. Now, Doctor, have you studied the question as to whether or not there is any limitation in S. 1606 upon the number of patients whom a doctor may receive in communities in which the per capita plan of payment is adopted?

Dr. LAWLESS. I think the Surgeon General's office has been given the right to limit that number to about 500. I think that is the figure.

Senator DONNELL. Is there anything in S. 1606 that mentions the number?

Dr. LAWLESS. There is something there about his ability to control the patients and the amount of the pay.

Senator DONNELL. Are you referring to subdivision (j) of section 205, or does the epitome to which you refer go into detail?

Reverend McPEEK. The publication states the objectives.

Senator DONNELL. I see. Doctor, are you familiar with the digest of the bill to which Mr. McPeek referred?

Dr. LAWLESS. Which digest was that?

Senator DONNELL. I do not know.

Reverend McPEEK. I believe that he is not.

Senator DONNELL. You do not think you are familiar with that digest?

Dr. LAWLESS. I am familiar with this digest and the digest as given by Senator Wagner.

Senator DONNELL. I see. You have been practicing medicine in Chicago for a number of years?

Dr. LAWLESS. Twenty-three.

Senator DONNELL. Twenty-three years. And you have studied at the University of Kansas and Talladega and European schools of medicine.

Dr. LAWLESS. That is right.

Senator DONNELL. What schools of medicine?

Dr. LAWLESS. The University of Paris, the University of Vienna, and the University of Freiburg, in southern Germany.

Senator DONNELL. And you have specialized in these two specialties, dermatology and syphilology?

Dr. LAWLESS. That is right.

Senator DONNELL. Is there anything further you have to present, Doctor, that you think would be of value at this time?

Dr. LAWLESS. No; we made no attempt to bring figures, because from the reports I read you had all the needed figures. We wanted to emphasize that our position is a humanitarian position and that this bill would provide what the American people have been lacking, especially when we read these reports of 26.4 percent of the young fellows between 18 and 35 who have been returned because of deficiency in education, 24 percent for venereal disease, 17 percent for mental deficiency. There must be something wrong with the medical care of an American young person. We think that this bill may provide an answer for it.

Senator DONNELL. Reverend Mr. McPEEK, is there anything further you would like to say?

Rev. Mr. McPEEK. I would like to reiterate what I did say, that our approval is given in principle. I do not believe we attribute anything to the particular formulation of the law. However, as Dr. Lawless has said, we have studied the principles of it, and we support them entirely.

We wish again to make it clear we are speaking for a limited group of the members of our churches.

Senator DONNELL. Yes, sir. Unless you gentlemen have something else to offer, I thank you very much indeed for your courtesy in coming before the Committee.

The next witness is Dr. Joseph P. Anderson.

#### STATEMENT OF JOSEPH P. ANDERSON, EXECUTIVE SECRETARY, AMERICAN ASSOCIATION OF SOCIAL WORKERS

Senator DONNELL. Dr. Anderson, for the record will you please identify yourself as to the capacity in which you appear here, and as to your previous experience, and educational background along the line that we are considering.

Mr. ANDERSON. My name is Joseph P. Anderson. I am the executive secretary of the American Association of Social Workers.

First as to myself. I was a practicing social worker for some 10 years working in private and also public agencies in settlement houses, in council for social agencies, as Director of the Emergency Relief Administration for two counties in Pennsylvania. I also worked with the housing authority in Pittsburgh, and with the veterans' housing in Washington, and then took my present job in May of 1943.

## THE AMERICAN ASSOCIATION OF SOCIAL WORKERS

The American Association of Social Workers is a professional organization of practicing social workers. We are much younger than the medical or the bar association. We are celebrating this year our twenty-fifth anniversary.

We have approximately 1,000 members in all sections of the country. They are employed in both private and public welfare agencies. We are organized in 96 chapters. Though our members become members of a national organization, they can affiliate in groups in areas where there are a sufficient number for them to do so.

Our purposes are twofold. First of all, we are concerned about improving the quality of social work in the same way Dr. Butler told you the AMA tries to do. We make studies and collect data and publish reports. We issue a magazine which goes out to all of our members and others who wish to subscribe to it.

We have annual meetings at which papers are presented with the idea of bringing our members up-to-date information about the developments in practice and increase in knowledge.

Our second purpose is to make available the knowledge that we have gained from our education and experience in terms of developing social programs.

When we first started we were concerned with what happened to the individual and thought that when people came to our agencies for care that all we could do was to give them either financial or other kind of assistance to help them. It was a job of alleviation.

But in the last 25 years we have discovered that many of the problems we have to deal with—dependency, break-down of families, break-down of individual morale—frequently are caused by outside facts, by environmental factors. For example, we are convinced that the low income from loss of a job has a very great effect on people, and we now believe that there is no substitute for a good job and decent wages and decent conditions. We see how overcrowded and bad housing, lack of education and recreation, can contribute to these problems.

That is why we are concerned about seeing that the people get adequate medical and public health services, because the lack of those services also contributes to the many problems that we have to deal with; and we want to make available that knowledge first to this committee to say that we believe that there is a need for more adequate public health and medical care services.

We operate in this way in presenting testimony: We try not to, or very rarely, take action on specific legislation. We develop a statement of principles as other organizations do, and that serves as our platform to indicate what our position is in relation to developing programs.

We have been concerned for a long time with medical care and public health service, and in 1941 we first issued a very brief statement in which we stated that it is the responsibility of Government, together with the medical profession, to see that all the people who are in need of medical care and public health service receive that. We take such action at the annual delegates conference, to which the representatives

of our various chapters come, and then by majority vote at that conference we adopt the statement of principles such and such.

Senator DONNELL. When was the most recent conference held?

Mr. ANDERSON. The most recent was in the middle of May of 1944. We did not have one in 1945 because there were no conferences being held. Our next is going to be held this coming May.

Senator DONNELL. Where was the May conference held in 1944?

Mr. ANDERSON. Cleveland.

Senator DONNELL. How many persons, approximately, were present?

Mr. ANDERSON. About 200.

Senator DONNELL. About 200. What is the total membership?

Mr. ANDERSON. 11,000.

Senator DONNELL. 11,000. How widely scattered were these 200?

Mr. ANDERSON. They came from 72 of our chapters, which represented a minimum of 36 States.

Senator DONNELL. A minimum of 36 States. This 200 met in this conference in May 1944, in Cleveland?

Mr. ANDERSON. That is right.

Senator DONNELL. Is there any specific resolution or principle they adopted at that time?

#### ENDORSEMENT OF S. 1050

Mr. ANDERSON. Yes. At that time the original Wagner-Murray-Dingell bill had not come up for hearings but had been introduced, and the action we took was first to endorse in principle S. 1050, and also to urge that hearings be started on that immediately. Those resolutions were communicated to the appropriate committees in both Houses.

Senator DONNELL. Would you provide for our records copies of those?

Mr. ANDERSON. Yes. I do not have them with me, but I shall be glad to furnish them.

Senator DONNELL. That is all right.

Mr. ANDERSON. Since that time we have been interested in continuing our study. This last year we had a committee that we call the Committee on Public Social Policies, which is composed of representatives of several chapters, which meets in Washington. It has looked at the social-security legislation. We looked again at S. 1050; and then when the new National Health Act came in we looked at that. I can report I have read it not once but several times. I have also read a good many digests of it; and in terms of principles that we have outlined, and also in terms of the provisions of the present bill, our board—and I should make it clear that I am not speaking now for the entire delegate conference—our board which met in New York on February 28 and March 1 and 2 authorized me to represent the association in saying that we support the kind of legislation which is in line with the principles that we have adopted, the board has adopted, and which will now come up for final action at our May 15th meeting.

Senator DONNELL. Mr. Anderson, may I interrupt to ask you two questions. First, how large a meeting was this that was held in New York?

Mr. ANDERSON. About 30 people.

Senator DONNELL. About 30 people present at that board meeting. Did they specifically authorize you to appear here in behalf of S. 1606?

Mr. ANDERSON. Well, at that time I can say that they did, yes, because I have the authority to appear at hearings in connection with legislation.

Senator DONNELL. You do not mean the particular bill.

Mr. ANDERSON. The number was not mentioned specifically.

Senator DONNELL. Was there a resolution passed by the board for authority to you?

Mr. ANDERSON. The principles were reviewed, and the minutes of the meeting indicate that these principles were adopted by the board.

Senator DONNELL. Would you mind furnishing for our records a copy of whatever portion you deem appropriate from those minutes?

Mr. ANDERSON. I would be glad to.

Senator DONNELL. Very well. Proceed, Mr. Anderson.

Mr. ANDERSON. Now, in terms of the statement, I do not think I need read that and take the time. It merely states that we support the provisions, we believe in S. 1606, because we believe in supporting progressive development of public social and health services. We believe that health is a basic right of our people in the community. We think that at the present time people are not getting these services. And then I mention the four factors, which I am sure have been presented before to this committee, as to why the services are not now available, and then we mention the principles which we believe any legislation should be based on.

And I believe that favorable action on this particular bill will represent a courageous and comprehensive attempt to break the old and vicious cycle of poverty begetting sickness and sickness begetting poverty.

Senator DONNELL. You desire to file your statement, I judge?

Mr. ANDERSON. That is right.

(The statement referred to is as follows:)

#### STATEMENT FOR THE SENATE COMMITTEE ON EDUCATION AND LABOR

Prepared for hearings on the National Health Act by Joseph P. Anderson, Executive Secretary, American Association of Social Workers, 130 East Twenty-second Street, New York 10, N. Y.

The American Association of Social Workers supports the provisions of the National Health Act, S. 1606, because it believes in and supports the progressive development of public social and health services. Since the founding of this democracy, such services have been recognized as a proper function of government. They now constitute one of the most important aspects of the relation of government to all the people. These services will not have reached a desirable level of operation until practical measures have been adopted which assure the economic, social, and physical well-being of every person in the United States, its territories and possessions. This objective requires national leadership and the combined resources and cooperation of all levels of government—Federal, State, and local. It is the responsibility of the Federal Government to assure that these services are provided. State and local governments should take advantage of Federal provisions with appropriate implementation to assure benefit to all the people.

#### BARRIERS TO ADEQUATE MEDICAL CARE

We believe that good health is a basic right of all the people and a responsibility of the community. To obtain and preserve good health all of our people must have public health services and good medical care in addition to sufficient and satisfactory food, shelter, and clothing. At the present time the people of this country are not getting the public health and medical care services which they need.

There are many factors which create the gaps between the services which are received and the services which are needed. I would like to reemphasize four of these factors:

1. The unpredictability of the individual case of illness in nature, occurrence, duration and severity which leads to the unpredictability of the variety, amount and cost of services and makes individual budgeting difficult or impossible for a large number of families.

2. The neglect of preventive measures and consequent increase in serious illness.

3. The inability of a large proportion of our people to pay for adequate health and medical care services under the traditional method of payment through fee for service at the time the services are needed.

4. The inability of many families to obtain hospitalization except for extremely serious conditions or emergency treatment and the inability of the smaller and less prosperous communities to provide adequate hospital and health facilities from their own resources.

To overcome these barriers and to bring about the high level of national health which this country can and should achieve, there is need for a comprehensive health and medical care program. Such a program should be based on the following principles:

#### PUBLIC HEALTH SERVICES

1. Provisions for public-health facilities and services should be extended and strengthened. They should be made available in all communities according to their public health requirements.

2. The highest standards of public-health services must be assured to all persons and communities in every part of the nation.

3. Education and training of administrative, professional, and technical personnel should be encouraged to increase the supply of qualified staff for programs of public health services.

4. Continuous, systematic study of health problems, and full application of existing knowledge of preventive medicine and sound public health practice are essential to attain public health services of a high quality.

5. A single responsible agency is a fundamental requisite to effective administration at all levels, Federal, State, and local. The public health agencies—Federal, State and local—should carry major responsibilities in administering the public health services of the future. The Federal Government should be responsible for joint financing, setting, standards, supervision, and coordination.

6. The activities of the multiple national, State and local agencies should be coordinated with the services provided by a federal program of public health services.

#### MEDICAL CARE

1. Complete preventive and curative facilities and services should be available to all, under conditions that assure early diagnosis and treatment.

2. Such care should include the services of general practitioners and specialists, hospitalization, and the services of dentists, nurses, medical social workers and other appropriate personnel working under professional supervision. Convalescent care, necessary drugs, medical supplies and all auxiliary services should be provided.

3. These services should be available for as long as a person requires them.

4. The highest quality of medical care must be assured to all persons and communities in every part of the Nation.

5. The conditions under which doctors function should encourage the maintenance and improvement of quality of service. The use of hospitals as medical education centers and provision of service through group medical practice should be encouraged.

6. Basic laboratory and clinical research and administrative studies and administration designed to improve the quality and lessen the cost of services should be continued. There should be a full application of existing knowledge to the prevention of disease so that all medical practice will be permeated with the concept of prevention.

7. Quality of medical service depends on well-trained administrative, professional and technical personnel, essential equipment and appropriate supplies for medication both preventive and curative, appropriate organization to insure proper distribution of this personnel and facilities so that they will be readily available regardless of cost to all the people.

8. Policy making in administration of medical care programs is a joint responsibility of consumers, physicians and related professional groups.

9. Federal leadership with decentralized administration is essential to insure that comprehensive medical services and facilities shall be physically and financially available to all the people.

10. All professional services in a plan for medical services must at all points be under the supervision of the appropriate professional personnel.

11. At the local level, medical care resources should be so coordinated and administered as to encourage their full use and to insure good quality of service.

12. Channels must be available for the patients, hospitals and physicians to obtain a fair and adequate hearing involving any of their rights in relation to medical care.

We believe that the provisions of the National Health Act are in keeping with the principles given above. It provides for adequate coverage; it provides for a program comprehensive in scope and of a high quality adequate to meet the needs of all the people; it provides for an organization and a system of administration to carry out the responsibilities which are accepted and it makes provision for personnel qualified to offer the necessary services.

It represents a courageous and comprehensive attempt to break the old and vicious cycle of poverty begetting sickness and sickness begetting poverty.

Senator DONNELL. May I ask you, have you ever practiced medicine?

Mr. ANDERSON. No, sir.

Senator DONNELL. Of what institutions are you a graduate?

Mr. ANDERSON. Of Western Reserve University, where I have a master's degree.

Senator DONNELL. In Cleveland?

Mr. ANDERSON. Cleveland, Ohio.

Senator DONNELL. You have a master's degree?

Mr. ANDERSON. That is right. I might mention that our knowledge comes from the fact that we see what the effects are of the lack of adequate medical care, and we know, for example, that many of the people who come to social agencies come there because they either were not able to obtain the necessary health and medical care services, or did not have information about preventive measures which could have helped them maintain good health.

And I would like to say, also, that I am talking not only about the very poor. I am talking about people in fairly comfortable circumstances. We see time after time in the records of our agencies where a chronic appendicitis develops into an acute stage, where an ear trouble develops into a mastoid, where a severe accident or illness, particularly to the chief wage earner, means that the family which has been self-sustaining, has been going along on its own way, not asking for help, has as the result of that acquired large debts and then found it necessary to seek assistance. It is because we know what happens to people, because we know the break down that occurs, we know what happens to children, that we think we ought to have a better system than we now have of providing medical care and health services at the time they are needed.

Senator DONNELL. Thank you, Mr. Anderson. Do you desire to supplement your statement by any further statement? You may have that opportunity at this time. Your written statement, of course, will be filed and made a matter of record.

Mr. ANDERSON. I could not help overhearing some of the questions that were raised before, and I would like to make one or two observations.

Senator DONNELL. Very well.

Mr. ANDERSON. One relates to this fundamental question of whether we give up some of our rights of independence when we enter into a system like that, and I think we hear of—at least, I have seen in recent material—the threat of regimentation and political medicine.

Well, it seems to me that to see that if the greatest good for 130,000,000 people in this country is to be achieved in some areas, we need a little regimentation.

For example, I own a car, and I pay for a license. I also pay taxes, and buy gas, to have roads built by the Government, and I ask the Government and I want the Government to build those roads. Because I am free an independent I would like to ride on those roads the way I want to, but the Government tells me I cannot, that I ride on the right-hand side, when I come to a stop light and it is red I have to stop, that there are certain places I cannot park, that there are speed limits. That is regimentation, but I accept that.

Senator DONNELL. I take it you recognize that that is an illustration of a police regulation that has proved essential? You appreciate that fact?

Mr. ANDERSON. But it is something a little bit more than a police regulation. It seems to me that it is an agreement that we as a people have agreed to as good for us. The kind of regimentation I object to is where one person says, "This is what all the people are going to do." But where we in a democracy make a decision as to how we want to do a certain thing, and when it goes through the processes of coming up to Congress and having hearings of this kind, where people have to see about things, then when a decision is reached I accept it as the will of the people.

Senator DONNELL. May I interrupt you to ask you, Mr. Anderson, do you favor the granting to the Surgeon General of the power conferred by section 205 (j)?

Mr. ANDERSON. Yes. I know what that is.

Senator DONNELL. To prescribe maximum limits to the number of potential beneficiaries for whom a practitioner may undertake general medical or general dental benefit.

Mr. ANDERSON. My answer is that unless Congress can figure out a better way of getting the job done I would be willing to give that a try. I do not accept this as perfect legislation, and I am sure there will be many imperfections in the first few years of administration, but we have got to make a start, and this is a start. I think we can work out some of the administrative details. In public administration there is a debate as to whether you should have a board. In welfare we have come up with that frequently, the question of whether there should be a board or whether the Governor should appoint one man. Then there are people to present evidence for both sides.

Now, to me at this moment that is not terribly important. I would say that if Congress, after these hearings, decides that that is a good way of putting this plan into effect, then I think we ought to do it and see what the experience is.

If you feel that there is a better way, that there ought to be a local board of some kind to make these rules, that is all right, too.

I feel that there should be several safeguards, and as I read this bill I think those safeguards are there, and that the money that is gotten in is collected in what I think is a very efficient and economic way. There are safeguards as to how that money should be spent.

Senator DONNELL. Pardon me just a minute. Is there anything in S. 1606 which refers to how the money is to be collected?

Mr. ANDERSON. I am sorry. I am still thinking of S. 1050. I might say, we have not taken a stand on whether it should be insurance or straight taxation; and if you fix either way it can be done. I am sorry; you are right, there is nothing in here on that.

Senator DONNELL. Very well. Is there anything further, Mr. Anderson?

Mr. ANDERSON. Well, let me end up by saying that I think that at the present time we ought to do everything that we can to mobilize for production. And I think that to get full production in this country we need to make the kind of conditions which will make for mobility both on the part of management and our labor force.

It is for that reason that I think questions like these must have national consideration and national leadership and some system whereby we have federal and state and local government participation. It is for that reason that I would oppose having some plan set up on a State-by-State basis, because I believe that to achieve prosperity and full production we ought to provide these social protections and services in such a way that it would permit mobility, and today that means helping all of us exercise this right of independence and free choice of a job, and does not make for the regimentation or the fear of not getting services and the fear of moving from one place to another.

Senator DONNELL. The committee, I can assure you, is very grateful to you, Mr. Anderson, for your thoughtful and courteous presentation to it.

The next witness is Mr. McMichael, is it not, Rev. Mr. McMichael. Now, Reverend Mr. McMichael, do you have a prepared statement?

Reverend Mr. McMICHAEL. Yes.

**STATEMENT OF REV. JACK R. McMICHAEL, EXECUTIVE SECRETARY,  
METHODIST FEDERATION FOR SOCIAL SERVICE**

Senator DONNELL. If you will be kind enough, before giving your testimony, please identify yourself, your education and background, and your professional experience, and then describe the organization for which you appear.

Rev. Mr. McMICHAEL. Surely.

My name is Jack R. McMichael, and I am now the executive secretary of the Methodist Federation for Social Service.

You asked about my professional experience. Before that, I was a chaplain of the United States Maritime Service, some two years or over.

Prior to that, I was a pastor of the Court Street Methodist Church, Alameda, Calif.

I graduated from Emory University, Georgia, where I received an A. B. degree; the Union Theological Seminary, New York, where I received a B. D., which is a bachelor of divinity postgraduate degree; and from the Pacific School of Religion in Berkeley, what is called an S. T. M., master of sacred theology.

Senator DONNELL. What is your present address?

Rev. Mr. McMICHAEL. My present address is 150 Fifth Avenue, headquarters in New York City.

Senator DONNELL. Thank you.

## THE METHODIST FEDERATION FOR SOCIAL SERVICE

Rev. McMICHAEL. It is with real pleasure, Mr. Chairman, that I accept this opportunity to present to this committee the attitude of the Methodist Federation for Social Service on this important measure, S. 1606.

The Methodist Federation for Social Service has been in existence since 1907 and is the group out of which grew the original draft of the well-known Social Creed of the Methodist Church, which became in substance the Social Creed of the Churches as adopted by the Federal Council of the Churches of Christ in America.

The organization has the moral blessing and backing of the General Conference of the Methodist Church. It seeks to apply the ethical imperatives of the Biblical gospel to the social relationships of men and women in our modern world.

It seeks, in other words, to help to build that more brotherly and truly democratic world towards which the ethic of Jesus impels us. It devotes itself, therefore, primarily to social education and action.

Its president is Bishop Lewis O. Hartman, president of the Massachusetts Council of Churches. Its vice presidents are Bishop James C. Baker, president of the International Missionary Council, and Bishop G. Bromley Oxnam, president of the Federal Council of the Churches of Christ in America. Its recording secretary is Miss Thelma Stevens, of Mississippi, who directs the Christian social Relations department of the Womens' Society of Christian Service of the Methodist Church, and its treasurer is Dr. Gilbert Q. LeSourd, treasurer, business division, of the Missionary Education Movement.

Our organization has long been dedicated to the realization of a program in America which would actually provide adequate medical care for all. From the beginning, it has given earnest support to the Wagner-Murray-Dingell bill as a great step in the direction of the ideal of universal and adequate medical care.

The members of the Methodist Federation for Social Service may be counted among those who are "doers of the word and not hearers only." Our federation members can be relied upon to back up the congressional supporters of this bill, not only in sentiment, but in individual and corporate action.

## COMPARISON TO CRUSADE FOR FREE EDUCATION

The significant struggle today to make adequate medical care universally available to the people of this land reminds one of the historic battle in America in earlier days for free and universal education. It was once regarded as very radical indeed to advocate a system of universal and free education in this country. We now see such a system as an essential and inextricable root of our cherished American democracy. So in the future it will be with universal and freely available medical care.

We are confident that the day is not distant when medical care will be universally available, and when it will be as inevitably a part of a democratic America, even, as we all have now come to regard universal and free education.

It is quite true that there are always difficulties in bringing about great and significant social changes. Jesus, with his keen psychologi-

cal insight, saw this quite well. Jesus said that "No man having drunk old wine desireth new: for he sayeth, 'The old is good.'"

Jesus had spoken of his own task as that of introducing new wine: that is, new attitudes and new ways of doing things. He fully understood and announced that he would meet opposition for his daring to propose changes.

So it is today that we have those who are so accustomed to the old ways of dispensing medical care that they are congenitally opposed to proposals for needed change and improvement.

#### PUBLIC OPINION POLLS

This does not, however, apply to the great majority of the American people. Many public-opinion polls have shown that the American people, by a large majority, support fundamental changes in this area, and are deeply dissatisfied with the present situation as concerns the availability of medical care.

This is even shown by the poll conducted for the National Physicians' Committee, which is so hostile to this bill. Nor is it by any means an altogether novel idea that the Federal Government should cooperate in a program to provide universal medical care.

As a chaplain in the recent war, I paid many visits to the marine hospital in San Francisco, where merchant seamen for a long time have been granted complete and free medical care and hospitalization. It is unthinkable that this splendid system of universal medical care could ever be abolished now that it has become so much a part of the world in which American merchant seamen live. It has been interesting to me to learn that such a system of universal and complete care for merchant seamen now administered by the United States Public Health Service and supported by social insurance and tax funds has been in effect in America since 1798.

#### FREEDOM FROM DISEASE

A goal of universal medical care has deep roots in our biblical religious heritage. It is in keeping with that heritage that we worship a God described in the New Testament as "No respecter of persons" and as a loving Father whose will it is that not one of the least of the people should perish.

It was in line with this universal concern of our religious heritage that our own Thomas Jefferson wrote into the original charter of our Nation the declaration that all men were intended by God to enjoy life and the pursuit of happiness through equality of opportunity.

Certainly this must include opportunity equitably distributed to be born properly and to enjoy needed medical care.

Only a few months have passed since the close of the most costly war in mankind's history. Millions of people during that war were inspired by the promise of freedom from want. Certainly such a slogan can only be adequately interpreted as including freedom from disease.

It is not surprising, therefore, that we see in many democratic lands today a determination that all of the people shall in the days ahead be enabled to receive needed medical care. We see this in England today.

Some years ago, in the early stages of Japan's wanton aggression upon China, I found this widespread determination among the Chinese people to develop in their land a true democracy which would include within its basic structure a program of universally available medical and hospital care.

The eyes of the world are on the United States. Even as we led the world in providing a system of universal education, so we are challenged today to give similar world leadership by developing within our Nation a system of adequate and universal medical care.

#### THE NEED FOR MEDICAL CARE

The widespread dissatisfaction in America with the situation as pertains to the availability of medical care and the unanimous support which has come from our organization's membership, for example, for the basic principles of this bill, are rooted in the serious and tragic facts.

It is simply and undeniably true that the medical needs of the American people are not today being met with anything like adequacy. The Selective Service figures are well known to the members of this committee. I think I need not remind you of what they are. As you know, the percentage of rejections was much higher in the South, from which I come.

Under our present system, those who need medical care most tend to get it the least, since those least able to pay are usually those most in need of that which they cannot afford.

The serious need for the distribution of doctors and medical facilities is well known to all members of this committee. The doctors have tended to establish themselves not on a basis of the extent of need for medical care, but on the basis of the extent of ability to pay for such care in the particular area where they establish themselves. Thus, the low-income areas have suffered.

We learn that in 1944, 553 counties had less than 1 doctor per 3,000 people, and that 81 counties had no functioning doctor at all. We learn, further, that 40 percent of the counties have no general hospital, and that a similar proportion have no full-time public health officer.

Senator DONNELL. Pardon me just a minute.

Do you take the view that substantially every county, regardless of population, should have a hospital, or do you feel that the population of the county should enter into it?

Reverend McMICHAEL. I think the population should enter in. My view is, there are many counties that need them that do not have them.

Senator DONNELL. But when you state 40 percent of the counties have no hospital, you don't mean to imply that all those should have hospitals?

Reverend McMICHAEL. No; but a substantial proportion of them.

Fifteen percent of all the counties, we are told, have no prenatal or well-baby clinics. These deprived counties tend to come from the low-income areas, the areas where the need for such facilities and clinics is greatest.

All of us are concerned about the children, who are the hope for the future of our Nation and world. We learn that 60 percent of the children in our country live in areas where only 4 percent of our

pediatricians practice. We learn, further, that 31,000 babies die needlessly each year during their first year of life in our country, and that 3,000 mothers die needlessly each year in childbirth.

It is estimated that one-half of all maternal deaths and one-third of infant deaths are preventable.

This committee has had ample occasion also to consider the tremendous cost to our Nation and its economy of the illness which could be prevented by a more universal and adequate system of medical care.

We are told that among industrial workers, 600,000,000 man-days of production are lost each year as a result of illness and accidents. Much of this could be prevented.

This committee has considered the fact also that much of the poverty within American families springs from sickness and the cost of medical care. It is striking indeed that the surveys made of the famed "Hundred Neediest Cases" of the New York Times revealed that 85 percent of these families are indigent because of illness and the cost of medical care.

This committee has had many opportunities to take note of the tragically uneven distribution of illness and the frequently sudden nature of its coming. As a chaplain in this recent war, I had much opportunity to see homes and families wrecked because of a sudden and unanticipated illness.

It has often been true that the mere cost of a suddenly necessary operation has destroyed and made invalid carefully laid family plans. These instances have brought much suffering both psychological and physical, to innocent family members.

#### VOLUNTARY PLANS INADEQUATE

The facts also seem to indicate very clearly that medical needs are not being met by the sum of the private or voluntary plans in existence in our country. Though there has been commendable progress in some of these plans, they still cover only a comparatively small percentage of the population, and meet only a small proportion of the medical needs of those covered.

Of those covered under the voluntary plans, less than 4 percent receive complete prepaid medical care. The Blue Cross has taken in a large proportion of the recipients of benefits under private plans.

It is important to remember that the Blue Cross covers generally only the hospital bill during ordinary illness. But such hospital bills take only 13 cents of the patient's medical dollar.

The doctor's bill, which accounts for 40 cents of the patient's dollar, is not covered by the Blue Cross plans. Nor do those plans cover dental care and preventive medicine—medical check-ups, et cetera.

This latter point is most important, since many a hospital bill would be altogether prevented through early enough medical attention.

Most of the recipients of benefits under the various private plans participate in the so-called commercial plans. We need to remember that only 40 percent of the money paid by the participants in these commercial plans come back to them in the form of benefits. The remaining 60 percent go into the large company overhead expenses and profits.

The so-called medical society plans—another category of private plans—are also limited, both in coverage—less than 2 percent of the population being covered by them in 1945—and in scope, usually covering only surgical care and obstetrical service after 10 months.

Senator DONNELL. Pardon me, going back for a moment to your statement—

We need to remember that only 40 percent of the money paid by the participants in these commercial plans come back to them in the form of benefits—

are you speaking there of the Blue Cross plans?

Reverend McMICHAEL. No; not the Blue Cross plans, but the private company plans.

Senator DONNELL. I wanted the record to be clear.

Reverend McMICHAEL. Not the Blue Cross.

Senator DONNELL. Do you know what the percentage of expense for operation is in the Blue Cross?

Reverend McMICHAEL. I do not. I would be glad to learn, if you know.

Substantially more adequate coverage of medical needs is found in the Kaiser plan and in similar group practice plans. Nevertheless, all of the private or voluntary insurance plans put together do not begin to meet the vast need for medical and hospital care in our country. As we have seen, the overwhelming proportion of the people are not covered by these plans.

In general, most of the medical and hospital needs are not provided. There are certainly many people who cannot afford to join these plans. Even if there is some dispute as to the validity of this last point, it cannot be denied that many people who need to join will not do so, but will prefer to gamble on the possibility that they will have no need for the benefits which the particular plan involved provides.

This probably helps to explain the high turn-over of membership in private plans. The participants drop out at the end of the year in which they put money in but did not receive. The succeeding year might well be the year when their tragic illness or enforced hospitalization comes. This high turn-over may help explain the high promotional and administrative costs of the private plans.

It is apparent that, as in any insurance system, wider coverage would lead to reduced unit costs, and it has also been contended that those who tend to be most sickly are most eager to join these private plans. This may lead to high cost for participation in the plan or, on the other hand, may produce such rigid eligibility requirements as to keep out those most in need of the plan.

#### PRIVATE CHARITY CANNOT DO THE JOB

Nor can it be contended effectively that the medical and hospital needs of the uncovered masses of the American people are met by the generous and charitable practices of the doctors and hospitals. We are told, for example, that less than 7 percent of the poorest rural families—those receiving less than \$500 per family per year—receive any free medical care during the year. Certainly this does not mean that they can afford \$100 per year, which a family needs on the average for minimum medical care. Nor does it mean that these particularly impoverished American families are not visited by illness. It simply means that they go without the care which they clearly need.

We have pointed out that those areas in which we find greatest shortage of doctors and need for hospital facilities are precisely those areas where the greatest needs are found. This is not a matter of hearsay with me, since I am from such an area, from the deep and predominantly rural South.

My grandfather was a doctor in central Georgia, and my father was a doctor in south Georgia. As a boy, I spent many hours with dad on calls in the country. We came to know the rural people, how much pride and self-respect they had. This meant, tragically, that they would often wait until too late to call the doctor.

My father knew the poverty of many of the people, black and white, to whom he ministered. He knew the inability of these rural people to pay for adequate medical care. He came to see the inadequacy of all private plans to meet the needs of these most impoverished folk.

This is why he became a firm supporter of the Wagner health bill. He brought his own life to a premature end by working night and day, year after year, in an area where there was always more work than any one man could handle. Time after time we saw him give up plans for definitely needed vacations, to deliver a baby or to minister to an acute illness. Babies do not follow a doctor's vacation schedule.

Dad was trying to meet the medical needs of a people who were disproportionately sick and in an area with a disproportionate medical and hospital shortage.

The national health plan envisaged in S. 1606 would assure a decent annual income to doctors in impoverished areas. It would increase the number of doctors in these areas and make life less pressing and difficult for all of the doctors there. It would also bring a new medical era to the medically disadvantaged common people.

We in the South have much to gain by the passage of this important National Health Act. But the South's gain would be the Nation's. It is in these impoverished areas that the largest proportion of children are found, and it is from these areas that people migrate in the greatest numbers to other areas when they leave childhood and reach productive age. The whole Nation stands to lose if we send out from impoverished areas men and women stunted and blighted by childhood disease which could have been prevented.

#### HEALTH INSURANCE MUST BE NATIONAL

We have a solid basis, therefore, for our conviction that this committee's health subcommittee is sound in its contention that only a national plan in which the Federal Government participates can make medical care universally available in the United States.

We agree also that only such a national plan can bring us substantial progress in eliminating those inequities as to medical care between low- and high-income areas in our country.

Certainly the Federal Government has a legitimate and inevitable concern in this matter. This would be so, even if we were thinking only within the narrowly conceived terms of national defense, as the Selective Service rejections during the last war make clear. It is a long-established part of the framework of the American democratic government that public funds are expended by public agencies responsive to the popular will.

We now consider the right to an education as a basic right of an American citizenship. We must come to so consider the right to be born decently and to have adequate medical and hospital care ever available.

S. 1606 is to be commended for the fact that it does not provide what social workers know as a "means" test. This is a great step toward the conception that decent medical care should be available to all, not as a form of charity, but as a basic right.

We all know the psychological humiliation which often comes from the charitable approach to the dispensing of medical care.

When Gene Talmadge was Governor of Georgia, he attacked various Federal Government measures to expand social security. He took the position that these measures were inimical to the churches, which depended on the existence of human objects for their charity.

According to this conception, the churches would have a stake in the preservation of poverty and injustice. But Mr. Talmadge, fortunately does not speak for the awakened churchmen of America, who know that true religion is dedicated to the abolition of preventable poverty and to the attainment of genuine justice.

#### COVERAGE SHOULD BE EXTENDED

We congratulate the authors and proponents of S. 1606 for helping us to progress toward an America in which medical care will be considered a matter of justice and not a matter merely of charity. We are concerned, however, by the fact that the bill as now written does not cover all of the population in the benefits which it makes available.

We agree with the position of the United States Public Health Service that 100 percent of the population ought to be covered. We fear that the proposal for a special category of "needy" cases may open the door to the kind of stigma which we are seeking to avoid. There may also be danger of the development of a double standard of medical care, a different standard for the so-called needy.

The bill is to be commended also for its inclusive approach to the medical needs which are to be met. This is very sound.

As suggested above, in our analysis of the shortcomings of most private plans, a medical check-up which comes in time might well save a hospital bill. Thus we see that the inclusive approach of S. 1606 is economically as well as morally sound.

#### DOCTOR-PATIENT RELATIONSHIP

All of us realize the close relationship between strictly physical and functional ills. We know that a happy interpersonal relationship between doctor and patient is of great importance both for doctor and patient. This often may be a real factor in speeding a cure.

It is commendable that S. 1606 provides free choice of patient to doctor and vice versa. Free choice is actually extended and doctor-patient relationship improved by eliminating present cost barriers.

#### S. 1606 WILL IMPROVE QUALITY OF MEDICAL CARE

S. 1606 will increase the quality of medical care by freeing doctors to use laboratory and other techniques now neglected often because of cost. The quality of medical care receives an additional boon by the

provisions encouraging research, basic medical training, and special graduate work.

I remember how my own dad longed for and finally secured for himself periods of special postgraduate study.

Nor does the act remove the doctor's incentive. A patient can choose his doctor freely. He can also abandon that doctor if his work becomes unsatisfactory. Naturally, one who has been a chaplain appreciates the provision in the bill to give priority to grants-in-aid to servicemen seeking postgraduate medical education.

As a chaplain who worked largely with the *unsung heroes* of the merchant marine, however, I hope that the act will be amended to include in its definition of "servicemen" those who served during the war in the United States Maritime Service or merchant marine.

#### DEMOCRATIC ADMINISTRATION OF THE BILL

Commendable also are provisions calling for maximum participation by local, State, and private agencies in the administration of the act and provisions for advisory councils, including representatives of the public as well as of the medical and other professions.

We ministers welcome this opportunity for qualified clergymen who work intimately with individuals in a community to serve in their behalf on advisory councils. We urge that specific representation be given on these important councils to Negro, Jewish, and other religious and racial minority groups, so as to assure to them an equitable role and share in the administration and benefits of the act.

We have been gratified by the interest recently shown by organized labor, not only in narrowly conceived trade-union problems, but in public affairs and in health problems. We are confident that representatives of organized labor will also have a great contribution to make on these advisory councils.

We have expressed some concern over the dangers in the so-called needy cases as distinguished from those otherwise covered. We are glad to note, however, that the possibility is left open for these needy cases to secure medical benefits "on the basis of equitable payments to the personal health services account established under title II." We hope this will enable the patient to receive treatment from a doctor without that doctor's knowing that he is dealing with a special category of patient.

#### AMENDMENTS TO TITLE I

Our primary concern is that the splendid medical and hospital benefits proposed in the act be in fact universally and completely available to all Americans. We support the amendments proposed by Senator Pepper to title I, part B of the act. We believe these amendments make more certain the universal availability of the special maternal and child-health services involved by adding further clarifying details rooted in S. 1318.

Human rights must come before "States' rights." The major task is to see that the people in all States receive the intended opportunity for adequate medical and hospital care.

We join with Senator Pepper in questioning the requirement for financial contribution by the States, since we do not want the slightest possibility to remain that the people in any State be denied benefits which ought to be the right of all Americans.

Senator Pepper applied this question specifically to title I, part B, which deals with maternal and child-health services. We would apply this question also to title I, part A, dealing with "Grants to States for public health services," and to title I, part C, dealing with "Grants to States for medical care of needy persons."

Our concern, we repeat, is that all Americans be covered, and we hope to see the elimination of all loopholes by which the universality of coverage could be thwarted and by which the residents of some States could be denied the important benefits provided under title I.

Above all, we urge that S. 1606, strengthened by these needed amendments, be passed—and passed at the earliest possible date.

Senator DONNELL. Reverend McMichael, when was held the most recent general conference of the Methodist Church?

Reverend McMICHAEL. 1944.

Senator DONNELL. 1944. Did that conference express itself on the subject of compulsory health insurance?

Reverend McMICHAEL. No.

Senator DONNELL. Has it ever expressed itself on that subject?

Reverend McMICHAEL. Not that I know of; no. It has expressed itself officially on the subject of medical care for all.

Senator DONNELL. But not on the matter of compulsory health insurance, is that right?

Reverend McMICHAEL. That is right, as far as I know.

Senator DONNELL. You mentioned on page 12 of your statement, and I quote: "He can also abandon that doctor if his work becomes unsatisfactory."

I call your attention to this situation: Take a community in which there has been adopted the per capita plan under the bill, and suppose that you should have selected Dr. Jones, and Dr. Jones should prove unsatisfactory to you, and you have the right to abandon Dr. Jones. Suppose, however, in the community there are three other doctors, and the panel of each of those is filled. Is there any right that you know of by which you can select one of those doctors regardless of how much you want his services?

Reverend McMICHAEL. Well, I do not know of any way that can be handled, except that there are, as I understand it, local committees which will be consulted on these matters, advisory committees, and advisory councils of various kinds, and it would seem to me it might be handled in this way: If I were sick, judging from the experience I have had with my own father as a doctor, and I could not get adequate attention from the doctor I had, and I went to another doctor, he would take care of me, if there were an immediate emergency situation requiring medical care.

Senator DONNELL. I was not talking about an emergency situation. Suppose you have selected Dr. Jones?

Reverend McMICHAEL. Yes.

Senator DONNELL. Thereafter, because of his record or for some personal reason, you did not consider him proper, and you decided you did not want him. You certainly have the right, as you have indicated, to abandon that doctor.

Reverend McMICHAEL. I believe that the right works both ways. I think that the doctor also has some choice in the matter of the patient, so that if there were another one of these three doctors who

wanted me as a patient, I believe that he would have the right to choose me as one of his patients.

Senator DONNELL. I am not certain as to that.

Reverend McMICHAEL. That is my impression.

Senator DONNELL. But I do call your attention to the section mentioned rather frequently in the testimony giving the Surgeon General the right to prescribe maximum limits to the number of potential beneficiaries for whom a practitioner may undertake to furnish general medical or general dental benefit. Had you considered that?

Reverend McMICHAEL. Yes. My understanding of that, Senator, is that this will only be done if the majority of the doctors in the area involved choose that particular plan of receiving payment.

Senator DONNELL. That is correct. That is the reason that I qualified my question.

Reverend McMICHAEL. I believe there is also a provision that allows the doctors who did not approve that decision reached by the majority, or, that there is a possibility that those representing the minority may choose some other than the per capita basis. I think there is a possibility, at least, that the doctors in the community could be receiving their pay on some other basis than that of the per capita, even if they live in the community which has decided on the per capita basis.

Senator DONNELL. I was speaking of the community in which the per capita basis was adopted and the quotas have been filled and you have abandoned your doctor. Then it would seem to be there would be a restriction on your part with respect to someone else to choose the doctor.

Reverend McMICHAEL. I think there is a restriction of choice in the present situation. If we look at the present situation, where in my own home county doctors have declined in number, and far more people with a great deal of illness than there are doctors to take care of them, they are very restricted in the choice of doctors, because the doctor is not available. And I do think it is sound, if we are going to have high-quality medical care, for there to be some limit to the load of a particular doctor.

I mention my own father. He had far too many patients, and it seems to me we must be concerned to take care that there is high-quality medical care.

I believe in the so-called voluntary plans there are often limits put to the number a doctor may handle. It seems to me physically impossible for a doctor to handle too many.

There is no specified number within a particular community that a doctor may have, 2,000 or 1,000 or whatever the number is; but it seems to me that the doctors in a particular community, if they want to have the load limited, should have the choice to vote on that question, and if they prefer another method they do have that opportunity. You do not only have to consider the patient, but you have to consider the doctor. If I go to a doctor now he can refuse to treat me, if he considers his load too heavy.

I think when we look at the present situation in which so many of the areas of the country have freedom restricted because of the absence of doctors, these doctors do not go to the low-income areas because they will not be paid adequately on the treatment basis, and

I think there will be more doctors going to such areas as the county from which I come, which will give not less but far more freedom of choice to the people in those communities.

Senator DONNELL. It is still true, is it not, Reverend McMichael, that today if you desire to separate yourself from your existing physician, that if another physician desires to take you as a patient he has that privilege?

Reverend McMICHAEL. That is true.

Senator DONNELL. Whereas under this law, as I understand it, in a community in which the practitioner has reached his maximum quota and in which the per capita basis has been adopted, he would not be at liberty to decide for himself whether his case load is as great as he can handle, but that would be left to the Surgeon General rather than the physician himself?

Reverend McMICHAEL. My impression is that the doctor would. There is some misunderstanding between us about the bill. My impression is that the doctor would have the freedom to choose me as a patient if he preferred me to someone on the group on his list. In other words, if a doctor wanted to put me on his list and he had 1,000 people on his list, and he preferred me, that he would have that choice under the bill.

Senator DONNELL. By eliminating someone on the list?

Reverend McMICHAEL. By eliminating some one of the thousand. The person eliminated might like the other doctor very well.

Senator DONNELL. Or he might like the one from which he was eliminated.

Reverend McMICHAEL. But the doctor has that choice of eliminating, whether he has his quota filled or not.

Senator DONNELL. He certainly has that right under existing law. Do you mean under the bill?

Reverend McMICHAEL. Yes. My impression is that the doctor does have a choice, and he could eliminate a person whether his quota was filled or not.

Senator DONNELL. Reverend McMichael, are there any further observations you desire to make at this time to the committee other than your statement?

Reverend McMICHAEL. No. I think I have covered the major points in the statements here.

Senator DONNELL. I am sure I express on behalf of the members of the committee here our appreciation for this very thoughtful and most interesting observation that you have given to us. It evidences much work and thorough preparation.

Reverend McMICHAEL. Thank you very much, Senator.

Senator DONNELL. The committee will be in recess until 10 o'clock on the morning of Tuesday next, to meet at a place subsequently to be announced.

(Whereupon, at 1:35 p. m., Thursday, April 11, 1946, the committee adjourned to meet again at 10 a. m., Tuesday, April 16, 1946.)

# NATIONAL HEALTH PROGRAM

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TUESDAY, APRIL 16, 1946

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

The committee met at 10 a. m., pursuant to adjournment, the Honorable James E. Murray (chairman) presiding.

Present: Senators Murray, Pepper, Ellender, Morse, Donnell, and Aiken.

The CHAIRMAN. Gentlemen, the meeting will come to order. Other members of the committee are on the way here, but we have a big schedule and I think we should open the hearing immediately.

Mr. William Green is the first witness here this morning. Mr. Green, you may proceed with your statement.

## STATEMENT OF WILLIAM GREEN, PRESIDENT, AMERICAN FEDERATION OF LABOR, ACCOMPANIED BY NELSON H. CRUIKSHANK, DIRECTOR, SOCIAL INSURANCE ACTIVITIES, AMERICAN FEDERATION OF LABOR

Mr. GREEN. Thank you, sir. Mr. Chairman and members of the Committee on Education and Labor, I appreciate the opportunity to present to you the position of the American Federation of Labor with respect to the proposals for the establishment of a national health program as they are set forth in the legislation you are considering, Senate bill 1606.

### AFL PROGRAM FOR SOCIAL SECURITY

This subject is not new to us. The American Federation of Labor has been working for the past several years to develop a program for extending our social security system in a manner designed to enable our people to bear the unpredictable hazards of our modern industrial society. Our committee on social security, of which Mr. Matthew Woll is chairman, has been now for several years engaged in a study of the inadequacies of our present social security program and has, with the assistance of experts in this field, drawn up a comprehensive plan for the development of a well-rounded, national social security system. The experts they have consulted include men of acknowledged attainment in Government service, in the universities, in the professions, and in business.

The program we have developed includes, in addition to provisions for extending the facilities needed for health services and provisions for grants to States for public health services and maternal and child health and welfare services and for public assistance, proposals for

the establishment of a national system of public employment offices and of a national social insurance system. This last item includes proposals for the development of insurance against temporary and extended disability, for the extension and improvement of our old-age and survivors insurance system, for the special protection needed by veterans, for a genuine and practical unemployment insurance program and for a national system of health insurance. This program also includes well-considered methods for meeting its entire cost.

A number of these provisions are now being given separate consideration. For example, the program for the construction of health facilities is largely incorporated in Senate bill 191, to which with strengthening amendments, the American Federation of Labor has given its wholehearted support. Likewise, the Committee on Ways and Means in the House of Representatives is now reviewing the old-age and survivors insurance program. We have presented to this committee with all the emphasis at our command, our proposals for strengthening this portion of the social security program.

Our entire program for the development of a unified, comprehensive social security program worthy of a great nation in a position of world leadership, is contained in Senate bill 1050, introduced in the Senate nearly a year ago by Senator Robert F. Wagner and his colleague, the distinguished chairman of this committee, and simultaneously in the House of Representatives by Congressman John D. Dingell.

The proposal you have before you in the Senate bill 1606, therefore, represents but another part of an over-all program. Though in our opinion the need is for the immediate adoption of an inclusive and comprehensive program, we support this proposal to provide for a national health program because it represents to us a worthy step in the right direction.

#### ENDORSEMENT OF NATIONAL HEALTH INSURANCE

The significance of the support given the bill by the American Federation of Labor does not lie wholly in the vast membership—now nearly 7,000,000 individuals—of our affiliated unions. I submit that there is great significance in the fact that our organization has not always held this position. In fact, 30 years ago we were definitely against the establishment of a health insurance program. But our great, democratic labor organizations, in response to the expressed needs and wishes of the membership, have steadily swung over to the support of this program, to the point where, in the last national convention of the American Federation of Labor, which was held in New Orleans in 1944, it was adopted unanimously.

Some of the enemies of this program have attempted to taunt us by quoting my predecessor, Samuel Gompers, in opposition to health insurance. They have even gone to the expense of printing large posters, which they offer free and on which they have reproduced a picture of this great leader and quoted his words of 30 years ago. I think I knew Samuel Gompers as well as the people who are paying for the printing of these posters. I know also, that some of the same interests who are now so willing to pay money to induce workers to follow Samuel Gompers' leadership were willing, when those words of his were uttered, to pay money to get workers to forsake his leadership.

I knew Samuel Gompers as a progressive leader—one willing and ready to change his views with the changing times. True to this tradition, the American Federation of Labor, which he founded, has changed its position regarding health insurance to meet the changed conditions of our times.

I shall not attempt to offer in support of the bill exhaustive statistical material. Such data are important and very necessary to an understanding of the problem, but they have already been presented by those who are particularly expert in this field. I am not here to present figures and statistics, but I am here representing the working people of America, who have expressed themselves as most earnestly desiring that legislation be enacted which will make it possible for them to obtain the services and have available the facilities that are essential to the achievement of good health. It is my purpose to present the reasons on which they base their conclusions.

#### WORKERS DISSATISFIED WITH PRESENT HEALTH LEVELS

Now, the working people of America are not satisfied with present levels of health in this country. This is not to say that they do not appreciate the notable achievements of modern medical science or that they do not share a sense of pride in the standards and attainments of our great medical centers and universities. They recognize that the span of life has been materially increased over the last half century, and that, generally, the health level of our people compares favorably with most other nations. They know this general picture tends to conceal the highly unsatisfactory conditions prevailing in the poorer agricultural States, in the rural sections of the wealthiest States, and in the low income areas of our great metropolitan centers.

#### SELECTIVE SERVICE REJECTION FIGURES

Working people were shocked, just as other people were, by the extent of physical unfitness that was revealed by the selective-service examinations. With the whole record now before us, these figures are more shocking than appeared at first. Where we have been saying that a third of our young men were found physically unfit for the "duties of citizens in wartime"—to use General Hershey's phrase—actually it is now revealed that fully a half of the young men failed to meet the Army's standards. This was true even in the latter stages of the war, when in times of manpower stringency the standards were substantially lowered.

We do not feel that a nation can be secure and we do not feel that we can be proud of our achievement in the field of health as long as this condition prevails. We do not think that our achievements in medicine can be measured in terms of scientific progress alone, no matter how brilliant may be our discoveries. Our medical progress must be measured by the degree of health enjoyed by our people, and in this we do not at present measure up. Even if our general health were the best in the world—which it is not—we should not be satisfied until it is as good as it is possible for it to be in America, and until the last laggard areas have caught up with the more advanced sections.

While working people are deeply concerned with the general health

conditions of the country, their demand for improvement arises mostly from their own personal experience with the inadequacies of the present system. Wage earners are no different from other people in their desire for good health for themselves and their families. They want, therefore, to know that adequate, modern medical care will be available when it is needed. They have, over the years, come to a realization that the services of the doctor, hospital, nurse, and laboratory must find a place in the family budget before a family can count itself secure.

Our people do not minimize the importance of the maintenance of satisfactory healthful conditions as they affect their life on the job and at home. They know that good housing, adequate nutrition, and other environmental factors contribute materially toward good health. To listen to some of the opponents of health insurance, however, you might conclude that if workers had these things they would not need doctors, nurses, or hospitals. They should know better, especially the doctors among them. Workers apparently have more faith in the value of the services furnished by the medical profession than some members of the profession seem to have. In a layman's manner they could tell you what the professional people appearing before this committee can tell you in more scientific terms. They knew that delay in getting medical care in many cases means the difference between life and death or between disability and recovery. They know how important it may be for the family doctor to be able to call in specialists, or to utilize modern diagnostic aids—how important and how costly. They have been hearing for years about the great progress of scientific methods, especially when practiced by well-organized groups. They have been reading of the wonderful medical advances made during the war and they want now to include this modern medical care in their standard of living. As they ponder these things they realize that the health goals to which they aspire for their families are far from being attained, and increasingly they are coming to realize that under the system of distributing medical care and service based on the ability of the individual to pay for it, they are too frequently unattainable.

#### UNPREDICTABILITY OF ILLNESS

Out of their own family experiences working people have come to realize that the methods of meeting the costs of medical care have a direct and practical relationship to the availability of that care. They know that, generally, individual savings do not provide a practical way of meeting these costs for the very simple reason that neither the time nor the amount of savings needed can be predicted. They can budget every other major item of family expenditure; housing, food, clothing, education, and recreation. But they cannot anticipate the frequency or the extent of the cost of the medical care and service that will be required for a family. The number of family plans, and hopes and aspiration for the children that have been upset by a completely unpredictable case of illness can never be counted. We do know that the most frequent single cause of dependency is sickness. And we know that the desperate resort to the "loan shark" often arises from the necessity of paying the cost attendant upon sickness and that the largest single reason for the cashing of War Savings bonds is illness.

While workers, like other people, cannot predict the frequency or the severity of illness in their individual families, they do know that for any major segment of the population these factors can be accurately forecast and the cost for larger groups of the population can therefore accurately be determined. They are convinced therefore that an extension of their present social insurance system can make possible, through setting aside small amounts of their income regularly, a means of meeting the cost of medical care for all. They see nothing socialistic or revolutionary about a proposal to extend the century-old, thoroughly American principle of insurance to meet these needs.

Our people are quite convinced, too, that it is entirely appropriate to use the instrumentality of their Government to collect these insurance contributions and to administer the program, provided that proper safeguards are included in the legislation establishing the system to guarantee that the authorities granted government agencies are limited to the degree necessary to carry out their responsibilities.

In coming to our present position of vigorous support of the principle of health insurance we have studied the practical alternatives and found them wanting.

#### NEGLECT OF ILLNESS

In consideration of such alternatives it has to be realized that doing without medical care is one of those to which families are frequently forced to resort. This often takes the form of postponement of examination or calling on the physician when the first symptoms of an ailment appear. To some this might appear as inexcusable improvidence on the part of workers, but this is in most cases an unjustifiable judgment. Who is to label as "improvident" the decision of a breadwinner sharing all the natural human desires to do the best for his family when he postpones taking care of his own physical needs or even concealing them because he fears what an examination might disclose or what adequate treatment might cost? But the records of family physicians are filled with instances where serious and costly illness could have been avoided by an early visit from the patient. The records that have been placed before your committee give you in statistical form what we receive by way of letters and direct communication from the members of our unions and from the testimony of friendly doctors with whom we work. Health insurance, by making available to all workers the means of paying the cost of medical care, would remove the fear that stands in the way of modern and effective preventive treatment.

#### VOLUNTARY INSURANCE PLANS

There are many sincere people who earnestly put forward as an alternative to compulsory health insurance the desirability of the further extension of voluntary insurance plans.

I should like to comment on the confusion that has been introduced into public discussion of the problem before you resulting from misunderstanding of the terms "voluntary" and "compulsory" as used in this connection. We in the American Federation of Labor have on occasions been charged with inconsistency because we have opposed

compulsory arbitration and other forms of compulsion and adhered to our traditional principle of voluntarism while at the same time embracing compulsory health insurance. We do not feel that our position is in the least in violation of our traditional principle, as the element of compulsion in health insurance is confined to the matter of coverage and to the payment of contributions. In other forms of compulsory legislation there are embodied compulsions that seriously limit the basic freedoms of citizens. The compulsory feature of health insurance is identical with the compulsory features of our public education system, where our children are required to attend school, and all property owners are required to support the system. To carry over into a discussion of this problem the usual connotations associated with the word "compulsory" as opposed to "voluntary" confuses rather than clarifies the issue. As a matter of fact, the plans of some of the voluntary programs have demonstrated that they can be quite undemocratic. Those, for example, now being advocated so vigorously by some of the medical societies, place complete control of the plan, including the expenditure of the funds, in the hands of a single group whose members have a direct pecuniary interest in their operation. They are completely devoid of any standards to govern the quality of service to be provided, and provide for no representation on the part of those who are to pay their costs.

It is not necessary for me to go into an extended analysis of the deficiencies of voluntary plans, since testimony that has already been presented to this committee is thoroughly adequate for that purpose. The analysis which Senator Pepper presented on the opening day of the hearings on this bill, which was based on the exhaustive study of his Subcommittee on Wartime Health and Education, said all that needs to be said on this subject; and we subscribe to his conclusions. We can only add that the experiences of our people point up the accuracy of his observations in that these plans are not reaching the low-income people and they are the ones who most need the protection of health insurance. We know, too, that the coverage provided under plans that give only partial protection is rapidly reaching the saturation point. The Blue Cross plan, for example, which is among the better of such plans, is now having to sign up four new subscribers for every three who remain on the rolls for any appreciable length of time. As the number of people covered under their plans increases, this rate of turn-over will undoubtedly continue to increase, adding to the costs for which the subscribers get no return. This feature is in addition to the fact that those who stay in the plan will always tend to include the poorer insurance risks.

It is possible that voluntary health insurance providing complete medical care and service would be a good thing for those persons who could get it and who could afford to pay for it, but it has been found impractical for the great masses of people.

I have spoken of the needs for health insurance for which our people are acutely aware and out of which has developed our support for a change in the method of meeting the cost of medical care. I should like now to comment on the specific proposal before you in its relation to those needs.

The heart of S. 1606 is in title II, which establishes a comprehensive system of prepaid medical care. This provision is so designed that

it can readily be incorporated in a system of contributory health insurance. To this, as to any other proposal, we apply certain tests. There are specific questions which working people ask about any such plan.

#### COVERAGE OF S. 1606 IS ADEQUATE

First, they ask: "Is the system sufficiently comprehensive in its coverage?" We estimate that under the provisions of this bill coverage would include between 80 and 90 percent of the entire population in a medical care program, and that its coverage is adequate and as nearly complete as is practicable. We favor the broad coverage provided, both because it represents a sound principle for insurance, and because it provides the care to all including the low-income groups who are in need of such care.

Workers are likewise concerned with the nature of the benefits. On this point too it is our opinion that the bill is adequate, since it provides that all insured persons and their dependents are entitled to the services of a general practitioner of their own choice in home, office, or hospital; services of specialists and consultants; complete laboratory services including X-ray and physiotherapy; special appliances; hospitalization; general and special dental and home nursing services. We feel also that the provisions of the bill which allow for limitation on these benefits in terms of specified situations are practical and sound.

#### QUALITY OF MEDICAL CARE WOULD BE IMPROVED BY S. 1606

Past experience of workers, particularly with certain types of contract care, have led them to be cautious about any proposal which might affect the quality of service. In our opinion, the passage of this bill would definitely encourage high-quality medical care. Doctors with whom we have consulted have informed us that when the ability of the individual patient to pay is a factor in his prescription of treatment, as it is under the present system, the best quality of service is often denied. Under the contemplated program this barrier would be removed. Patients would also be encouraged to visit the doctor in the early stages of illness. Moreover, when taken in conjunction with a program for construction of hospitals and health centers in areas of need, there would undoubtedly result from this program a vast improvement in the type of care available to our general population. The impetus given to group practice will also contribute substantially to this end and the provisions of the bill for the encouragement of research would aid tremendously in the development of better medical care.

#### EXISTING SERVICES WOULD BE UTILIZED

Especially during the past several years many of our unions have developed medical care programs for their members. Our people naturally want to know whether the adoption of a national health program would permit the continuance of these cooperative endeavors. During the preparation of this legislation we insisted upon provision for the continuance of these plans being included, and we are satisfied that the provision is adequate. We are convinced that the bill makes

ample provision for utilizing existing services and actually encourages the establishment of new ones when they are able to meet standards of service.

#### FREEDOM OF CHOICE

One of the questions which workers always ask when these proposals are under discussion is: "Under the plan will we be able to choose our own doctor and our own hospital?" I am very sure that the proposal for the establishment of health insurance would not have received the widespread support that it has among our trade-union people if they were not assured that the freedom of choice of physician would be preserved and actually improved. Our people are no different from others in that they cherish the personal relationship between doctor and patient and we have insisted that the provisions in this respect make doubly sure that free choice is protected. Actually, we feel that the bill, if adopted, would in a great many instances extend the principle of free choice as under our present system of payment; the actual choice of physician on the part of those in dire need of service is limited to the number of doctors who are willing to render service in the face of the possibility or even probability that the patient will not be able to pay.

#### THE BILL PROVIDES FOR DEMOCRATIC ADMINISTRATION

Our membership is concerned about the degree to which any proposed legislation threatens to set up any centralized or autocratic control. Despite the contentions of the opposition, we are convinced that in S. 1606 there is established a fair balance between administrative responsibilities and democratic administration. Certainly officials of Government agencies are given duties to perform and they are properly given the necessary authority to carry out these duties, but their authority is limited through a system of checks and balances. The rights of insured persons and of persons and agencies rendering services are carefully spelled out, and rights of appeal from decisions are provided. In addition, the Surgeon General is specifically directed to decentralize the administration through the States and localities.

A very important provision of the bill in our opinion is that which directs the Surgeon General to establish a National Advisory Policy Council, which is to be made up from names submitted by professional and other appropriate organizations and which is to include representatives of the consuming public. The Surgeon General is required to consult this body on all important questions of policy and administration, and to include in a periodic report to Congress a record of such consultations. Provision is also made for the establishment of special advisory, technical, regional, and local committees to advise on general or special questions, professional and technical subjects, and other matters.

We have had considerable experience for many years with advisory councils. Some of them are only paper organizations and the advice and counsel of their members is almost meaningless. In other instances attempts have been made to give advisory councils so much power that there is a tendency to dilute administrative responsibility. The advisory council as set up in this bill avoids both those errors and implements genuine democratic participation in the program.

While the entire program contemplated in this bill centers about title II, the provisions of title I are of vital importance. We heartily approve part A of this title providing increased grants to States for health services. The present system of grants-in-aid carried on co-operatively with the United States Public Health Service and the various State departments has been successful, but so limited in scope that it fails to meet the need.

#### MATERNAL AND CHILD HEALTH SERVICES

We are particularly interested in part B of this title which provides for increased grants to States for maternal and child health services. We feel that it is entirely appropriate that there be a special part for such a program, as we recognize that society has a special responsibility to make real the right of all children to good health.

Children and mothers today in many cities and towns do not get the kind or the amount of medical care or health services that they should have and that doctors know how to give, for three reasons: First, in many cases the facilities and the expert services that children need just do not exist where they live; second, many parents do not know what good care for children means, nor how to get it even if it is there; third, they do not have the money to pay for the care when they need it.

This third lack will be taken care of under the personal health-service provisions of title II and under the proposed amendments to section 121 of title I, part B, which together provide for payment of costs for care of all maternity patients and children. However, paying bills for care now available—or even for the additional care that we predict will become available when money to pay bills is in the insurance pool—will not of itself mean that maternity care and medical care for children are going to be of the kind and quality that are essential if children are to grow up really sound in mind and body and able to take their places effectively in our work-a-day world.

It is, therefore, of the greatest importance to the future of the workers and the Nation that an agency of the Federal Government whose primary concern is the health and welfare of children be given appropriate responsibility for planning ways and means for assuring that all mothers and children have access to care of the highest type that physicians and hospitals know how to give, and for setting the standards of care.

#### PROPOSED AMENDMENT TO TITLE I

In my letter to the chairman of this committee on March 12, 1946, I recommended an amendment providing that the Children's Bureau program under title I be basically directed toward community services, special research, demonstrations, training of personnel, and special educational programs to assure high standards of maternal and child care, and that any personal health services provided through the Children's Bureau be limited to those for persons not eligible for insurance benefits. Such an amendment has been recently proposed by Senator Pepper in his testimony before this committee.

The American Federation of Labor was one of the national organizations that sponsored the creation of the Children's Bureau. The position that the Children's Bureau has always taken with respect

to the welfare and health of children has been one activated only by a concern that the conditions under which children live and grow shall be the best. The Bureau has through the years shown courage and leadership in carrying out its functions in the interests of all children, and we do not want to see any steps taken that will weaken this ability to stand for the interests of children.

#### MEDICAL CARE FOR THE NEEDY

We further commend the provisions of part C of this title for grants to States for medical care of needy persons. No matter how carefully drawn may be the legislation providing for health insurance offering the widest possible coverage, there will be persons who are in need but who are not eligible for the benefits of the insurance system. The provision of this part for variable grants to the States depending upon the States' per capita income would make it possible to meet the needs of the distressed areas of the country in a practical way. This part, therefore, serves to round out the entire structure of the national health program by providing medical care and service to those most in need.

#### SOURCE OF OPPOSITION FUNDS SHOULD BE INVESTIGATED

The members of this committee are aware that the proposal for national health insurance has been subject to serious attack from various quarters. We do not say that all of those who oppose this measure and who are in disagreement with us are dishonest men. We do say, however, that some of the organizations which have been busily stirring up opposition to this bill depending largely upon false and misleading slogans, and expending huge amounts of money, should be thoroughly investigated. I say quite frankly to the members of this committee that in our opinion you will not have fulfilled your responsibility to the public in these hearings unless the sources of the funds for some of these organizations have been thoroughly investigated and made known to the public. The people of the country have a right to know and they have a right to expect from this committee what individuals and what corporations have contributed to the misleading campaigns of such organizations as the National Physicians' Committee for the Extension of Medical Service and the Association of American Physicians and Surgeons, Inc. I have tried to make clear the reasons on which the American Federation of Labor bases its support of this bill. Our purposes and our records are open, and the basis of our support is common knowledge. We think that the reasons for the opposition of the organizations I have named and their allies should be made equally public.

#### CONSTITUTIONALITY OF S. 1606

There is one other question which I shall mention in closing since I understand it has been raised in the course of these hearings, and that is the question of the constitutionality of the bill under consideration. When this bill was being drafted we received various informal opinions on this matter from our general counsel and have now from him a formal opinion which indicates that the provisions of the bill are entirely in accordance with the Constitution. If the committee so desires I shall be glad to submit this for the record.

The CHAIRMAN. Mr. Green, this committee will be very glad to have that opinion, and will incorporate it in the record following your statement.

Mr. GREEN. Very well; I shall be glad to include it in the record.

The CHAIRMAN. Thank you.

(The document referred to is as follows:)

MEMORANDUM TO PRESIDENT GREEN ON THE CONSTITUTIONALITY OF S. 1606  
NATIONAL HEALTH ACT OF 1945

Although there have been some questions raised as to the constitutionality of the National Health Act, notably by the American Bar Association in 1944, it is clear beyond doubt that this bill is within the constitutional power of Congress. It may be observed that the report of the American Bar Association merely assumes that the proposal is unconstitutional but cites no supporting authority.

All constitutional aspects of S. 1606 have been conclusively settled by the Supreme Court of the United States (*Steward Machine Company v. Davis*, 301 U. S. 548, and *Helvering v. Davis*, 301 U. S. 619) when it upheld the Social Security Act. It is inconceivable, in the face of those decisions, that S. 1606 will be held unconstitutional.

In those cases the Supreme Court of the United States laid down the doctrine that article I, section 8, of the Federal Constitution empowers the Congress to provide for the general welfare of the United States; that Congress has a wide discretion in determining what is necessary for the general welfare, and that Congress' exercise of that discretion cannot be challenged in the courts unless it be shown that the Congress was clearly wrong and arbitrary. The following extracts from the Supreme Court's decision in the *Helvering* case fully apply to S. 1606.

"Congress may spend money in aid of the general welfare. \* \* \* There have been great statesmen in our history who have stood for other views. We will not resurrect the contest. It is now settled by decision \* \* \* There is a middle ground \* \* \* in which discretion is at large. The discretion, however, is not confided to the courts. The discretion belongs to Congress, unless the choice is clearly wrong, a display of arbitrary power, not an exercise of judgment. This is now familiar law. 'When such a contention comes here we naturally require a showing that by no reasonable possibility can the challenged legislation fall within the wide range of discretion permitted to the Congress.' Nor is the concept of the general welfare static. Needs that were narrow or parochial a century ago may be interwoven in our day with the well being of the Nation. What is critical or urgent changes with the times."

\* \* \* \* \*

"The hope behind this statute is to save men and women from the rigors of the poorhouse as well as from the haunting fear that such a lot awaits them when journey's end is near."

\* \* \* \* \*

"The problem is plainly national in area and dimensions. Moreover, laws of the separate States cannot deal with it effectively. Congress, at least, had a basis for that belief. States and local governments are often lacking in the resources that are necessary to finance an adequate program of security for the aged. This is brought out with a wealth of illustration in recent studies of the problem. Apart from the failure of resources, states and local governments are at times reluctant to increase so heavily the burden of taxation to be borne by their residents for fear of placing themselves in a position of economic disadvantage as compared with neighbors or competitors. We have seen this in our study of the problem or unemployment insurance."

\* \* \* \* \*

"When money is spent to promote the general welfare, the concept of welfare or the opposite is shaped by Congress, not the States. So the concept be not arbitrary, the locality must yield."

Surely it cannot be suggested that it is constitutional for Congress to provide for unemployment insurance and old-age security, but unconstitutional to provide an insurance scheme for adequate medical care. The latter is as clearly for the

"general welfare" of the people as the former and hence equally within the constitutional power of Congress.

So much for the basic underlying power of Congress to make provision for the medical care of the people of this country. As to the details of the plan embodied in S. 1606, they are, from a legal point of view, identical with those of the social security, workmen's compensation, and similar laws, all of which have been the subject of review by the Supreme Court, which upheld their constitutionality.

Accordingly, it is our confident view that S. 1606 is in all respects constitutional. Respectfully submitted.

JOSEPH A. PADWAY,  
*General Counsel, American Federation of Labor.*

The CHAIRMAN. Are there any questions the gentlemen wish to direct to Mr. Green?

Senator DONNELL. I should like to ask some questions.

The CHAIRMAN. You may proceed.

Senator DONNELL. Mr. Green, you referred to S. 1050, stating that the entire program for the development of a unified comprehensive social security program is contained in that bill?

Mr. GREEN. That is the Murray-Wagner-Dingell bill. Yes, sir.

#### FINANCING OF S. 1050

Senator DONNELL. I want to ask you, Mr. Green, whether or not you have investigated or caused to be investigated the question as to the probable cost under S. 1050, to which you have referred?

Mr. GREEN. Well, not the entire cost, because that would be very difficult, but we have gone into it in a quite extensive and practical way.

Senator DONNELL. Would you be kind enough to tell us substantially the results of your inquiry as to the probable cost, and as to the portions of that program to which your figures apply?

Mr. GREEN. I will be glad to do it; but I do not have it with me now.

Senator DONNELL. I have before me a document entitled, "Proposals for Health, Old-Age, and Unemployment Insurance," by Earl E. Muntz, New York University. He is comparing the 1945 bill, S. 1050, with the 1943 bill, which was S. 1161. And he is giving the revised figures as he gets them from the various sources as to the aggregate cost under S. 1050, the bill to which you referred in your testimony.

Mr. GREEN. I see.

Senator DONNELL. This is on page 63. After referring to certain additional costs attributable to S. 1050 over and above the figures of S. 1161, he says:

This would raise the estimates previously given to the following totals:

1. Based on Senator Wagner's figures and remarks, \$11,625,000,000.
2. Based on tax foundation study, \$11,787,000,000.
3. Based on author's estimate, \$13,405,000,000—

I take it that is Mr. Muntz' estimate—

4. Based on Hirschfield's study, \$14,625,000,000.

I understand that is Mr. Gerhard Hirschfield.

Do you recall whether or not the figures you have examined into would exceed the approximate somewhere between \$11,625,000,000 and the \$14,625,000,000 a year for these services under S. 1050?

Mr. GREEN. We have not made a comparison between our figures and those figures to which you have referred, so I could not at the moment say how they would measure up.

Senator DONNELL. I am wondering, Mr. Green, if it would be too much trouble to you to furnish the committee with your estimate of the total expenditures involved, to carry out the proposed program S.1050, broken down to the component parts; and include also estimates of the S. 1606.

Mr. GREEN. I would be glad to supply all the information we can in response to your suggestion. (The information is inserted on p. 518.)

Senator DONNELL. Yes.

Senator AIKEN. Let me get those figures again.

Senator DONNELL. \$11,625,000,000 up to \$14,625,000,000.

Senator AIKEN. That is an average of \$100 per capita for the population of the United States.

Mr. GREEN. That is the annual cost.

Senator DONNELL. I think that is the annual cost; yes, sir.

Mr. GREEN. It covers the early period.

Senator DONNELL. That is my understanding; yes, sir. Now, Mr. Green, I observe also in this document, this statement is made at page 64. I would be obliged if you would give us your conclusion as to the correctness of this statement:

The social security program, as set up in this bill, would require a Federal subsidy, based on the most conservative estimates, in excess of 50 percent of the total annual expenditures.

Would you be kind enough to give us your ideas on that?

Mr. GREEN. We will be glad to, Senator.

Senator DONNELL. As I understand this document, in arriving at this Federal subsidy he is assuming a 4 percent contribution from employers and a 4 percent contribution from employees, and bases his view on the proposition that over and above that 4 percent contribution from employees and 4 percent contribution from employers there would be necessary Federal subsidy of more than 50 percent of these entire figures to which he refers.

Mr. GREEN. Fifty percent of that total?

Senator DONNELL. That is my understanding. I may be in error. And if you have not at hand one of these documents I will be glad to see that you get a copy of this.

Mr. GREEN. We will do all we can, sir.

Senator ELLENDER. Well, I wonder if Mr. Green would give us an idea of how he thinks this whole plan should be financed? Have you studied it any to determine that?

Mr. GREEN. Yes. We have set that forth in the Murray-Wagner-Dingell bill.

Senator ELLENDER. We are considering S. 1606 at the moment.

Mr. GREEN. Yes. Well, that does not specify the method.

Senator ELLENDER. I understand that. That is why I asked the question.

Mr. GREEN. It will have to be covered in either the Murray-Wagner-Dingell bill as the basis, or some other supplemental legislation, and as we figured it, will run about 4 percent contributions.

Mr. CRUIKSHANK. A total of four from each.

Senator ELLENDER. That is four from employees and four from employers?

Mr. CRUIKSHANK. For the entire program.

Senator ELLENDER. What contributions are contemplated from the Federal Government out of the Treasury?

Mr. GREEN. There is no special definite amount fixed.

Of course, we figure that whatever it is would be a sound investment on the part of the Government, because we cannot conceive of anything being included as a more chief asset to the Nation than good health.

Senator ELLENDER. I agree with you. The point is, though, that in the event that the 4 percent from employers and 4 percent from employees is not sufficient, would you advocate that the Federal Government dip into the Treasury for the purpose of getting sufficient funds to operate the program?

Mr. GREEN. Well, that should be reduced to the lowest possible cost. Because we do not want it to be a purely paternalistic affair. We base it upon the principles of insurance. That is what I emphasize in this statement, a contribution by employers and employees to the cost of providing the insurance payments, hospital care, medical care, laboratory care, special care, specialists, whatever may be needed in order to protect the health of the Nation. The health of the Nation; that is the point.

Senator DONNELL. Mr. Green, may I ask you, please, if you have given thought to this question: It was suggested by one of the witnesses here earlier in the hearings that this program could be financed in one of two ways or a combination of those two ways.

One is a pay-roll contribution exclusively. The other is an earmarked income tax. The third is a combination of those two methods of financing.

Have you given thought to which of those various methods should be used or whether it should be a combination?

Mr. GREEN. Yes, we have, Senator, and we favor the pay-roll plan.

Senator DONNELL. You favor the pay-roll plan?

Mr. GREEN. Yes. Because that seems to be the practical, constructive, and permanent way in which the money can be raised. It has to be borne in mind that there is a social purpose to social insurance if the health of the workers is protected and improved, all segments of society benefit. It is proper, therefore, that insurance contributions be supplemented by payments from the general revenue of the Government.

Senator DONNELL. Are you able to tell us, Mr. Green, approximately the aggregate pay roll upon which this tax would be imposed?

Mr. GREEN. No, I could not give you that, because that fluctuates, too.

Senator DONNELL. Do you know what the variations are, say in 1945 and 1946? What the variations were in this country?

Mr. GREEN. I have not gone into that, Senator. I do not think I can. I do not know whether our research department have prepared those figures. I do not have them with me.

Senator DONNELL. The point I was getting at, Mr. Green—and I am sure we would be happy to have your views—this writer, Dr. Earl E. Muntz, takes the view that the social security program as set up in S. 1050, which is the over-all program you favor, would require not merely the 4 percent contribution from employers and the 4 percent contribution from employees, but would require a Federal subsidy

from some other source of more than 50 percent of these aggregate bills or dollars of figures.

Mr. GREEN. Fifty percent of the total amount?

Senator DONNELL. In other words, if I may make my statement more correctly, as I understand his proposition, he thinks that if you impose a tax of 4 percent on employees and 4 percent on employers, that you will fall short of meeting the total expenditures under this entire program by more than 50 percent, so that if you adopt Hirschfield's figures you will have to raise over \$7,600,000,000 through other sources.

Mr. GREEN. I see.

Senator DONNELL. If that be true, Mr. Green, would you favor increasing the pay-roll payments by this additional amount, which would be more than 100 percent of the 4 percent from employers and employees, so that each would put up over 8 percent? Would you favor that rather than dipping into the Public Treasury and making a general charge against the entire public?

Mr. GREEN. That is an "if" proposal.

Senator DONNELL. Yes.

Mr. GREEN. Our whole theory upon which S. 1050 is based is that the contributions made by employers and employees during the early years of the program will be adequate to meet the insurance requirements in order to provide all these things for the people. Later on, it may be necessary to have additional Government help in financing.

Now, then, based on that theory, we would want the plan to measure up to the standard requirements we have set, but at the same time we have to keep in mind that we cannot make it burdensome, that is, too great for the average worker to bear. He is not, probably, economically able to bear a heavy burden, and it needs to be as light as is possible, and the administration of it as economical as possible, so as to save the money.

Senator DONNELL. If it be true that the total cost carried into effect in the program in S. 1050 would require over twice as much as would be derived from the 4 percent on employers and the 4 percent tax on employees, would you favor increasing the contributions of employers and employees from 4 percent to 9 percent each? Nine percent against employers and 9 percent against employees? Or would you favor making up the difference between the respective 4 percent by general contributions out of the Public Treasury?

Mr. GREEN. I would be opposed first to the imposition upon employers and employees of costs that would be economically unsound and burdensome. At the same time, I think, in order to avoid the public being required to pay or to bear too much expense, that then we would have to make the service conform to what we were able to pay and what we could raise.

Senator DONNELL. That is, if you should conclude that the maximum payments that are practical to be made from employers and employees are 4 percent from employers and 4 percent from employees on the pay rolls, you would favor cutting the garment by the cloth and not giving more service than those would pay for?

Mr. GREEN. I do not know that I would fix it at that definite amount, but the principle you have just announced is sound.

Senator DONNELL. I did not mean to hold you down to that exact figure, but that is the principle?

Mr. GREEN. Yes.

Mr. CRUIKSHANK. May I comment on that?

The CHAIRMAN. Yes.

Mr. CRUIKSHANK. It has to be borne in mind that S. 1050 carries benefit provisions for a great many people not included under the direct insurance system. The dependents are extended disability and all, which are already recognized as part of the Government responsibility.

Senator DONNELL. Yes, sir.

Mr. CRUIKSHANK. Therefore, you would have to separate the cost in terms of coverage. You would have to identify them, and not all of that can be referred to as an increased cost on the Government or an increased responsibility of the Government.

Senator DONNELL. I appreciate the correctness of what you have said. That under S. 1050 there are numerous services, as I understand it, that are not applicable solely to the persons that would receive the benefits under compulsory health insurance. I think you are correct in that.

Senator PEPPER. For example, S. 1050 would provide for old-age assistance, and that should be provided out of the Federal Treasury without being a tax on pay rolls, for example.

Mr. GREEN. Another thing you must take into account, Senator, is this: The local governments, State governments, and the Federal Government are required under our present system to take care of a lot of dependents.

Senator DONNELL. Yes.

Mr. GREEN. It is contemplated that under this bill we will relieve them of that very largely. And that is S. 1050. That cost must be taken into account when you are arriving at a definite conclusion.

Senator DONNELL. That is, your idea would be to relieve the States of a greater part of that burden and take it over as a Federal obligation?

Mr. GREEN. Under this operation of your bill it will automatically do that.

Senator DONNELL. That is what I mean, that S. 1050 would automatically take over from the States many of those functions to which you refer?

Mr. GREEN. Much of it; yes.

#### SELECTIVE SERVICE REJECTIONS

Senator DONNELL. Much of it. You also referred, Mr. Green, in your testimony, to the figures of physical unfitness revealed by the selective-service examinations, and I quote this language from your statement:

With the whole record now before us, these figures are more shocking than appeared at first. Where we have been saying that a third of our young men were found physically unfit for the "duties of citizens in wartime," to use General Hershey's phrase, actually it is now revealed that fully a half of the young men failed to meet the Army's standards.

What is the source, Mr. Green, of your statistical information there?

Mr. GREEN. Selective Service.

Senator DONNELL. Selective Service. Now, I hold in my hand a document which I am told is from the Selective Service official figures. Am I right in that, doctor?

Dr. GOODRICH. Yes.

Senator DONNELL. And I observe these facts, if I may summarize just a little. This is the figure at the top. The "total number of rejections" were set out as 4,049,000, which I understand from a penciled note to me is 30 percent of all registrants examined. Also, in this 4,049,000, there are a considerable number who as I understand it are persons whose rejection was not cast as the result of facts arising from inadequate medical care or from disability which would disable a person from normal civilian activity. For instance, here is "mental diseases," 657,100. "Mental deficiency," 563,300. Then there is a series of physical defects, "eyes," 206,100; "ears," 156,100. Now, I shall submit later for the record more in detail on this, but the figures as given to me by my informant indicate that of the 4,049,000 persons rejected, of that 100 percent, 70.7 percent were as the result not of inadequate medical care or disability from normal civilian activity. I am wondering whether or not your investigation and analysis of the Selective Service figures indicate substantially the same conclusions with respect to those figures?

Mr. GREEN. I have not gone into that in detail in the way you have pointed it out.

Senator DONNELL. Yes, sir.

Mr. GREEN. But I have accepted the Selective Services report, and, of course, the "eyes" and "mental deficiency" and "mental trouble," "eye trouble," "ear trouble," all of that may mean that if these people had been given proper medical care and attention for eyes and ears and mental deficiency, they might have been restored to normal life.

The CHAIRMAN. At that point, Mr. Green, is it not true that most of the eye defects in the country occur at the time of birth?

Mr. GREEN. That is what I say.

The CHAIRMAN. Due to inadequate attention?

Mr. GREEN. I was going to make that point, that most of the eye troubles occur during the infant period, many times, and sometimes during the birth period. If you take a poor man, he has not the money to go out and get a specialist. Under this plan they might save a lot of those eyes, and that is what we are trying to do, save them.

Senator DONNELL. As I stated in my question, I shall go into this matter more fully when we have the physicians on the stand.

The CHAIRMAN. We would be glad to have the author of that appear as a witness.

Senator DONNELL. Dr. Goodrich, from my State, furnished this, and he has in turn selected this from the Selective Service records.

Dr. GOODRICH. Yes, sir.

Mr. CRUIKSHANK. Those are total rejections.

Senator DONNELL. They are.

Mr. CRUIKSHANK. The difference in the figures is largely that that is a rejection figure, whereas the Selective Service figures we used include the Army figures on the number of corrections and the number of discharges after induction, which brings them up to about 50 percent. The round number figures on this are as follows: There were 4,500,000 selectees classified 4-F. One million plus were discharged after induction for health reasons; 1,500,000 more inducted and physically rehabilitated before they could be put into active service. This totals 7,000,000 plus—roughly 50 percent of the total of 14,000,000.

The CHAIRMAN. So that under the Selective Service many young men were brought into the service who had to be discharged.

Mr. GREEN. That is right. They found from experience that they were deficient.

Senator DONNELL. I shall examine into that more thoroughly, Mr. Chairman, with the permission of the committee, a little later.

I would like the record also to show that there appears in this exhibit from which I have been reading this line:

Mental deficiency. (1)

Then the figures 563,000; the percent as 13.9. And that note "1" appears as follows:

includes registrants rejected for educational deficiency before June 1, 1943, and for failure to meet minimum intelligence standards after that date, as well as those rejected for mental deficiency.

I offer that for the record.

The CHAIRMAN. I might suggest at that point that many of those cases of rejection because of mental deficiency or educational deficiency may be due, more or less, to the failure of an adequate health care system in the United States.

Mr. GREEN. Oh, yes, certainly. Certainly, Senator.

Senator DONNELL. Mr. Chairman, I do not want to monopolize the time of the committee. I would like to ask just a very few more questions.

#### FREE CHOICE OF DOCTORS

Mr. Green, I would like to ask you, also, as to a statement which appears in your testimony on page 4 that—

We do not feel that our position is in the least in violation of our traditional principle, as the element of compulsion in health insurance is confined to the matter of coverage and to the payments of contributions.

In that connection I call to your attention the provision of subdivision (j) of section 205 of the act, which appears at page 50, which reads:

In order to maintain high standards in the quality of services furnished as medical or dental benefit, the Surgeon General may prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish general medical or general dental benefit, and such limits may be nationally uniform or may be adapted to take account of relevant factors.

Now, I call your attention to the fact that as I understand that section, it refers to the situation in which in a given locality the so-called per capita basis of payment has been adopted by majority vote of the physicians concerned.

I will ask you to state, Mr. Green, please, whether or not you agree that this situation could easily develop: We will take a community where there are five doctors who go into this governmental plan. There are 5,000 people in the community, who would come under the plan. The most popular of those five doctors would be rather promptly selected by many of the people in that group. Suppose that they would select the doctor to the extent of the maximum number of potential beneficiaries prescribed by the Surgeon General. Then suppose you or I, living in that community, should come to that particular

physician and desire treatment from him. He would respond that his quota was already filled. Would you not agree that in that case, whether it be an exceptional one or not, that in that illustration there would be a restriction on your choice and mine? We would not be able to choose him as our doctor, would we, Mr. Green?

Mr. GREEN. Well, you present a very unusual problem, but of course in one sense it is unusual, and in another sense it is not unusual. It is not unusual today under our private practice program. We find that the popular doctor, even in small communities, cannot respond to all the requests made upon him for service, and the ailing person or those whom the ailing person depends upon must find some other doctor to come in and render service. That is because of the population problem, the unusual amount of sickness that might occur, the unusual amount of illness that might prevail in a community. These are factors which of course we cannot cover in legislation. If a doctor is just physically unable to respond to every call you cannot change that condition. You have just got to do the best you can, Senator.

Senator DONNELL. May I present two thoughts in response to that suggestion.

First, under existing conditions today, at this minute, the matter of decision as to whether or not the doctor will accept you or me would rest with him, would it not, rather than be determined by the Surgeon General? That is correct, is it not?

Mr. GREEN. Oh, certainly. He decides that.

Senator DONNELL. So that under the bill there is this difference: That in the case to which I refer the decision as to whether or not he could take us as patients would rest not with the doctor but with the Surgeon General? That is correct, is it not?

Mr. GREEN. You must bear in mind that he makes that decision in connection with his advisory board.

Senator DONNELL. I do not think so in this case, Mr. Green.

Mr. GREEN. I think his action is all based upon a consultation with his advisory board.

Senator DONNELL. I do not believe that you are correct.

Mr. GREEN. Well I think I am.

Senator DONNELL. I know you are perfectly honest in thinking that, and I might be mistaken, but I think the language of subdivision (j) on page 50 vests that particular authority exclusively in the Surgeon General with no remarks. However, at any rate, the advisory council is merely advisory and not vested with authority to determine; that is correct, is it not?

Mr. GREEN. I think this is a little different. I think by implication, at least, the Surgeon General is required to carry out the advice of the advisory council.

Senator DONNELL. Do you think there is any legal obligation in this bill?

Mr. GREEN. Probably not, but a moral obligation.

Senator DONNELL. Then you think the ultimate right is not in the Surgeon General but in the advisory council?

Mr. GREEN. I think in most of the questions that will come up that it will rest with the advisory council.

In section 204 of this bill authorities and responsibilities of this Council are thoroughly spelled out. It says—I refer to page 43 beginning line 18—

The Advisory Council shall advise the Surgeon General with reference to questions of general policy and administration in carrying out the provisions of this title including \* \* \*

and then it lists seven specific areas of responsibility.

Number 6—page 44, line 14—is as follows:

Studies and surveys of personal health services—

Now note also that section 203 (1)—page 41 beginning line 16—under the general heading “Administration” states:

The Surgeon General shall make a full report to Congress, at the beginning of each regular session, of the administration of the functions with which he is charged under this title. Such report shall include a record of consultations with the Advisory Council, recommendations of the Advisory Council, and comments thereon.

Now in our democratic system it is very difficult to imagine the Surgeon General operating under that kind of requirement to become arbitrary or dictatorial. If he should, it would be even more difficult to imagine him remaining long in his office.

Senator DONNELL. Do you not think the bill should be clearly stated to the effect that the advisory council makes the decision and that that decision supersedes that of the Surgeon General?

Mr. GREEN. If there is any conflict. Either that it is the Surgeon General or the advisory board.

Senator DONNELL. As I read the bill, and I may be in error, but as I read the bill what I have read on that question in the bill would seem to indicate that the council is an advisory council, and that the Surgeon General is not legally obligated to follow its recommendations.

Mr. GREEN. We will go into that.

Senator DONNELL. Very well. The point I am making is this: As I see it, Mr. Green, today if you or I were to go to this doctor I have spoken of he could decide for himself whether or not he had arrived at the maximum of his capacity, and there would be no Government official to tell him whether he had or not? That is correct, is it not?

Mr. GREEN. Well, you must take the situation as you find it.

Senator DONNELL. Yes.

Mr. GREEN. I have found that doctors in a community respond to every call made by those whom they have served and who regard him as their family physician. They respond if it is physically possible for them to do so. If it is impossible they simply say, “Get Dr. John Jones or Dr. Bill Smith instead, because I cannot come.”

Senator DONNELL. Yes.

Mr. GREEN. In order, I suppose, to meet that situation this bill puts into the hands of the Surgeon General certain authority to deal with those unusual cases.

Senator DONNELL. The point I make, Mr. Green—

Mr. GREEN. That is how I interpret it.

Senator DONNELL. I understand your point. The point I make in response to that is that today, right this minute, the situation is that if you were to become ill and go to a doctor, if the doctor decides that he has not arrived at his capacity he can accept you, and he is the man that makes the decision? That is right, is it not?

Mr. GREEN. That is right.

Senator DONNELL. Whereas under the bill, this (j) of 205, the Surgeon General determines the maximum number of potential beneficiaries for the doctor, and it is the decision of the Surgeon General rather than of the individual doctor that governs the case? That is correct, is it not?

Mr. GREEN. It does, in this particular matter there.

Senator DONNELL. That is what I mean.

Mr. GREEN. Yes, sir.

Senator DONNELL. I want to ask one other question for the moment. You mention over on the final page of the statement—which, by the way, is a most interesting one, and I know we are glad to have it—your statement is that you feel this committee would be derelict in its responsibility to the public unless the source of the funds for some of these organizations had been thoroughly investigated and made known to the public. May I ask you if you have investigated the attitude of the American Medical Association with respect to this compulsory health insurance?

Mr. GREEN. In what respect? As I understand it, the American Medical Association is opposed to it.

Senator DONNELL. Yes.

Mr. GREEN. As an association.

Senator DONNELL. Did you mean, though, by reference here to these various organizations the source of whose funds should be investigated, did you mean to include the American Medical Association?

Mr. GREEN. I certainly did.

Senator DONNELL. You think that association should be included?

Mr. GREEN. I certainly do.

Senator DONNELL. You know that that association does contain a very large proportion of the practicing physicians and surgeons in the country?

Mr. GREEN. Yes, sir.

Senator DONNELL. And it is considered generally a very reputable organization?

Mr. GREEN. That is right.

Mr. CRUIKSHANK. May I make a comment on that, Mr. Chairman?

The CHAIRMAN. Yes.

Mr. CRUIKSHANK. Some time ago Miss Florence Thorne and I, both of whom were on President Green's staff, received a request from a committee of the American Medical Association to come over to the Mayflower Hotel in Washington to discuss with them the various proposals. We consulted with President Green, and he told us by all means to consult with them, as representatives of the predominant group of the medical association. We went over, and they, in the course of their discussions, asked us if we would be willing to confer with a committee of the American Medical Association on health insurance provisions, and particularly the provisions of the Wagner-Murray-Dingell bill. I think I can say that they were somewhat surprised when we responded that we would be very glad to confer with them any time, any place, at a meeting of their choosing. We followed that up with a confirming letter. That was over a year ago, and we are still waiting the invitation of the American Medical Association to confer with them on this problem.

The CHAIRMAN. I might ask there, do you infer from that that they had no intention of discussing these problems with you at the time, and merely expected you to refuse to consult with them?

Mr. CRUIKSHANK. We can only go on the record, Mr. Chairman. The indication at the meeting was that they were somewhat surprised by our ready acceptance of their offer, and we have not yet received the invitation to confer with them.

Senator DONNELL. Do you recall to whom your letter was addressed?

Mr. CRUIKSHANK. It was the chairman of the committee; and the name of the committee has skipped my mind.

Senator DONNELL. Do you have a copy of that?

Mr. CRUIKSHANK. Yes.

Senator DONNELL. Would you mind giving us that information?

Mr. CRUIKSHANK. Not a bit.

(The letter appears in Volume II of the hearings.)

Senator PEPPER. Mr. Green, you did not have to make an extended investigation or inquiry to discover the attitude of the American Medical Association?

Mr. GREEN. Certainly not.

#### SURVIVAL OF OUR SYSTEM DEPENDS UPON ECONOMIC SECURITY

Senator MORSE. Mr. Chairman, I would like to discuss with Mr. Green for just a moment or two a problem which may not seem at first glance to be directly connected with this bill, but I think it is pretty underlying as we come to consider the philosophy of government that we want to have maintained in this country.

Now, I am sure that Mr. Green's answer will be in the affirmative to my inquiry, whether or not it is not true that the American Federation of Labor believes that the economy that can best maintain a decent standard of living for the American workers is a private property economy? That is true, is it not?

Mr. GREEN. That is right.

Senator MORSE. And that in order to maintain a private property economy we are going to have to maintain in this country to the maximum extent possible the profit motive, subject to regulations of government that will protect people from exploitation under that system. That is correct, too, is it not?

Mr. GREEN. That is correct.

Senator MORSE. And would you agree with me that we are faced in this country, as are so many nations of the world, with competition among ideologies as to economic forms that ought to prevail. To be perfectly specific about it, we might as well face the fact that probably in a decade ahead there is going to be a considerable movement in this country for some form of state socialism in various activities of our economic life, and that to the degree that state socialism comes to dominate this country, to that same degree, of course, the rights of workers as well as other individuals must be subordinated to a master state? Would you agree to that?

Mr. GREEN. I agree with that.

Senator MORSE. In this struggle, however, for the government to fulfill what I think are its minimum obligation to protect, as I have said so many times the economic weak from the exploitation of the

economic strong, our workers and people generally say to a democratic form of government, "you do have, as a government, the responsibility of removing from us as free men a constant fear of economic insecurity"; do you think that is true?

Mr. GREEN. That is quite true, Senator. All of that is sound.

Senator MORSE. We might as well face the fact that inherent in the labor movement in this country is the demand of free workers that this economy of work under a private property form be so operated as to reduce to the minimum the fear of economic security, and thus we who call ourselves liberals are constantly fighting for minimum wage legislation, or legislation that sets up minimum economic and social standards that will protect our people as a whole, and, in my judgment, protect the preservation of private property economy. Now, with that movement going on in the decade ahead, would you agree with me that one of the demands is going to be that the Government use its resources in cooperating with the medical profession of this country to see to it that the fear of economic insecurity constantly hovering over the roof of every house in this country—at least of our medium- and low-income groups—be removed by providing those householders with decent medical care under a system which at the same time preserves to the greatest degree possible the private property conception and the private property economy conception and at the same time fulfills the obligation of the Government to protect our people from the danger of ill health?

Or, to put it this way: would you agree with me that the law of survival of the fittest still prevails, even in our civilized society, but that the workers of this country are insisting that the law of survival of the fittest should not operate on the basis of economic ability of the individual to survive as far as health is concerned?

Mr. GREEN. Yes. You have brought out some very convincing points which I agree with.

Senator MORSE. So far you are with me?

Mr. GREEN. Yes.

Senator MORSE. There is just one more point. Would you agree with me that there is an obligation on the part of the medical profession to come forward with a program that will remove this fear from the workers of this country, and still give to the American medical profession this so-called private property economy that they claim under this proposal? Do you agree that there is an obligation on that profession to come forward with a plan that removes that fear that is hovering over every roof in the land?

Mr. GREEN. I agree heartily with that conclusion, and I want to say to you that never in the history of America did such an opportunity present itself to the medical profession to organized labor; and to business groups to contribute toward the maintenance, the establishment and maintenance of our free enterprise system than now. Than now!

Senator MORSE. I agree with you.

Mr. GREEN. And enactment of legislation of this kind will do more to maintain and establish our free enterprise system in America than anything I can think of. The picture, as it unfolds in other lands, is that the movement is to the left, very decisively to the left. Why? Because the masses of the people have arrived at the conclusion that they cannot get the protection they need, the economic

security they need, the freedom from want that they need, under a free enterprise system.

That is menacing. It is a shadow that is hanging over the world, and unless we measure up to the requirements of the situation and emphasize more and more the creation of a feeling of security, the removal of fear of want, from the minds and hearts of the masses of the people, our free enterprise system is going to be severely menaced.

#### WORKMEN'S COMPENSATION

Let me give you an illustration that is concrete and definite, regarding this voluntary and this compulsory insurance plan. And the medical profession know about this, because they participated in it, too.

From 1911 to 1915 I served as a member of the Ohio Senate, and while serving as a member of the Ohio Senate I was elected to be the majority leader in the senate. I introduced at that time a compulsory workmen's compensation law; and it was regarded as revolutionary, Senator, because it was compulsory in character; and when I explain to you briefly one or two of its outstanding provisions you will agree with me.

I worked in the mines for 20 years. And I saw thousands of our miners injured and killed during the course of employment. And they suffered and died because there was no compensation for them, no hospital care. They did not have the money. The only way they could get anything was to go into court and sue.

The CHAIRMAN. And the lawyer took 50 percent of what they recovered, generally?

Mr. GREEN. Yes. That was the old system.

Well, it hurt me so that when I was elected to the senate, along with some of the other leaders there, I drafted this bill and introduced it. There were no compensation laws in effect at that time except in perhaps one other State. There was none of the character that we enacted in the Ohio Legislature, for it provided that every employer in Ohio was compelled to contribute a percentage of the earnings of the company or the investment of the company to a State fund, to be administered by the State, and out of that State fund compensation at so much per week would be paid to an injured employee and so much to the dependents of a killed employee; and it provided further for hospitalization, the best that could be given, expert service, care for the injured person until he was recovered.

Senator MORSE. I do not want to add anything more, Mr. Chairman, except that I think after all the underlying philosophy of this type of legislation is pretty important, and it involves, as I see it, pretty much a balancing of interests here between the obligations of the State and the obligations of the segments of our economy such as the medical profession, in this instance. Or, in some other instance, perhaps it may be employers in the other group balancing the interests whereby the individual economic group can have the maximum possible freedom under our private property economy, and at the same time the State will fulfill what I consider to be its obligations to maintain minimum standards of health and decency in this country.

I am so much concerned about it that I would like to have Mr. Green give me his point of view on just one other angle of it, because I think this is no time to be sticking our heads in the sand in America.

Would you agree with me, Mr. Green, that down in the working groups within your trade-union movement one of the most fertile apostles of a radical movement within a union is the individual who has suffered a tremendous loss in his family out of illness? He has seen a child die because he has not been able to give it the care that it needs, or a wife taken away because of inadequate medical care? Are not those individuals in this country fertile apostles who would agitate us into a Socialist form of economy?

Mr. GREEN. That is true. We deal with that. That is a part of our problem. We have got to answer these people, tell them what we are trying to do, and protect them.

Senator MORSE. I just want to close by saying that I think the medical profession is entitled to protection in the private property economy, but it has an obligation, too, in that it can best preserve that form of economy for the country as a whole if it will rise to its obligations to see to it that this fear of insecurity growing out of the failure of the great masses to have medical care, which is one of the great dangers to the preservation of private property economy, is done away with.

And the medical profession needs to keep in mind always that whenever a large segment of our people see individuals in a better economic position who have benefits out of the private property economy that these others do not enjoy, that they then form the ranks of the army.

I would put it this way: when you have a large segment or army of people that have little to lose in a change to state socialism, you encourage development of State socialism. I have yet to be convinced on the merits of all the features of the so-called Wagner-Murray-Dingell legislation, but I have said at the medical profession meetings, and I say here now, that I think the medical profession has got to go much further than it has gone yet to see to it that adequate medical care is given the masses of our people, large segments of which do not get it now. It is a great citizenship service they can perform if they really want a private property economy.

I close with this comment: just as sure as we are sitting here, and there is no sense in kidding ourselves about it, and the doctors had better recognize it, that just as sure as we are sitting here, the next decade is going to see a demand on the part of the majority of the people of this country for greater attention on the part of our Government to the health of the people of this country; and friends of the medical profession in the Congress of the United States, in my judgment, are going to be driven from the Congress if they take the position that no legislation at all shall be passed to improve the health of the Nation.

Mr. GREEN. Pardon me for interrupting you, Senator; I thought you were through.

Senator MORSE. I am through now.

Mr. GREEN. I mean a while ago.

Senator MORSE. I have probably said too much.

Mr. GREEN. I was up to this point.

The medical profession in Ohio opposed the law as they are opposing this, because it provided for the selection of doctors on the part of the patient in the same way as this. Employers united in opposition to the law because they said it was compulsory, "You are making us do it." We had an awful fight; but finally we secured the enactment of the law; and now in Ohio the employers are denied the right to buy workmen's compensation insurance. Insurance companies are prevented from selling workmen's compensation insurance in Ohio. Every dollar that is collected is used to pay benefits; none for premiums to any insured company.

Senator MORSE. Or for properties.

Mr. GREEN. No property. All goes into the state fund. It is administered economically, and as the result of it the cost for workmen's compensation payments in Ohio is less than most any other State in the country.

Now, I recall in those days when the medical profession came in in groups and the employers came in in groups, and said, "This will drive us out of Ohio. It will confiscate our property, destroy our profession. It is socialism in the most violent form." And all that. And we had tremendous opposition. That was back in 1912, the pioneering in that sort of social security legislation.

Today the employers in Ohio, the medical profession, and labor are united in support of the bill. They would not have it changed or amended. But you had to practically compel employers and the medical profession to accept the bill. It is about the same thing here.

#### S. 1606 IS NOT SOCIALISTIC

Senator PEPPER. I was just going to say that we all know that one of the most severe criticisms leveled against this bill is that same old catch word of "socialism."

Mr. GREEN. That is right.

Senator PEPPER. They say, "Are you in favor of that Wagner-Murray-Dingell bill? That is that socialized medicine bill."

Do you regard, Mr. Green, a national law which requires compulsory membership in a national insurance program as being socialism in any form?

Mr. GREEN. None whatever.

Senator PEPPER. Is it any different in principle from the present law that nobody has suggested the repeal of that has been on the statute books of the nation, by which under national compulsion employees and employers contribute to a fund to insure the worker against unemployment in the country?

Mr. GREEN. The same principle is involved.

Senator PEPPER. Exactly.

Mr. GREEN. There is no difference. There is nothing socialistic about that.

Senator PEPPER. In the various states of the union we have compulsory school laws, where parents are required by the state to send children to school in the public interest, and we do not want to call those things socialistic.

Mr. GREEN. No.

Senator PEPPER. Socialist medicine would perhaps be the kind in Russia, where the patient pays nothing at all; where the state does the whole thing?

Mr. GREEN. Yes. The whole thing.

Senator PEPPER. And that, of course, is not this bill in any sense.

Mr. GREEN. This is positively insurance, based upon our sound insurance system.

The CHAIRMAN. This maintains the American medical profession in this country, and will have the effect of raising the income of a great majority of the doctors of the country.

Mr. GREEN. That is right.

Senator DONNELL. May I ask Mr. Green a few questions, Mr. Chairman.

Mr. Green, under this plan in S. 1606 doctors who are paid from the moneys raised in pursuance of the development of this plan will be employees of the government to that extent, will they not?

Mr. GREEN. No, I would not regard them as employees of the government. They are simply being paid out of a fund created through contributions from employers and employees.

Senator DONNELL. You would not regard them as employees of the Government?

Mr. GREEN. No.

Senator DONNELL. Let me ask you this: Mr. Green, while I appreciate the comments made with respect to the health of our people, after all the question here is the means of bringing that about. There may be an honest difference of opinion as to that?

Mr. GREEN. That is right. But the trouble is, we have been experimenting for how long has the government been here? 175 or 200 years.

#### VOLUNTARY HEALTH INSURANCE

Senator DONNELL. Of course, it has been a gradual development. For instance, there are some 20 or 21 million people now availing themselves of the voluntary Blue Cross plan; is that not your understanding?

Mr. GREEN. Yes.

Senator DONNELL. I wanted to ask you, Mr. Green, do you know whether or not the medical profession is itself at this time working along the line of some voluntary nonprofit prepayment plan of medical care?

Mr. GREEN. I understand they are.

Senator DONNELL. Yes, sir.

Mr. GREEN. But the trouble is that that plan fails, because everywhere the difficulties are added to by a population problem.

Senator DONNELL. Of course, it would have to keep going on.

Mr. GREEN. There is always an increasing number who for economic reasons cannot secure medical care at all.

Senator DONNELL. At any rate, it is your understanding that the medical profession is engaged in thought upon this question?

Mr. GREEN. They offer a voluntary plan.

The CHAIRMAN. Well, Mr. Green, it is only recently they have even adopted that system. They fought the group medical programs that were developing in the country just a few years back.

Mr. GREEN. I think it was recently they formulated that plan.

Senator DONNELL. Pardon me, just a second. Of course, as Mr. Green pointed out in his statement, such a great man as Mr. Gompers took once a different view.

Mr. GREEN. Yes.

Senator DONNELL. That is, our minds change as the time goes on.

Mr. GREEN. For different reasons.

Senator DONNELL. I am not questioning that. The medical profession is at this time, according to your general understanding, is it not, Mr. Green, very seriously considering the development of some voluntary nonprofit prepayment plan of insurance for people? That is correct, is it not?

Mr. GREEN. I understand they are.

Senator DONNELL. What I am getting at is this: if it be true that under this proposed plan, S. 1606, and I understand that you do not agree with this hypothesis, but if it be true that it would tend to dull the initiative of physicians who when they have a particular contract cannot go beyond it, have little incentive for employing themselves and bettering themselves, if it should be that the medical profession could work out a plan which would be substantially all inclusive, as S. 1606, which, by the way, is not all inclusive, but only covers about 80 or 90 percent; but if they could work that out, do you not think there is some advantage in giving the medical profession the opportunity to submit those plans and attempt to work them out?

Mr. GREEN. Senator, I do not agree with your hypothesis at all.

Senator DONNELL. I know.

Mr. GREEN. And, secondly there is nothing in the world that teaches you a lesson more valuable than human experience.

Senator DONNELL. Yes.

Mr. GREEN. There is where we learn valuable lessons, in the field of human experience. We have learned during the years that we have lived that the voluntary plan does not work. Now, I have given you an illustration of the voluntary and compulsory plans.

Senator DONNELL. Yes.

Mr. GREEN. In the development of the social justice program in Ohio.

Senator DONNELL. Yes.

Mr. GREEN. Now, the medical profession assumed the same position toward that legislation that it is assuming now; but now it admits it was mistaken and is satisfied to go along.

Senator DONNELL. Yes, sir.

Mr. GREEN. Should not we learn through that experience that they were wrong?

Senator DONNELL. Of course, it does not necessarily follow that because they may have been wrong in something else they may be wrong today?

Mr. GREEN. But the same principle is involved.

Senator DONNELL. I am not so sure.

Mr. GREEN. The doctors are brought in under this plan. The injured worker has the right to select his physician out of a panel, but they are paid out of a State fund.

Senator DONNELL. May I ask two other questions on this matter on experience. You referred to "experience" and I had the word "experience" down to ask you about.

Mr. GREEN. Yes.

Senator DONNELL. I am asking for your observation. Have you studied what happened in England with respect to initiative and the development of ability among the physicians over there?

Mr. GREEN. Perhaps not as much as I should. Do you know about the health insurance they passed over there in England?

Senator DONNELL. No; I am not informed on it. But I want to say this: What I am asking you about is whether or not you have studied the English experience with a view to determining what has been the effect on the development of initiative among the English physicians? Have you studied that?

Mr. GREEN. No; I have not gone into that.

Senator DONNELL. May I ask you this: And I will say that I cannot answer this. We are studying here, trying to find out things. We are happy to have testimony from anybody who knows and can give us advice. I do not claim to know all about this, and what I do not know fills more volumes than what I do know, which is very small.

In the matter of the experience of New Zealand; they have had experience which for some reason has not proved satisfactory. Do you know why that is?

Mr. GREEN. I do not know. I could not tell you, Senator.

Senator DONNELL. My understanding is that in New Zealand their plan has pretty largely failed. It may be due to something entirely contrary to the basic principles; I do not know.

Mr. GREEN. I am sorry. I could not give you information on that, because I admit I have none.

Senator DONNELL. Yes, sir. Well, thank you very much, Mr. Green, for your information and observations.

Mr. GREEN. All right, Senator.

Senator PEPPER. Senator Donnell a minute ago referred to the 21,000,000 covered under the Blue Cross plans. I am sure the Senator did not mean to infer that in excess of about 3 percent of the people of this country have anything like the total coverage under the voluntary plans that is provided in this bill. There are perhaps 21,000,000 people who have different kinds of coverage.

Senator DONNELL. Yes.

Senator PEPPER. But our subcommittee disclosed facts, after comprehensive examination of all voluntary plans in existence, that only about 3 percent of the total people in the country have anything like the total coverage of this bill.

Mr. GREEN. Yes.

Senator DONNELL. I had no intention of leaving any thought like that.

Senator PEPPER. We also disclosed in our inquiry that under the most favorable system the voluntary plans were not a success. For example, that the Department of Agriculture, through the Farm Security Administration, tried in the rural area and got, through experimenting and subsidizing the voluntary plans with Federal funds, poor results. Even there, where they were voluntary plans in character, the ones who needed the medical care the most dropped out first or failed to join.

Mr. GREEN. That is the way it operates.

Senator PEPPER. So the Department of Agriculture, in a brochure they prepared at the request of this Committee, advised us that under any most favorable system the voluntary plan had not been a success.

Mr. GREEN. That is my understanding.

Senator PEPPER. Thank you, sir.

The CHAIRMAN. Mr. Green, I want to thank you for your very splendid contribution to this hearing.

Mr. GREEN. Thank you, Senator.

The CHAIRMAN. Your testimony here is very valuable. I appreciate your appearance.

At this point I should like to insert in the record of the hearings statements on behalf of the national health bill that have been submitted by the State Federations of Labor of Kentucky, Kansas, Connecticut, and West Virginia.

(The documents referred to are as follows:)

LOUISVILLE 2, KY., April 12, 1946.

HON. JAMES MURRAY,

*Chairman, Senate Committee on Education and Labor,  
Senate Office Building, Washington, D. C.*

DEAR SENATOR MURRAY: A short time ago when I learned that hearings were to be held on the National Health Act, S. 1606, I wrote you requesting the privilege of testifying in behalf of said bill. I was later advised that the requests were so numerous that it would be impossible for me to be granted the privilege of appearing before the committee. However, you urged that I write the committee our thoughts on the bill for the record and that my communication would be carefully studied by the members of the committee. Therefore, may I offer the following in favor of the passage of S. 1606, which I hope will be read into the record and studied by the members of your committee:

The last two conventions of the Kentucky State Federation of Labor have adopted resolutions supporting national health legislation. It is our opinion that without national health we have little if anything. With national health we may have everything. Of course, we, the Kentucky State Federation of Labor, are from a State that ranks forty-sixth, forty-seventh, forty-eighth in so many many things, and health is one of our greatest shortcomings.

#### TUBERCULOSIS

Kentucky has the third highest tuberculosis death rate in the Nation. About 1,800 Kentuckians die each year from this disease. While our death rate has been cut in half in the last 25 years, our rate is still 50 percent above the national average, and some 14,000 of us have active infections. This we are unable as a State to overcome as there are fewer than 200 beds available for the more than 2,000,000 people outside of Jefferson and Fayette Counties. In the State as a whole we have 800 beds. How can we care for 14,000 tuberculosis infected persons in 800 beds? Furthermore, there are very few adequately staffed and equipped clinics available in Kentucky for case-finding and follow-up procedures. Perhaps there are even more than the 14,000 infected that we have a record of. The program for rehabilitation of arrested cases is very limited.

#### SANITATION

Filth-borne diseases kill 800 Kentuckians and cause the illness of 14,000 others in an average year. Although the death rate for typhoid fever has been greatly reduced, there are only 5 other States that have more deaths from this cause than Kentucky.

Diarrheaenteritis is a leading cause of infant deaths. Our death rate from dysentery is twice the rate for the Nation as a whole. One-fifth of us harbor intestinal parasites, such as hookworms or roundworms.

Three hundred thirty-three communities with populations of from 200 to 3,000 have no public water supplies. Although there are many communities with public sewers, few treat sewage in any way before it is dumped in streams or sinkholes, which in turn pollute the springs, wells and cisterns of the State. One-half of the State's population is served by open privies.

Two-thirds of the total milk consumed in Kentucky homes is not pasteurized and 45 counties have no pasteurized milk available.

Few commercial slaughterhouses, meat-packing or chicken-killing plants have either Federal or local veterinary inspection.

#### CANCER

One out of every 300 Kentuckians has cancer. Some 2,500 die each year from this disease, which ranks third among the leading causes of death in our State. Of the estimated 10,000 persons in Kentucky who have the disease, not more than 4,000 know they do. The rest of them, of course (6,000) will seek medical care far too late to be effective. Kentucky needs more case-finding and treatment facilities. Although six cancer clinics for the medically indigent have been established through joint action of the field army of the American Cancer Society, the State medical association and the State board of health, the number is too small. Personnel and facilities are available in these clinics for examining only about 600 persons a year. The number of hospital beds available for treatment of medically indigent cancer cases is negligible. There are no homes for incurable cases.

#### MENTAL HEALTH

Six Kentuckians per day are admitted to our four State institutions for the mentally ill or mentally deficient. There are over 7,000 persons being cared for daily in these institutions. One-ninth of all Kentucky men examined for military service in World War II were rejected because of mental ill health or mental deficiency.

Mental hygiene assistance is not available to most Kentuckians. Mental illness is officially considered a crime in Kentucky, as most admissions to mental hospitals are through trial and commitment by criminal courts. Only a very few are voluntary. Incidentally, the law allows \$1 per day for food for each inmate of a county jail, but only 57 cents per patient is available at our largest mental hospital for food, laundry, medical care, and all other services.

Our mental hospitals are overcrowded; yet 50,000 Kentuckians are so mentally deficient as to need supervision, it is conservatively estimated. With all of our institutions, Kentucky is meeting only about 25 percent of its responsibility for the feeble-minded chiefly because of insufficient State funds.

#### VENEREAL DISEASES

Some 100,000 Kentuckians have syphilis. One out of every eight persons admitted to Kentucky hospitals for the insane is there because of syphilis. More than one-tenth of all deaths due to diseases of the heart and blood vessels have this infection as their basic cause.

Annually at least 50,000 Kentuckians contract gonorrhoea, causing sterility in women and blindness in infants.

#### DISEASES OF LATER LIFE

Heart diseases, cerebral hemorrhage, and nephritis are leading causes of death in Kentucky. Combined they account for two-fifths of the deaths from all causes. Nearly three-fourths of these deaths occur in persons over 60 years of age. Few Kentuckians receive examinations to inform them of these diseases in their early stages.

#### DENTAL HEALTH

Seven out of ten school children in Kentucky need some kind of dental care. More men were rejected because of dental defects than for any other single cause in the early selective-service program of World War II.

Kentucky dentists are so scarce that Kentucky actually has only one dentist for every 4,000 persons and these dentists are very poorly distributed. In 1940 six counties had no dentists and 29 had only one each. As a result, there are 2,000 persons per dentist in counties of first- and second-class cities, while there are nearly 6,400 persons per dentist in rural areas.

#### INDUSTRIAL HEALTH

Although Kentucky is becoming increasingly industrialized there were approximately 260,000 industrial workers in the State according to the 1940 census. There are many serious industrial health hazards existing. The accident, dis-

ease and death rates from these causes are too high. The average industrial worker loses from 7 to 10 working days per year, less than 10 percent of which is due to industrial injury or occupational disease. The remaining lost time is due to ordinary illness or other non-industrial causes, a large part of which could be averted by adequate medical and nursing service. Yet 80 percent of the industrially employed in Kentucky are without in-plant medical or nursing service, which can be understood when it is realized that in Kentucky 95 percent of the industrial workers are employed by firms with less than 100 employees.

#### PHYSICAL DEFECTS

More than one-fourth of all Kentucky men examined by Selective Service in World War II were rejected because of physical defects. A National Youth Administration survey in 1941 showed one youth in three had physical defects that limited his employability. 10,000 crippled children are known to the Kentucky Crippled Children Commission, a large proportion of whom are not receiving care because of lack of funds. State and county health departments have found that out of each 10 school children examined, 3 have eye, ear, nose or throat defects, 7 have dental defects and 7 have poor posture or other defects. While many corrections are being made annually, the achievements thus far represent hardly a good beginning.

#### MATERNAL AND CHILD HEALTH

For every 1,000 babies born alive in Kentucky 4 mothers die in childbirth. Of these 1,000 babies, 60 die before their first birthday: of these 60, more than half died in their first month. This, of course, is higher than the national average.

From one-half to two-thirds of maternal deaths are preventable by adequate medical supervision during pregnancy and the lying-in period. However, nearly one-fifth of Kentucky mothers do not have a physician at childbirth, and only one-sixth of the total births occur in hospitals. In reality one-fifth of our Kentucky mothers go through childbirth assisted by only ignorant "granny women".

#### NUTRITION

Although there is a great malnourishment in Kentucky, the few surveys that have been made do not provide comprehensive information as to the extent or degree. Kentucky is in crying need of an adequate survey in this field.

#### MEDICAL CARE

Adequate medical care is not available to many many Kentuckians chiefly because personnel and facilities for medical care are so inadequately distributed. In counties with cities of the first and second class, there are only 650 persons per doctor, while in rural areas there are more than 2,300 persons per doctor. Specialists can be found in only a few cities in Kentucky. Furthermore the rural doctor on the average is an older one and less able to travel the tremendous amount of miles in his district; he is also hampered by poor roads and lack of hospitals.

Professional personnel and facilities for medical care tend to be distributed in accordance with ability to pay rather than in accordance with medical need. Thus in counties with first and second class cities where the annual purchasing power is approximately \$900 per person, there is one doctor to 650 persons, whereas in rural areas with an average of only \$200 per person, there is only one doctor to more than 2,300. A similar situation prevails in regard to the distribution of dentists, nurses, pharmacists, and hospital facilities.

Paying for medical care would still remain a problem even if sufficient professional personnel and facilities for adequate care were equitably distributed. Persons with large incomes are financially able to purchase needed medical care under almost any circumstances. Those with moderate to low incomes have little if any difficulty in meeting the expenses of relatively minor illnesses but find it difficult or impossible to meet the expenses incurred when catastrophic illness strikes.

For this latter group S. 1606 is so vitally important.

## PUBLIC HEALTH ORGANIZATION

Prevention of disease has been the primary concern of public health organizations. It is true Jefferson County organized the first full-time county health department in the United States in 1918. It is true that of our 120 counties, 104 now have provisions for full-time public health service, but this is not as good as would appear on the surface. 16 Kentucky counties do not have health departments. Even among the 104 counties which have provided such organizations, the majority have thus far been able to provide only skeleton services because of limited personnel and facilities. For example, there should be a minimum of one public health nurse for each 5,000 people; we have only one nurse to more than 10,000 people.

While public health authorities contend that in normal times a minimal annual expenditure of \$1 per person is necessary to maintain a local health department, Kentucky spends only approximately 48 cents per person for this purpose. Furthermore, inability to pay salaries comparable with those paid by other states and agencies causes the loss of the majority of our more capable public health personnel. For example, we annually train 10 new county health officers and lose seven largely because of inadequate salaries.

## CONCLUSION

Our pathetic health conditions in Kentucky are not the fault of science nor Kentuckians so much as they are the fault of poverty, perhaps ignorance of Kentuckians. If we are to win this battle against unnecessary disease and death, we must be assisted financially and physically, as would be possible through the passage of S. 1606.

Fifty years ago Kentucky was great—ranked among the leaders of the Nation, but Kentucky has been growing steadily ill. Now we rank forty-fifth, forty-sixth, forty-seventh, in some cases forty-eighth. This illness is contagious, and it is our hope that the rest of the Nation, not so ill as ourselves, will agree to assist us in this hour of trouble through the provisions and passage of S. 1606.

To assure the authenticity of the statements included herein, may I advise that they are supported by a study made by the eminent State health commissioner of Kentucky, Dr. Philip E. Blackerby, for the committee for Kentucky, of which I happen to be secretary-treasurer.

Respectfully submitted.

EDWARD H. WEYLER,

*Secretary-Treasury, Kentucky State Federation of Labor.*

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KANSAS STATE FEDERATION OF LABOR,

*Topeka, Kans., April 12, 1946.*

Senator JAMES E. MURRAY,

*Chairman, Senate Committee on Education and Labor,  
United States Senate Building, Washington, D. C.*

DEAR SENATOR MURRAY: The following remarks are made in support of S. 1606, the National Health Act of 1945, and we desire to have this statement included in your records of testimony supporting this legislation.

The workers and families of the low-income group will receive medical and hospital attention through this type of legislation that is impossible for them to obtain otherwise. S. 1606, if enacted, will result in more healthy and sturdy citizens mainly because of the provision whereby physical examinations and early attention could be had in cases of illness or disease. Most of the workers and their families in the low-income group are never able to lay aside any savings for hospital or medical care, consequently these families are unable to secure the services of physicians, dentists, and optometrists and in many cases the individuals are forced to go through life suffering from lack of medical attention and in many instances physical handicaps are the result of not having sufficient funds to secure proper attention. Our hospitals have been continuously confronted with their financial problems brought about through many of their patients not being able to compensate the hospitals for services rendered.

Hospitals and health centers are inadequate to properly handle the population in need of their service at the present time and if the citizens as a whole were financially able to arrange for hospital service it would still be impossible for many of them to receive it because of lack of facilities. Many localities in Kan-

sas, including a group of several counties in one grouped area have no hospital nor health facilities available whatsoever. As a result there are few doctors located in these areas and very few registered nurses, consequently the citizens are in most cases financially unable to receive any kind of medical attention except in rare cases. The bill in no manner will deny an individual from selecting a doctor, dentist, nurse, or hospital of his own choice nor force the doctors, dentists, hospitals, etc., to be participants in this arrangement. They are all guaranteed the right to participate in this plan; however, it is not compulsory.

No doubt attempts will be made to use the Blue Cross and other plans as factors in opposition to this legislation. The Blue Cross has been helpful to many but is entirely inadequate and doesn't serve the needs of persons who will receive the most benefit from this Health Act. Labor in Kansas has generally supported the Blue Cross, strictly because we had no better plan to offer them. You will find the workers in Kansas entirely behind and in support of this legislation and we are hopeful that S. 1606 will be enacted at an early date in order that the persons in need of this service can receive it as early as possible.

Thank you for giving us an opportunity to speak in support of the National Health Act of 1945.

Very sincerely yours,

F. E. BLACK, *Secretary.*

CONNECTICUT FEDERATION OF LABOR,  
*Bridgeport, Conn., April 5, 1946.*

Senator JAMES E. MURRAY,  
*Chairman, Education and Labor Committee,*  
*Senate Office Building, Washington, D. C.*

DEAR SENATOR MURRAY: Enclosed you will find a statement that I would like to have you record with your committee pertaining to our support of the Murray-Wagner-Dingell bill.

The Connecticut Federation of Labor wholeheartedly endorses the provisions of this bill and we sincerely hope that the committee will bring out a favorable report.

Sincerely,

JOSEPH M. ROURKE, *Secretary-Treasurer.*

STATEMENT OF CONNECTICUT FEDERATION OF LABOR IN SUPPORT OF S. 1606,  
MURRAY-WAGNER-DINGELL BILL

The Connecticut Federation of Labor strongly supports S. 1606, known as the Murray-Wagner-Dingell bill, hearings on which are now being held before the Senate Committee on Education and Labor.

It does so because it recognizes the need for expanding and modernizing the Social Security Act. Millions of Americans who under the existing act cannot look forward to security in their old age would be covered with the adoption of S. 1606. The bill, furthermore, would change the present unemployment insurance system which is both inadequate and inefficient. A uniform system covering all the States and 15,000,000 workers now excluded is highly essential.

A feature of the bill which has been widely misrepresented but which labor warmly endorses is that which would provide for a national health insurance system. It is obvious that under existing conditions the large majority of the workers of this country cannot afford adequate medical care. S. 1606 would set up a system that would provide hospital and medical service for all through equal contributions from workers and employers.

Those opposing this health provision have resorted to unfair methods, attacking it as fascistic and communistic. It is inconceivable that the American Federation of Labor, which is committed to democracy and the free enterprise system, would tolerate any legislation of a totalitarian character. As a matter of fact, the principle of spreading the risk is sound and democratic and thoroughly consistent with American traditions. The only thing compulsory about it is financial, but then the cost of maintaining our public-school system is compulsory, and no one would think of calling it regimentation.

As Senator Robert F. Wagner has pointed out, the Surgeon General of the United States would administer the health program with the aid of an advisory council. Anyone, whether an insured person, doctor or dentist, who thought the bill's provisions were being violated could appeal to the courts for redress.

No doctor under the plan would be compelled to join the system, nor would doctors be selected for individuals needing medical care. They would be able to call in physicians of their own choice.

The charge, therefore, by Dr. Morris Fishbein, of the American Medical Association, that President Truman is attempting "to follow the steps of his predecessor in socializing America" is utter nonsense in which labor takes no stock.

What labor is concerned about is the fact that when illness strikes, it imposes great anxiety and heavy financial burdens upon the working people. The provisions of the Murray-Wagner-Dingell bill would help to alleviate the mental and financial strains that illness brings.

The Connecticut Federation of Labor urged the Senate Education and Labor Committee to report S. 1606 favorably to Congress.

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WEST VIRGINIA STATE FEDERATION OF LABOR,  
*Charleston 1, W. Va., March 21, 1946.*

Senator JAMES E. MURRAY,

*Chairman, Education and Labor Committee,  
Senate Office Building, Washington, D. C.*

DEAR SENATOR: Thanks for your letter of March 16. It ill be impossible for a representative of the West Virginia State Federation of Labor to attend the hearing. We thank you for this opportunity accorded us for submitting a written statement for the committee.

Our observation of the practice of medicine and dentistry in our particular State shows that not only our own students coming out of the colleges who are residents of the State of West Virginia going into populated cities. During the war period many of our rural sections have been sadly neglected and that is one reason in particular that we are in favor of the Senate bill 1606, so that the rural communities can be accorded this service just the same as the suburban and populated sections of our State. Furthermore, we want to see the best of service rendered to all of our citizens and we know that there is a great segment of our population who are unable financially to maintain the proper service, which in our mind, can be looked at this way. As long as there are some people that do not have the money to obtain this service, or in outlying sections where it cannot be obtained, they are neglected and are a health hazard to the rest of the population it would be eliminated.

We feel that this Senate bill 1606 will go a long way toward doing that. Again thanking you, I remain,

Respectfully yours,

VOLNEY ANDREWS,  
*Secretary-Treasurer.*

The CHAIRMAN. I should also like to insert statements we have received from the Building Service Employees' International Union; the Atlanta (Ga.) Federation of Trades; the Central Labor Union of North Platte, Nebr., and the American Federation of Women's Auxiliaries of Labor, Nashville, Tenn.

All of these organizations are affiliated with the American Federation of Labor.

(The documents referred to are as follows:)

BUILDING SERVICE EMPLOYEES' INTERNATIONAL UNION,  
*Milwaukee 3, Wis., March 21, 1946.*

Hon. JAMES E. MURRAY,

*Chairman, Senate Committee on Education and Labor,  
United States Senate, Washington, D. C.*

DEAR SENATOR MURRAY: In the interest of brevity, I shall condense the opinions of this international union on the subject of the National Health Act, 1945, S. 1606, to two simple statements:

1. Our membership is wholeheartedly in favor of S. 1606 and is composed of some of the lowest income groups in the country and knowing from personal experience how inadequate presently available medical care to the low-income families is, as well as how the cost of emergency medical care digs into the budget and savings (if they have any in these families) these people definitely need the assistance that S. 1606 will give them.

2. Our membership is especially concerned with the question of coverage. The Social Security Act does not cover a great number of them because they are employees of so-called nonprofit institutions and we firmly believe that a revision of that act should be made to cover them. These members sincerely want to contribute to the cost of their social security and in the same way they want to contribute to the cost of their medical care. We, therefore, earnestly request that any legislation which implements title II of S. 1606 be so written as to include the employees of charitable and nonprofit institutions.

Sincerely yours,

WM. H. COOPER,

ATLANTA FEDERATION OF TRADES,  
Atlanta 1, Ga., March 20, 1946.

HON. JAMES E. MURRAY,  
*Chairman, Education and Labor Committee,*  
*United States Senate, Washington, D. C.*

MY DEAR SENATOR: The Atlanta Federation of Trades sincerely appreciates the information, contained in your letter of March 16, 1946, pointing out that President William Green of the American Federation of Labor would present testimony on behalf of the entire membership of that organization. This arrangement is perfectly satisfactory to the members of this federation. However, it is the expressed desire of the 60,000 men and women, identified with this affiliate of the American Federation of Labor to make the following brief observations in favor of S. 1606:

1. Adequate facilities to maintain unimpaired the health of our people is imperative to the preservation of our concepts of democracy.

2. If this goal is to be achieved, the Federal Government must include in its functions, the basic financial assistance, not only for its activation, but to facilitate its successful operation.

3. The records in this city, and for that matter throughout the entire State of Georgia, indicate conclusively that methods now in effect are totally inadequate to cope with health and related needs of the common people.

4. It is obvious that health programs have not kept pace with the Nation's growth, and that if this appalling social condition is to be corrected, Federal aid must be provided without protracted delay.

Very respectfully,

A. C. LAWRENCE, *Secretary.*

NORTH PLATTE VALLEY CENTRAL LABOR UNION,  
Scottsbluff, Nebr., March 19, 1946.

Senator J. E. MURRAY,  
*Chairman, Education and Labor Committee,*  
*Senate Office Building, Washington, D. C.*

DEAR SENATOR MURRAY: This will acknowledge receipt of your letter of March 16 for which please accept our thanks.

In your letter you stated it would be impossible to hear all the parties interested in S. 1606. But you would accept statements from our union, and would place it on file for the committee hearing.

The North Platte Valley Central Labor Union and its affiliated unions is gravely concerned about bill 1606. The workers, organized or unorganized, will be affected by the failure of the bill to pass the Senate. It was brought out in World War II the health of our workers was greatly degenerated, due to the fact of our inability to pay high doctor bills. By the enactment of 1606 we will be able to remedy this cause.

The Senate will be doing a favor to every citizen of the United States by passing 1606. We are also concerned about the failure of Congress to carry out the social security program as it was originally planned. The social security payments were to go up 1 cent for employer and employee, but Congress refused to raise the payments. We believe this should be done immediately in order to put the social security program on a sound basis.

Hoping that your committee will report this bill to the Senate as it was originated.

I remain,

Sincerely yours,

J. H. THOMPSON, *President.*

AMERICAN FEDERATION OF WOMEN'S AUXILIARIES OF LABOR,  
*Goodlettsville, Tenn., April 15, 1946.*

HON. JAMES E. MURRAY,  
*United States Senator,  
 Chairman Committee on Education and Labor,  
 Senate Office Building, Washington 25, D. C.*

DEAR SENATOR MURRAY: I am grateful for your invitation to submit the enclosed statement to the Senate Committee on Education and Labor in support of the National Health Act, S. 1606.

Very sincerely yours,

MRS. HERMAN H. LOWE.

STATEMENT OF MRS. HERMAN H. LOWE, PRESIDENT OF THE AMERICAN FEDERATION OF  
 WOMEN'S AUXILIARIES OF LABOR

In support of the National Health Act (S. 1606) April 16, 1946

Mr. Chairman and gentlemen of the committee: In appealing to you for favorable consideration of the National Health Act (S. 1606), I am cognizant of the fact that I am unqualified to delve into the technicalities of the legislation. However, the need for such health protective measures, as the bill offers, is so great for the nation as a whole and wage earners and their families in particular, speaking as president of the American Federation of Women's Auxiliaries of Labor (A. F. of L.), I should like to call your attention to a few reasons why the enactment of this measure is imperative.

As wives, mothers, sisters, and daughters of wage earners, it falls our lot to watch the family budget and the family's health. It is we who, all too often, diagnose Jimmy's or Susie's childish ailments as measles, croup, or a cold and proceed to doctor according to our most successful methods, because the budget does not permit professional diagnosis and medical treatment at the hands of a physician. We know, of course, that there are many pitfalls in doing the family ailment labeling. For instance what yesterday seemed to be only a bad headache for Jimmy may be polio by tomorrow—Susie's cold may already be pneumonia or the early stages of tuberculosis, grandma's pain in the chest or left arm may be a slight or acute heart trouble, the lump we massage as a possible bruise or superficial enlargement of a muscle may be a breast cancer or the violent stomach ache of the husband, we doctor with laxatives and hot and cold packs, may be a ruptured appendix.

The homemaker is, for the most part, versatile. Proficient in many details besides the duties of what the word homemaker implies, including home nursing, but there never was a wife or mother who did not realize at times that her home-nursing ability was far from adequate to match the gravity of certain situations. Yet, because physicians have to be paid for their services, which is right, and hospital bills must be met, which is as it should be, the homemaker takes a look at the family till when sickness strikes her family and decides to exhaust every known remedy before calling the doctor and perhaps visiting a loan shark for funds with which to pay the bills.

A little set aside from the weekly pay envelope to provide for health insurance would eliminate many anxious moments when sickness invades the home and make possible ready funds for hospitalization when special treatment is indicated.

We of this Nation are proud to say we are all Americans, regardless of race, creed, color, or social standing. Likewise, we are all human beings by the handiwork of nature, regardless of race, creed, color, or social position—subject to the same ills and body weaknesses. America, as a nation, can be no stronger than its people are physically.

It is unjust for a small percentage of our people to have access to the best medical and hospital care simply because they can afford it, while the majority have to jeopardize their well-being by shopping around for a doctor whose services they can afford and be forced to forego proper hospitalization for the same reason. Under the provisions of S. 1606 truly we could say, "We are all Americans."

It is not my purpose to place undue blame on those of the medical profession for existing laxities, but I know of a number of instances of child-birth cases, in low-wage families, where we are forced to admit that instead of making health progress we are reverting to the midwife era. Cases where mothers have not been admitted to a hospital until a few minutes before delivery occurred—allowed to remain in the hospital for 3 days, sent home where there was no one to wait

on either mother or baby except the father and the other children. The physicians did not see mothers or babies after leaving the hospital.

I know of other cases where physicians did not keep in close enough touch with prospective mothers to prevent babies from being born en route to hospitals or before leaving home, where nothing was in readiness for such an event. Yet another practice which would be funny if it were not so ridiculous; prospective mothers are rushed to a clinic—baby delivered—rushed home again without so much as seeing, let alone occupying a hospital bed. All told, less time was given to the birthing of these future presidents than to people who have funds for the strapping of a sprained ankle and much less time than for an ordinary tonsillectomy.

Another story of what happens to those unable to pay for hospitalization is that of a grandfather who was hospitalized for prostate gland treatment. A large catheter was inserted through the abdomen, with a process of irrigation necessary as daily treatment. When he reached the limit of his ability to pay, grandpa was sent home with only neighbors available to do the nursing—irrigating and dressing of the incision. The man lived about 6 weeks. Had he been able to afford it, doubtless, hospital care would have prolonged his life.

Simmered down, the adage money talks is a profound truth where the Nation's health is concerned.

I know a 10-year-old boy who can't run or play with other boys any more because his father couldn't afford a second operation. The lad was accidentally shot in the stomach while hunting with some other boys, too young to know how to use guns. Removing the bullet was a difficult job and complications developed. A metal plate was inserted in the boy's middle and he was sent home because the father couldn't afford the second operation to correct the trouble. The boy now seems doomed to wearing his armor-plate for the rest of his life for his father died last year from blood poisoning, following a pricked finger accident on his job. He couldn't afford medical care, so he doctored his finger himself until it swelled out of all proportions and he could do nothing to decrease his intense temperature. He visited a physician then—but it was too late.

Here's a broken family, an American family, for your consideration. A father who could still be alive and a young son who would be able to run and play like other boys if the provisions of S. 1606 had been in existence.

Numerous other cases among low-income groups, the country over, could be presented in support of the dire need for the acceptance of President Truman's plea for the enactment of the National Health Act, but the cited instances herein presented are sufficient to show that a sad lack of health provisions exists.

For the security, peace of mind and well-being of all Americans, I urge your most sincere consideration of and favorable action for the enactment of S. 1606, thus giving all the citizens of the Nation a chance to keep physically fit.

The CHAIRMAN. Dr. W. Montague Cobb is the next witness. Dr. Cobb, will you state your full name and the organization that you represent, for the purpose of the record?

**STATEMENT OF DR. W. MONTAGUE COBB, REPRESENTING THE NATIONAL MEDICAL COMMITTEE OF THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE**

Dr. COBB. My name is William Montague Cobb. I am a physician, professor of anatomy in the School of Medicine of Howard University, president of the Medico-Chirurgical Society of the District of Columbia, and I am appearing as a member of the National Medical Committee of the National Association for the Advancement of Colored People.

The CHAIRMAN. You may proceed with your statement.

**ENDORSEMENT OF S. 1606**

Dr. COBB. Mr. Chairman and members of the committee: It is my honor to represent, as a member of its national medical committee, the

National Association for the Advancement of Colored People, in support of the national health bill, S. 1606. The national association, founded in 1909, has over 520,000 members, organized into 1,200 branches, youth councils and college chapters in 43 States. It is the oldest and largest organization devoted to the securing of equal rights and opportunities for the more than 14,000,000 citizens who constitute America's most disadvantaged tenth. In its constant attention to the job for which it was organized and to which it is unswervingly committed, the NAACP knows it is safeguarding the democratic privileges of all American citizens, and at the same time is defining America in terms of democracy to the rest of the world. The association approaches the problem of health in the interest of the common welfare.

Numerous comprehensive and detailed studies have adequately defined, proved and stressed the urgent need of proper medical care for all Americans. No program previously proposed or instituted has indicated ability to close the gap between advances in medical technology, on the one hand, and the social and economic arrangements by which medical services are made available, on the other.

President Truman's message to Congress of November 19, 1945, marked the first time in our history that a full length presidential message has been devoted exclusively to the subject of health. This message reflected significantly both the importance of the problem and the exhaustive consideration which all its aspects had received. The President recommended legislation embodied in the present bill. This association is most acutely aware of the need for such legislation in respect to that segment of the population which it primarily represents. It cannot be overemphasized, however, that health is not a racial problem, that the health conditions of Negroes are largely a reflection of their socio-economic circumstances, and that poor health in any segment of the population is a hazard to the Nation as a whole.

In the 7 years since February 1939 when the first national health bill, S. 1620, was introduced in the Senate, the salient facts about all phases of our national health have become public knowledge, so that topical reference to a few items will suffice to establish background for the national association's advocacy of the present bill.

#### HEALTH PROBLEMS OF THE NEGRO

Even though health conditions in the country as a whole are far from satisfactory, the plight of the Negro is worse than that of the white. In 1940, the latest census year, the standardized death rate for the country was 8.2 per 1,000 for whites and 14.0 for Negroes, a mortality rate 71 percent higher than the white. In 1930 the Negro excess was 82 percent. In that year, the Negro mortality in the registration States was 81 percent higher than the white in rural areas and 95 percent higher in cities, a fact of especial significance in view of the continued urban migration of Negroes.

In 1940 the life expectation of Negroes at birth was about 10 years less than that of whites, the expectancy being for males, 52.26 years in Negroes and 62.81 years in whites, and for females, 55.56 years in Negroes and 67.29 years in whites.

The consistent population increase shown by the Negro in spite of the high mortality and morbidity he has suffered has been due chiefly to his high birth rate which in 1942 was 23.3 as compared with 20.7

for the white. But the reproductive process in the Negro is attended with almost double the rate of casualties that prevails in the white. In 1942 the Negro maternal death rate was 5.5 and the white 2.2; the Negro infant mortality rate was 64.2 and the white 37.6; and the still-birth rate was 50.5 in the Negro and 25.5 in the white.

In retrospect, this approximately current unfavorable health picture shows considerable improvement over the past. The Negro mortality rate has declined from 24.1 in 1910 to 14.8 in 1943. Since 1910 Negro life expectancy has increased about 10 years or 25 percent. There has been significant decrease also in reproductive mortality.

Under similar environmental conditions there should be no appreciable racial differences in mortality or life expectation. The circumstances attending the arrival of the Negro in America as well as those under which he has lived here both connote an inherent constitutional hardihood. Certainly, a people which has contributed Paul Robeson, Jesse Owens, Joe Louis, Henry Armstrong and a galaxy of athletes of similar caliber, cannot be said to be genetically lacking in physical stamina.

The NAACP has two chief points of interest in the profile of Negro health just outlined, first, that the excess Negro mortality and concomitant morbidity are due to preventable causes, and second, that as improvements are achieved, the Negro generally lags behind the white, indicating that he does not share as rapidly or as fully in the application of medical advances, even though the general progress is far from optimal due to conditions the present bill is designed to correct.

Diseases for which the cause and mode of transmission or development are known, and for which a specific control program has been established are preventable. Nearly all diseases showing excess mortality in the Negro fall into this category. High occurrence of these conditions is also associated with any group of low economic status where there is ignorance, overcrowding, poor nutrition, bad sanitation and lack of medical care.

The National Health Survey of 1935-36 found that the amount of disability per person due to illnesses which incapacitated for a week or longer was 43 percent higher in the Negro than in the white population. The higher disability rate for Negroes was due chiefly to chronic diseases which disabled the average Negro 8 days per year compared with 5 days for the average white person. The higher rate was observed for all disease groups. Pneumonia was almost twice as frequent in Negroes as in whites, and certain chronic diseases—the cardiovascular-renal group, rheumatism, and asthma, and hay fever—were of significantly higher rate.

The survey noted that improvement of standard of living associated with a rising income increased the health status of Negroes as measured by various indicia of illness. The average Negro in the nonrelief class experienced only one-half the disability per year as the Negro on relief. The survey concluded that low economic status, rather than inherent racial characteristics in reaction to disease appeared to account principally for the higher disability rate in Negroes.

In the light of these facts, the NAACP has a natural and vital interest in any measures which make for the improvement of the gen-

eral health, particularly that of the economically poorly circumstanced. The first part of S. 1606, title I, part A, providing for measures against venereal diseases and tuberculosis, deals with preventable conditions associated with low economic status which unduly ravage Negroes. The tuberculosis mortality rate in the Negro is more than three times that in the white. It has been stated that syphilis occurs six times more frequently in Negroes than in whites. Because of the unfortunate tendency on the part of many, including even some health officials, to make invidious racial implications from such data, it is desirable to quote a statement from H. H. Hazen's authoritative monograph, *Syphilis in the Negro*.

The problem transcends racial boundaries. Where the Negro syphilis rate is high, the rate in the white group as well is likely to be unusually high. One finds, by comparison of these areas with those having lower rates for both Negro and white, that a less vigorous effort has been made to control the disease. Treatment facilities in the areas of high prevalence prove to have been inadequate and largely inaccessible. Likewise, the public is not well informed on the value of early and adequate treatment in arresting the disease and in preventing its spread. And he reaches the conclusion that the most outstanding characteristic of these areas of high prevalence is a low economic status in a large proportion of the population \* \* \*.

Despite the alliance of syphilis and poverty, syphilis has receded wherever the people have been informed of the methods of prevention, detection, and cure, and meanwhile, provided with facilities for obtaining treatment irrespective of their financial status.

The same spirit of cooperation from the people has been manifest in the application of newer techniques for the control of tuberculosis. Communities tend to welcome such measures as mass X-ray surveys when they have been made to understand the objectives.

Tuberculosis mortality in white adults has declined at a more rapid pace than the total death rate from the beginning of the century through 1943, the last year of available data. This was true also in Negro adults until 1935. From 1935 through 1937 the rate of decline was essentially the same as that of the total death rate, but beginning with 1938 and for each subsequent year the decline in tuberculosis mortality has been less than that of deaths from all causes. This would indicate that since 1938, progress against tuberculosis mortality in the Negro has not been as satisfactory as against deaths from all other causes combined.

Title I, part B, providing for grants to States for maternal and child health services, like part A, deals with a phase of health where the Negro has vital need. In this group, between 1915 and 1942 maternal mortality rate had been reduced from 10.6 to 5.5; infant mortality from 181.2 to 64.2; stillbirths from 73.4 (1922) to 50.5. Yet, as already stated, these final figures are approximately twice the comparable rates for the white.

More than four-fifths of Negro babies are born in the Southern States; two-thirds are born in rural areas; four-fifths are born in States where per capita income is below the national average. The wholehearted acceptance by the Negro of health facilities so far made available warrants all possible development and expansion of activities which will bring Negro mothers safely through childbirth and Negro infants safely through the first year of life.

## TITLE I OF S. 1606

Title I, part C of the bill, dealing with grants to States for medical care of needy persons, is an obvious necessity, which appears to be universally recognized, as one of the chief opponents of the bill, the American Medical Association, in its national health program of February 23, 1946, recommends that for medical care of the needy, local funds be supplemented "with the assistance of Federal funds when necessary."

Title I of the bill referring to grants to States for health services and specifically to provisions for venereal diseases, tuberculosis, maternal and child welfare, and the care of the indigent, appears in all its subdivisions to cover vital areas of need for medical care in our country today. The need for the measure provided for in this title is particularly acute among our Negro citizens.

With the plans for the administration of the S. 1606, the NAACP must have certain vital concerns. About 79 percent of our Negro population are concentrated in the 17 Southern States where they comprise approximately one-fourth of the total population. Another 18 percent live in the 3 Middle Atlantic and 5 North Central States, making a total of 97 percent in these 25 States. Until very recently about 90 percent of those living in the South were rural dwellers in contrast to 80 percent of those living in the North. These facts of regional and rural and urban concentration would entail variations in the mechanics, but not the principles of procedure in implementing the bill as it would affect the Negro.

The NAACP is concerned that, irrespective of the means by which it would be planned to implement the bill in any locality, there should be no discrimination against any citizens because of race, creed, color, or national origin. It is concerned that in the provisions for training of the large new personnel that will be needed for State and local health work, Negroes be integrated into the program at all levels, administrative as well as professional, without respect to section of the country.

The association is further concerned that in the needs for medical care and facilities to be determined by the respective States, the same standards should be used for such determination for all political subdivisions of the States and for all citizens.

## TITLE II, S. 1606

Title II of the bill, referring to prepaid personal health service benefits, appears to have many progressive features in keeping with democratic practice. The provisions for a national advisory council and local advisory councils on which both the professions and the public would have representation extends representation to areas where it has not extended before, and affords an opportunity to the public and to groups of the professions, which hitherto have not had such opportunity, to work for the improvement of both the national health and that of their own communities. The association does not find, as has been frequently alleged, that the traditional free choice of physician by patient, and patient by physician, has been impaired by the provisions of the bill. Section 205, (A) specifically states in effect that any physician, dentist, or nurse legally qualified to prac-

tice in a State shall be qualified to furnish services. Section 205, (B) states very clearly that every person entitled to receive general medical, or general dental benefits shall be permitted to select, from among participating practitioners, those from whom he shall receive such benefit subject to the consent of the practitioner or group of practitioners selected, and every such individual and every group of such individuals shall be permitted to make such selection through a representative of his or their own choosing and to change such selections.

The remaining provisions of this section all are directed at ensuring not only that achieved medical standards be maintained, but shall be advanced. It is further specifically stated that "payment shall be adequate, especially in terms of annual income or its equivalent and by reference to annual income customarily received among physicians, dentists, or nurses having regard for age, specialization, and type of community; and payment shall be commensurate with skill, experience and responsibility involved in furnishing the service." Were it not for the fact that fees can be paid in a variety of ways it would still be impossible for the association to see any way whereby medical care, even under the bill, could be extended to those particularly economically underprivileged areas where it is most sorely needed.

In the past it has been impossible for physicians to remain long in either rural or urban areas where they are needed most, because of lack of facilities on the one hand and the fact that the population was too poor to afford them an adequate income on the other. The Hill-Burton hospital construction bill, S. 191, which has been passed by the Senate and which has received endorsement of the American Medical Association, would provide a means for the construction of lacking facilities. S. 1606 for the first time, offers a means whereby the necessary professional personnel could be paid in such areas. As has been repeatedly pointed out in earlier testimony, no form of voluntary prepayment medical insurance could be of benefit to these people, because they could not afford it. In this connection it should be emphasized that the furor over free choice of physicians can have no meaning for millions of Negroes as well as of millions of whites in poor economic circumstances, because down the years these people have been without any medical services whatever. Ofttimes when such services have been available they have been the indifferent services of physicians who do not want them as patients or similarly unsatisfactory services of crowded clinics.

#### ATTITUDE OF THE AMERICAN MEDICAL ASSOCIATION

Major objection to the bill from the medical profession has been voiced by the American Medical Association, consequently the counterproposals of this organization have been studied with great interest. In the considered judgment of the association these counterproposals are far inferior to the proposals of the national health bill. The American Medical Association's proposal, as stated in its Journal of February 23, 1946, recognizes apparently that some form of prepayment medical insurance is necessary, and it is the determination of the American people to obtain such insurance. There may be said, therefore, to be general agreement that prepayment medical insurance is both necessary and desirable. Operating upon the sound and

time tested insurance principle that a large number of insured will permit a greater coverage in services, smaller premiums and less administrative expense than will smaller groups of insured persons, the national health bill proposes that the entire population earning an income be taxed a small percentage of earnings (percentage to be determined), which shall provide ultimately for complete coverage of medical services with a similar provision for the medical care of the indigent. The American Medical Association proposes that on a trial and error basis various forms of voluntary prepayment medical care plans be tried out until optimal procedures are determined by experience. It further proposes that regional plans shall be locally determined.

Already it has been evident that all such plans so far proposed have the weakness that they are available to the relatively small groups who are able to pay for them and have but limited coverage and high premiums, so that still the people who need medical care most are not able to provide for it. The American Medical Association's proposal then blandly suggests that the indigent, who are not able to be provided for through some prepayment medical care plan, or local public funds, should be cared for by Federal funds. Where the Federal Government would obtain these funds the American Medical Association does not indicate. The voluntary prepayment plans are particularly little available to the poorly circumstanced of the American population of whom Negroes constitute the largest group. In addition, where these plans have already appeared and are operating, besides being little available to Negroes on an economic basis, they have been closed to them by reason of racial discrimination as well. The law has been the best safeguard of the underprivileged throughout our history. Therefore, the association firmly believes that equal justice in the securing of adequate medical care for all citizens would be better obtained by national legislation to that end than by other means.

The association affirms that the profession of separate, but equal facilities for the care of Negro population in those areas where that population is concentrated has always been a myth, and would prove again to be a myth should it be attempted. Specifically the association wishes to declare against the principle in the application of this bill to the development of separate hospitals, separate health centers, separate training programs, and separate public health programs. We wish to declare emphatically for the elimination of the entire racial separation practice in the construction of any new facilities, and in the operation of all new plans for the distribution of medical care and for the integration of Negro professional personnel into all levels of the plan according to qualification. Recent experience with attempts to assure adequate professional personnel through the separate system of professional education have proved how sterile and ineffective is this plan. It has resulted in there being not only inadequate numbers of general practitioners (and nurses), but also of specialists in the respective fields.

The association's study of this bill indicates that it might be possible for the administration of the program to be assigned through private auspices, particularly State and local medical societies. This association would be unequivocally and unalterably opposed to any arrangement of this kind. In many States, including the entire

South and the District of Columbia, local medical societies have consistently barred Negro physicians from membership, and the American Medical Medical Association, through the technicality of not admitting to its membership physicians who are not members of their local societies, has extended the effect of this racial discrimination. This association, therefore, would see no outlook but the perpetuation of these discriminatory practices in the administration of a national health program and advocates that the administration be entirely in the hands of responsible public officials.

## SUMMARY

In the summary it may be stated that from the point of view of the NAACP, S. 1606, for the first time in our history, provided a means whereby the economic barrier to the extension of medical care to the millions of American citizens who so sorely need, but cannot afford such care, may be overcome. It provides a means, further, whereby the tragedy of economic collapse brought upon families by expensive illness may be averted. This plan appears conceived upon the soundest possible basis; namely, the distribution of cost over the entire earning population so that maximum coverage for all may be achieved while administrative expenses are held to a minimum. The association would like to note the endorsement of this bill by the Medico-Chirurgical Society of the District of Columbia.

This organization of 188 physicians, is the oldest Negro medical organization, and the largest local society of this group. This body was formed in 1884 as the result of the determined refusal of the Medical Society of the District of Columbia, supported and confirmed by the American Medical Association, to admit qualified Negro physicians to membership. These physicians individually and collectively are a prosperous group, but they have seen in the national health bill the same advantages for the American people which the Association has briefly described.

In closing, the NAACP regards S. 1606 as one of the most progressive and potentially beneficial pieces of legislation of recent years. It is sorely needed by the great majority of Americans, but it is most acutely needed by our 14,000,000 American Negro citizens. The association unqualifiedly endorses this bill and strongly urges its passage.

The CHAIRMAN. Thank you, Dr. Cobb.

Are there any questions?

Senator PEPPER. I have no questions, except that you have made a very fine statement.

Senator DONNELL. I have just one or two questions, Doctor. I believe that you stated that you are on the faculty of Howard University.

Dr. COBB. Yes, sir.

Senator DONNELL. And you have been a practicing physician for approximately how many years?

Dr. COBB. I am not in active practice at the present time. I am a full-time professor of anatomy and I was licensed to practice in 1930.

Senator DONNELL. Have you been a practicing physician?

Dr. COBB. No, sir.

Senator DONNELL. And you have never been a practicing physician?

Dr. COBB. No, sir.

Senator DONNELL. Now, the NAACP, that is a very large organization of over 520,000 members?

Dr. COBB. That is right.

Senator DONNELL. And you are a member of the national medical committee of that organization?

Dr. COBB. Yes, sir.

Senator DONNELL. Has the organization itself the custom of having annual meetings?

Dr. COBB. Yes, sir.

Senator DONNELL. Has there been any resolution adopted by the association itself on this matter of S. 1606?

Dr. COBB. At the regular monthly meeting the board of directors of the association, held in New York City on February 11, 1946, upon motion duly seconded it was voted "That the association actively support the Wagner-Murray-Dingell health bill."

Senator DONNELL. Just how does the national medical committee derive its authority to speak for this membership?

Dr. COBB. From the board of directors of the association, and I was instructed to present this statement by the chairman of the board of directors, Dr. Louis T. Wright.

Senator DONNELL. How large a body is the board of directors?

Dr. COBB. Approximately 50, I should say.

Senator DONNELL. Has it passed any resolution with respect to this particular bill, S. 1606?

Dr. COBB. That I do not know.

Senator DONNELL. You do not know of any; is that correct?

Dr. COBB. That is correct.

Senator DONNELL. Your authority to appear here today is derived from the instructions which you received from Dr. Wright?

Dr. COBB. From the board of directors, through Dr. Wright.

Senator DONNELL. Did you see any direction from the board of directors or did you simply receive word from the board of directors as he stated, to appear here?

Dr. COBB. It is in writing from him as chairman of the board of directors.

Senator DONNELL. That is all.

The CHAIRMAN. Has your organization in its national meetings discussed this problem of medical care?

Dr. COBB. Well, that I cannot say. I have not attended any.

The CHAIRMAN. You were just selected for the purpose of presenting this statement?

Dr. COBB. I have been a member of the national medical committee for some time.

The CHAIRMAN. You were designated by your national committee to present this matter here this morning?

Dr. COBB. That is right.

The CHAIRMAN. Thank you very much for your statement.

The next witness is Miss Pauline M. Newman. Do you have a statement that you want to make to the committee?

Miss NEWMAN. I do.

The CHAIRMAN. Will you state the organization that you represent and where you reside, and so on.

Miss NEWMAN. The name is Pauline M. Newman, national executive board member of the National Women's Trade Union League of America.

**STATEMENTS OF PAULINE M. NEWMAN, REPRESENTING THE NATIONAL WOMEN'S TRADE UNION LEAGUE OF AMERICA, AND MISS ELIZABETH CHRISTMAN, SECRETARY-TREASURER OF THE NATIONAL WOMEN'S TRADE UNION LEAGUE OF AMERICA**

**ENDORSEMENT OF S. 1606**

Miss NEWMAN. Mr. Chairman and members of the Education and Labor Committee; the National Women's Trade Union League of America, with a direct and affiliated membership of more than a million persons, wishes to go on record in support of the Wagner-Murray-Dingell National Health Act. Because of our long years of association with wage-earning men and women in many parts of this country, we know that the one thing these people never had and do not have now, is adequate medical care. This great need they have never been able to fill; this want they have never been able to satisfy. They look to this measure now before you as a solution to their medical problems. They, and the organization I represent, hope for your favorable action. We are satisfied you will give it your serious consideration.

And now, Mr. Chairman, I would like to tell you some of the reasons why we are supporting S. 1606. With your permission I should prefer to leave those phases of the bill which have to do with costs, taxation, and other technical questions to persons more qualified than I am. I propose to confine myself to the questions of health services and preventive medical care. On this I can speak with some authority and experience. I am going to attempt to tell you what a prepaid medical plan has accomplished for a large group of workers; how health education and preventive medicine has instilled in them the kind of health consciousness which has led them to a healthier, hence happier, life.

**THE UNION HEALTH CENTER**

Thirty-three years ago, the International Ladies Garment Workers' Union undertook a health survey among its members in cooperation with the United States Public Health Service. The findings of this survey made it quite clear to both the leadership and the members that one way in which their health problems could be solved was to organize a health service of their own. They knew then that they individually could not cope with the high cost of medical care—any more than they can today. Neither did they cherish the thought of standing at charity's door, waiting long hours for an unsatisfactory medical "hand-out." How to save the members' pride, pocketbook, and health was the question, and the answer came in the establishment of our union health center. Thus far, it is the only industrial clinic owned by and operated for the members of a labor organization.

Its beginning was modest. The first few years of its existence was limited to general medical examinations. Today it is perhaps the largest and best-equipped ambulatory clinic in the country. Its services are inclusive and range from a preunion admission examination to hospitalization and control of tuberculosis. Diagnostic, preventive, and curative medical care is given by competent and reputable physicians.

I have been associated with this institution from its inception. I have had ample time and an excellent opportunity to observe the results of a prepaid medical plan; what it actually does for the individual and, in the long run, for the community as a whole.

The CHAIRMAN. I am required to go to the Senate to present a matter that I am interested in there, and I am sorry that I cannot hear the full statement that you have to make, but I will read it with great interest. I appreciate your appearance here this morning, and in my absence Senator Donnell will have charge of the hearing.

Miss NEWMAN. Thank you very much.

(Senator Donnell assumed the chair.)

Senator DONNELL. You may proceed, Miss Newman.

Miss NEWMAN. Under a prepaid medical-care plan the individual man or woman no longer need hesitate to see a physician because of his or her inability to pay. Under a prepaid plan there is no need to neglect a minor illness which if not cared for in time may end in a major catastrophe. Under such a plan frequent and periodic physical examinations—which in my opinion is the best way to prevent the spread of disease—are no longer a financial liability but a physical and mental asset. Under such a plan the specter that haunts wage-earners who are in need of surgical care or hospitalization is removed. The foundation of one's earnings and savings need not collapse at that point. The right to adequate medical care and opportunity to secure it are assured. A prepaid medical plan obviates needless worry, pain, distress, and removes the financial barrier which today stands between the skilled physician and the patient from the low-income groups. But a prepaid medical plan does more. It makes people think about guarding their health. It teaches them to realize that good health is a precious gift from God and should be protected and preserved.

#### HEALTH CARE IS PROHIBITIVELY EXPENSIVE AT PRESENT

However, we are told that good health is purchasable. Certainly; so are precious jewels in Tiffany's. How many of us would even dream of going to Tiffany? How many of us can afford to purchase medical care from private physicians? Suppose, Mr. Chairman, we try and see what an ordinary diagnostic examination or as our English friends call it an "overhauling," in a private physician's office comes to:

Jennie the operator decides to have such an examination and finds that the fee for the first visit to the doctor is \$5. This doctor is not a "top-notcher," but an average, reputable man. He will want some laboratory tests—a blood count and urinalysis will cost \$5. No routine examination should be made without a chest X-ray; that will cost a minimum of another \$10. If there is nothing organically wrong with Jennie, the doctor will prescribe some medication which will come to about \$2. Here you have a total of \$22 for an incomplete medical check-up.

I repeat that this examination is incomplete. It does not include an electrocardiograph. It does not include a gastrointestinal X-ray examination and the additional tests which are essential to a thorough diagnostic examination. And yet Jennie has paid \$22 merely to find out if anything is wrong with her health! Do you see now why it is that Jennie and her kind think long and hard before they will go to a private physician? Their limited income does not allow for such

luxury. It is this inability to meet the cost of medical care that prevents the wage earner from consulting a physician until he is no longer able to work, or to see a dentist until he is no longer able to endure his toothache.

#### PUBLIC HEALTH CLINICS INFERIOR

At this point someone may well ask: "Why should not Jennie and her kind use the services of our public-health clinics?" This is a pertinent question. But I think I can give you the reasons why Jennie and her kind do not like to go to those clinics.

1. She will, in all probability, have to absent herself from her work a whole day. The services of those clinics are not now available in the evenings.

2. Jennie does not care for charity, any more than do the rest of us. In fact Jennie would much rather pay for medical or any other service she gets providing the cost is within her ability to pay. Jennie and her kind do not want to get anything for nothing.

3. And finally, Jennie will tell you that if our public-health clinics are to be used by people like herself they will have to be of a different type from those with which we are now familiar. I happen to know quite a bit about those clinics and I am here to tell you that they are not what they might have been—the pride of a community.

The physical surroundings alone are enough to discourage a sick person from going there—those hard and uncomfortable benches; the cheerless and frosty atmosphere; the lack of privacy; the absence of kindness and understanding; the needless questioning; the humiliation; the hard-boiled attitude—all this and more is cause enough for Jennie and her like to stay away from these clinics. Until these health clinics are infused with a spirit of helpfulness and a real desire to render decent service, Jennie and people like her will be reluctant to use the public-health clinic.

I maintain, Mr. Chairman, that while we have made excellent progress in medical science, the fruits of this scientific knowledge are not now available to the working men and women of our land. But the most deplorable thing of all, I think, is the fact that even the clinics I have described above are nonexistent in so many parts of this country! That this should be so is unbelievable, but it is a fact, as you gentlemen of the committee must know.

#### IMPORTANCE OF HEALTH EDUCATION

And now, Mr. Chairman, as one who has devoted 33 years to health education, I would like to say a word or two about it. To me health education is a prerequisite to preventive medical care. I do not think any medical plan can attain its objective unless a well-planned educational program is part of it. In our union health center we made health education an active and vital force in the lives of our people.

The great Goethe is quoted as having said: "Who on efficient work is bent, must use the fittest instrument." We have found that to be true in our educational work. Posters and literature; lectures and individual contacts with our people have brought very satisfactory results. Not only are our people conscious of the need to guard their own health, they are very much concerned with the health of their coworkers.

They are no longer in the dark about possible contagion. Let one of the workers continue to cough for a few days in succession, and lo and behold the entire shop will want to have a chest X-ray examination. That may be health consciousness with a vengeance. But I would rather have this sort of interest than the utter indifference of years gone by.

Now, the point I want to make is simply this: If it was possible for one labor organization to do all that, I submit that the United States Government and the people should be in a position to do as much and more.

#### VOLUNTARY HEALTH AGENCIES NOT EQUAL TO THE TASK

Voluntary health agencies cannot do it. I am told that there are in this country no less than 20,000 such agencies. No one will question their contribution to the health movement in general and to health education in particular. But we also know that it is not in the province of such voluntary agencies to build hospitals in communities where there are none; to establish health centers in the rural part of our land. It is the obligation of the Government to see to it that the people are provided with the care they need. Depending on or waiting for voluntary agencies would be less than futile. They offer no solution to the problem before us.

#### THE OPPOSITION TO S. 1606

I cannot conclude my remarks without a word about the opposition to S. 1606. I am one of those who do not mind honest opposition. The opposition to this bill, however, has not been honest. It has created—and on purpose—a forest of misunderstanding and a jungle of fear. On the whole, however, it has followed the general pattern of resisting change. It fears the new and the untried. It is the same kind of opposition—only more vicious—that has always fought any and all legislation which would benefit the vast number of our citizens. You, Mr. Chairman, and members of the committee, have met such opposition before. So have I. The hearts of the opponents to this measure bleed for the poor and sick who will—if this measure is enacted into law—lose the “personal touch” that is supposed to exist today between the doctor and the patient. What bunk! And what a basis on which to build their opposition. By attributing to this bill everything which it does not contain they have earned nothing but contempt from every decent citizen.

In conclusion, Mr. Chairman, let me say that S. 1606 may not be the final solution to the problem of adequate medical care facing the low-income groups today. It may not be perfect. We of the National Women's Trade Union League look upon this measure as a foundation upon which to build a more satisfactory structure. As time goes on and we gain experience, we may find it necessary to make alterations: We shall learn by doing. That's the history of all social legislation. We see nothing wrong with this method. Therefore, Mr. Chairman, you and the members of your committee have the rare opportunity to advance the cause of adequate medical care for so many of our citizens by reporting favorably on this bill. We look to you to take the lead.

Senator DONNELL. In your statement you mentioned that you have had experience in health education. Would you mind telling us for the record where your experience has been in health education?

Miss NEWMAN. In the International Ladies Garment Workers' Union. We started the organization of it in 1913.

Senator DONNELL. Now, I notice that you say this organization has a direct and affiliated membership of more than a million persons. How many of those are direct members?

Miss NEWMAN. We have the secretary of that organization here. Miss Christman might be able to divide the direct and affiliated better than I can because she is the secretary of the organization.

Miss CHRISTMAN. I will be glad to give you a statement on that and if I do not give it accurately we have that. We have many thousands of direct members. I think that I might explain something about the membership of the National Women's Trade Union League. We have a twofold membership, the trade unionists themselves, and people who are not members of trade unions, but sympathetic with labor's program, in that we differ from the regular organizations.

We are endorsed by the American Federation of Labor and we have been organized for 43 years, so that we have this national membership all over the country. We have membership in nearly all of the 48 States.

Senator DONNELL. And the direct members are the members of the labor union; is that right?

Miss CHRISTMAN. They are affiliated and direct.

Senator DONNELL. You divide the membership into two classes. Would you tell us what are the direct members?

Miss CHRISTMAN. The direct members are the members at large in the 48 States. The affiliated membership are local and international unions. We have affiliated to the league some of the largest labor unions of both the A. F. of L. and the CIO.

Senator DONNELL. How many direct members are there?

Miss CHRISTMAN. Thousands of them, several thousands of them.

Senator DONNELL. Could you give us approximately the number? Is it 15,000, or 10,000, or 20,000?

Miss CHRISTMAN. I think about five or six thousand of them.

Senator DONNELL. Those are direct members?

Miss CHRISTMAN. Yes, sir.

Senator DONNELL. And then the affiliated members are, you say, members of labor unions?

Miss CHRISTMAN. That is right.

Senator DONNELL. Do the labor unions themselves belong to the National Women's Trade Union League of America?

Miss CHRISTMAN. They affiliate on an annual basis and they contribute to the support of the National Women's Trade Union League.

Senator DONNELL. So that as you take in a union, the entire membership of that union becomes an affiliated membership of the league?

Miss CHRISTMAN. That is right. We try, however, not to duplicate. For instance, locally we have 16 local leagues in different parts of the country, and those leagues have affiliated the local unions, and we try not to duplicate that membership in our estimate.

Senator DONNELL. Now, the affiliated membership as I understand it consists of members of labor unions?

Miss CHRISTMAN. That is right.

Senator DONNELL. Are there any national labor unions as such that have affiliated or are they local unions entirely?

Miss CHRISTMAN. No, in the national league they are national organizations, I would say the printers are there. I will be glad to submit to you a list of these organizations.

Senator DONNELL. What I am trying to get at is how the approximately 1,000,000 affiliated members are made up. You have 5,000 to 6,000 direct members?

Miss CHRISTMAN. That is right.

Senator DONNELL. Miss Newman's statement said "the National Women's Trade Union League with a direct and affiliated membership of more than a million persons," and now I understand of those the direct members are numbered from 5,000 to 6,000; is that right?

Miss CHRISTMAN. Yes.

Senator DONNELL. That would leave somewhere in the neighborhood of 1,000,000 who are affiliated; is that right?

Miss CHRISTMAN. Yes, sir; that is right.

Senator DONNELL. Now, those affiliated members—what I am trying to get at is this: Are those the members of local unions here and there over the United States, or do they include the entire membership of some national unions?

Miss CHRISTMAN. We speak for the national organization. They include national unions.

Senator DONNELL. Now, just tell me one national union now whose membership belongs. As I understand it, there are some national unions which by affiliation cause all of their members to be members of the National Women's Trade Union League; is that right?

Miss CHRISTMAN. That is right.

Senator DONNELL. Now, would you tell us please one of those national organizations, for illustration?

Miss CHRISTMAN. I will give you the International Ladies Garment Workers Union, and the Amalgamated Clothing Workers, and I will give you the United Mine Workers of America, who have been affiliated to the National Women's Trade Union League since before my time.

Senator DONNELL. How many members are there of the International Ladies Garment Workers Union?

Miss NEWMAN. There are 325,000.

Miss CHRISTMAN. And in the Amalgamated Clothing Workers, we have about 300,000.

Senator DONNELL. I think that we might do better from the stenographic standpoint if one lady might testify at one time, and then we will supplement that. Which one is going to give the figures on this matter?

Miss NEWMAN. Miss Christman will give those figures.

Senator DONNELL. And the third organization that you mentioned was what?

Miss CHRISTMAN. The United Mine Workers.

Senator DONNELL. How many members does it have?

Miss NEWMAN. It has 500,000.

Senator DONNELL. You have got over 1,125,000 already of affiliated members. Now, are there other national organizations affiliated?

Miss CHRISTMAN. Yes; a whole slough of them. There would be many millions, Mr. Chairman. May I say this, in explanation: that I tried to say that nationally we do not try to duplicate the membership of our local leagues. For example, the local unions of the International Ladies Garment Workers, locally they are affiliated with our

Chicago League, and are affiliated with our New York League, and are affiliated in Kansas City, and we try to arrive at an approximate membership in that way.

Senator DONNELL. Pardon me, Miss Christman, but you have already given us here 1,125,000 in these three national organizations. Now, I am not going into great detail, but I did not understand what you meant here by saying that you have a direct and affiliated membership of more than 1,000,000. Now, you have told us that the direct membership is only about 5,000 or 6,000, and these affiliated members make up the difference, but you have already gone 125,000 over the 1,000,000. How many millions are there in this organization altogether, of these affiliated members?

Miss CHRISTMAN. That is an interesting question.

Senator DONNELL. Would you file a statement with us on that?

Miss CHRISTMAN. I will be glad to do it because I would be interested to know, because we have tried not to duplicate in our statement, you see.

Senator DONNELL. Very well. You will file a statement showing how your membership is made up?

Miss CHRISTMAN. I will be glad to do that.

Senator DONNELL. Now, may I ask Miss Newman, does the National Women's Trade Union League hold meetings of any kind, of its membership?

Miss NEWMAN. Definitely.

Senator DONNELL. How often are those meetings held?

Miss NEWMAN. The national executive board meets on an average, I suppose, of about once or twice a year. Last May we held a conference of all of our officers of all of our local leagues.

Senator DONNELL. Now, let me see. Does the entire organization hold an annual meeting as distinguished from the Board?

Miss NEWMAN. You mean the national convention?

Senator DONNELL. Of the National Women's Trade Union League of America.

Miss NEWMAN. It holds a national convention of its members, certainly, the affiliated memberships and delegates.

Senator DONNELL. How many people come to those meetings?

Miss NEWMAN. I would say several hundred, I suppose, from the different local unions.

Senator DONNELL. What is the maximum, would you say?

Miss NEWMAN. I would say about 600 or 700 delegates.

Senator DONNELL. That is 600 or 700 delegates?

Miss NEWMAN. Yes, sir.

Senator DONNELL. That is who come to this national meeting?

Miss NEWMAN. Yes, sir.

Senator DONNELL. When was the last one of those held, those meetings?

Miss NEWMAN. Last May we had a conference right here in Washington, with delegates coming from everyone of our local affiliates.

Senator DONNELL. And you had six or seven hundred people at that meeting?

Miss NEWMAN. Not at the last conference.

Senator DONNELL. How many did you have?

Miss NEWMAN. At the last conference I should say that there was close to 100 delegates from our local units.

Senator DONNELL. That is close to 100 delegates?

Miss NEWMAN. That is right.

Senator DONNELL. When was that meeting held?

Miss NEWMAN. Last May.

Senator DONNELL. Here in Washington?

Miss NEWMAN. That is right.

Senator DONNELL. That is what you call the delegate meeting of your entire membership?

Miss NEWMAN. Just one moment. May I explain this: You remember, do you not, that conventions were forbidden for a time while the war lasted?

Senator DONNELL. Yes.

Miss NEWMAN. And in place of a convention we had a conference of the local officers from all of our units, which met last May in this city.

Senator DONNELL. That was last May in this city?

Miss NEWMAN. Yes, sir.

Senator DONNELL. Now, that is the last general membership meeting?

Miss NEWMAN. That is right.

Senator DONNELL. Then in addition to that type of meeting you have these national executive board meetings.

Miss NEWMAN. That is right.

Senator DONNELL. Those are held once or twice a year?

Miss NEWMAN. That is right.

Senator DONNELL. Have you had one or two of those meetings since the meeting of last May?

Miss NEWMAN. There will be one held probably within the next month.

Senator DONNELL. Has there been one held since last May?

Miss NEWMAN. No.

Senator DONNELL. Did you hold one of those executive board meetings last May?

Miss NEWMAN. Yes, sir.

Senator DONNELL. About how many were present at that meeting?

Miss NEWMAN. The national board consists of the vice presidents of the national organization.

Senator DONNELL. How many people were there at the last meeting?

Miss CHRISTMAN. Nine members of the board. There is one vacancy on the board.

Senator DONNELL. The most recent meeting that you held was here in Washington, first of about 100 people to the national delegate convention, or the conference, which number was restricted because of the war conditions that you mentioned, and a meeting of the national executive board at which all nine of the members were present.

Miss NEWMAN. That is right.

Senator DONNELL. And it all took place the same month here in Washington?

Miss NEWMAN. That is right.

Senator DONNELL. Now, to go back to the meeting consisting of approximately 100 people, did that meeting pass any resolutions approving compulsory health insurance?

Miss NEWMAN. That is right.

Senator DONNELL. Now, do you have a copy of that resolution?

Miss NEWMAN. We will be glad to submit that to you.

Senator DONNELL. Would you be kind enough to submit a copy of that resolution for us?

Miss NEWMAN. Yes, sir.

Senator DONNELL. You do not have that today with you?

Miss NEWMAN. No, sir.

Senator DONNELL. That is in writing, is it?

Miss NEWMAN. Yes, sir.

Senator DONNELL. That is in the minutes of the meeting, and you are going to file one of those with us in the next few days?

Miss NEWMAN. I am sure that Miss Christman will take care of that.

Senator DONNELL. Then the national executive board, the nine persons, did it pass any resolution with respect to compulsory health insurance last May?

Miss NEWMAN. It approved this bill, Mr. Chairman.

Senator DONNELL. This particular bill, S. 1606?

Miss NEWMAN. That is right.

Senator DONNELL. I do not think that it had been introduced at that time.

Miss NEWMAN. We went on record for a national health act, leaving the details to you people to finish.

Senator DONNELL. Did that meeting approve by resolution compulsory national health insurance?

Miss NEWMAN. That is right.

Senator DONNELL. It did?

Miss NEWMAN. Yes, sir.

Senator DONNELL. So that there were two resolutions passed, one by the group of 100, and the other by the group of 9, both of them favoring national compulsory health insurance?

Miss NEWMAN. That is right.

Senator DONNELL. And both of those resolutions were passed last May?

Miss NEWMAN. Yes, sir.

Senator DONNELL. Those are the latest official actions of those groups of people; is that right?

Miss NEWMAN. That is right.

Senator DONNELL. And then you came here as the member of this executive board; is that right?

Miss NEWMAN. That is right.

Senator DONNELL. And were you directed by the executive board to come?

Miss NEWMAN. That is right.

Senator DONNELL. Did they direct you to do that along last May or just recently?

Miss NEWMAN. By correspondence recently, Mr. Chairman.

Senator DONNELL. And they told you to come by reason of that?

Miss NEWMAN. You do not for a moment think that I would come on my own, do you?

Senator DONNELL. I was asking you what your authority was and you came in pursuance of that authority?

Miss NEWMAN. That is right. I came here to speak in behalf of the National Women's Trade Union League of America.

Senator DONNELL. Miss Newman, where is your home?

Miss NEWMAN. In New York.

Senator DONNELL. And Miss Christman is here in Washington?

Miss NEWMAN. Yes, the national headquarters is here in Washington.

Senator DONNELL. And they are at 317 Machinists Building, of this city?

Miss NEWMAN. That is right.

Senator DONNELL. Is there anything further that either of you ladies care to mention?

Miss NEWMAN. Not at the moment.

Senator DONNELL. Miss Christman?

Miss CHRISTMAN. Not now; no.

Senator DONNELL. If not, we thank you for your coming and for the help you have given the committee.

The hearing will recess until 10 o'clock tomorrow morning. (Whereupon, at 12:55 p. m., a recess was taken, to reconvene again the following morning, April 17, 1946, at 10 o'clock.)

(Subsequently, the chairman directed that the following statements and letters be inserted in the record:)

AMERICAN FEDERATION OF LABOR,  
Washington 1, D. C., May 17, 1946.

HON. JAMES E. MURRAY,

*Chairman, Senate Committee on Education and Labor,  
United States Senate, Senate Office Building,  
Washington 25, D. C.*

DEAR SENATOR MURRAY: In the course of my testimony before the Committee on Education and Labor on April 16 I was asked to supply estimates of the cost of the component parts of the programs under S. 1050 and the aggregate costs of S. 1606.

The costs of social security, health, and welfare measures vary inversely with the level of national income and employment. Furthermore, the costs of the social insurance program under S. 1050 may be expected to rise over the years as the population ages, as the proportion of the population eligible for old-age and extended disability benefits increases, and as health facilities, personnel, and procedures become more adequate. There are many other special problems involved in preparing estimates of costs, and any estimates are necessarily subject to possible error. I am sending you a memorandum which I hope will serve your purpose.

The figures cited by Senator Donnell during the April 16 hearings in general relate to the peak load of social security costs—costs which would be incurred many decades hence. These figures were published in a pamphlet by Earl E. Muntz, of New York University, *Proposals for Health, Old-Age, and Employment Insurance*, and summarize estimates of the Tax Foundation and of Mr. Gerhard Hirschfeld. The earliest year to which any of these figures relate is 1960. Earl Muntz' own figures relate approximately to the year 2000 and Mr. Hirschfeld indicated that his estimates relate to approximately 1970-75.

You will note that we estimate that the comprehensive social security, health, and insurance measures included under S. 1050 would call for a net additional outlay of less than \$3,000,000,000 per annum in the next decade. Eventually—about fifty years from now—these costs may increase to a net addition of perhaps \$3.5 to \$4.5 billion per annum, as compared with Mr. Hirschfeld's estimate presented in *Social Security Tomorrow* of more than twice these amounts.

I should appreciate it greatly if you would include this letter and the attached memorandum in the record of the hearings on S. 1606.

Sincerely yours,

W. GREEN,  
*President, American Federation of Labor.*

## ESTIMATES OF COST OF PROGRAMS UNDER S. 1050 AND S. 1606

S. 1050 provides for grants and loans for construction of health facilities; for grants to States for public health services, maternal and child health and welfare services, and public assistance; and for a national system of public employment offices. In addition, it sets up a comprehensive and unified national social insurance system under which old-age, survivors, extended and temporary disability, unemployment, and health-service benefits would be provided. Some of the measures included in S. 1050 are already in operation; S. 1050 would expand these existing programs. The disability and health service benefit provisions of S. 1050 are not now in effect under a Nation-wide plan. However, the workers of the Nation are now meeting the cost of these two risks privately.

## NONINSURANCE PROGRAMS

About \$1,350,000,000 was spent in 1944 for existing noninsurance programs which would be expanded under S. 1050. Of this total, \$550,000,000 was spent by the Federal Government and \$800,000,000 by the States and local governments. The largest single portion of these costs, \$1,000,000,000 was incurred for public assistance to the needy, with the Federal Government carrying about 40 percent of the total assistance costs and State and local governments about 60 percent.

Under S. 1050, existing noninsurance programs would be improved considerably and the acute need for expansion, such as that for hospital construction in rural areas, would be met. The Senate has already adopted a separate bill embodying many of the hospital construction provisions of S. 1050; favorable action on this measure is expected in the House of Representatives. Our analysis of the cost of the noninsurance programs under S. 1050 suggests that about \$2,100,000,000 per annum would be needed to finance these measures. The immediate increase in annual cost would be about \$750,000,000, all of which would be spent for additional Federal grants-in-aid or loans to the States. With expansion of the social insurance programs, the long-run costs of the noninsurance programs may decline below their present level.

## SOCIAL INSURANCE PROGRAMS

As far as the cost of the social insurance programs is concerned, employees and their employers, on the average, are now contributing a total of more than 4 percent of wages for protection against the risks of old age, death, and unemployment; 2 percent for old-age and survivors insurance; and in excess of 2 percent for unemployment insurance. S. 1050 calls for an 8-percent contribution for the over-all comprehensive social insurance program. This contribution would be divided equally among employers and employees. Hence, the immediate effect of S. 1050 would be an increase of less than 4 percent in present contribution rates.

Our study of the costs—both present and prospective—lead us to the conclusion that an 8-percent contribution on the first \$3,600 of earnings per annum would be sufficient to meet the costs of the comprehensive social insurance system under S. 1050 for at least the next half decade. In fact, in the first few years, the 8-percent contribution also would provide a margin for reserves against contingencies.

The costs of benefit liberalization under the old-age and survivors insurance program and of the addition of extended disability in the next few years would be offset by extension of coverage to many groups now excluded and the resulting expansion of the contribution base. The costs of benefit liberalization under the unemployment insurance program would be offset in large measure by the reduced margin required by reserves when the unemployment risk is pooled on Nation-wide basis.

The cost of more liberal benefits for old-age and survivors insurance and extended disability protection would increase over the years, due to the increase in the number insured and increases in benefits resulting from length of time in the insurance system. As Mr. Altmeyer indicated in his testimony before the Ways and Means Committee on February 25, 1946, ultimate costs per annum for these benefits might be 1 to 2 percent of pay roll higher than the estimated eventual costs of the present old-age and survivors insurance program.

The increase in present contribution rates is estimated to cover the immediate costs of temporary disability and health-service benefits, with the exception of the cost of dental and home-nursing care included in the health insurance plan. The health and disability benefits are estimated to cost about 3.5 to 4.5 billion dollars in the first years of operation, and 4.5 to 5 billion dollars a decade or so later. Of these totals, between \$500,000,000 and \$1,000,000,000 per annum would be spent for temporary disability benefits. Health-service benefits would amount to about \$3,000,000,000 in the early years and about \$4,000,000,000 later.

At approximately a \$150,000,000,000-level of national income the contribution base under S. 1050 would amount to about \$85,000,000,000. An 8-percent contribution rate, after making allowance for the lower contribution rate assessed on the self-employed, who are not eligible for temporary disability or unemployment benefits, would yield about \$6,500,000,000 per annum. This is about \$4,000,000,000 more than would be contributed by employers and employees under the present old-age and survivors insurance and unemployment compensation program, at the same rate of earnings. In addition to contributions of \$6,500,000,000, dental and home-nursing benefits would call for a Government appropriation of approximately \$500,000,000 per annum in the first decade or so, making a net increase in cost of \$4,500,000,000 in the early years.

This cannot be considered the net additional cost to the Nation. The health insurance programs under S. 1050 and under S. 1606 represent in the main simply a new way of paying for health care. The costs and burdens of wage loss due to sickness and disability are now falling on workers and their families. Those excluded from coverage of the present old-age, survivors, and unemployment insurance programs are suffering the financial drains resulting from these risks. Workers are now spending about 4 to 5 percent of their income to meet medical and dental bills. Under the prepayment plan provided in S. 1050 and S. 1606, a large part of these bills would be paid by the insurance fund. At least \$2,500,000,000 is now being spent for sickness care which would be provided under S. 1050 and S. 1606. At least these private bills appropriately may be deducted from the net additional cost of \$4,500,000,000 cited above. Thus there would be a total net additional cost to the Government and individual contributors of less than \$2,000,000,000 for the social insurance provisions.

As was indicated above, old-age, survivors, and extended disability benefits under S. 1050 eventually will cost 1 to 2 percent of pay roll more than would benefits under the present old-age and survivors insurance program. A comprehensive health insurance program a decade or so later may cost about 1 percent of pay roll more than in the early years of the plan when some of the benefits are limited due to limited personnel and facilities. Costs of other programs may be expected to either remain at the level of the early years or to decrease. Without any allowance for such a decline, the eventual net increase in costs over the early year costs under S. 1050 would aggregate 2 to 3 percent of pay rolls. These additional amounts may be met from a Government contribution to the social insurance program. At about an \$85,000,000,000 rate of taxable earnings, the eventual or peak costs of the comprehensive social insurance system would be \$3,500,000,000 to \$4,500,000,000 above the amounts which would be spent under present social insurance programs and through private expenditures for medical care.

The prepaid health benefits under S. 1606, in general, are similar to those provided under S. 1050. The cost figures cited above of about \$3,000,000,000 in the early years and about \$4,000,000,000 per annum a decade or so later, relate equally well to S. 1606.

THE AMERICAN ASSOCIATION OF MEDICAL SOCIAL WORKERS, INC.,

*Washington 5, D. C., April 17, 1946.*

HON. JAMES E. MURRAY,

*Chairman, Education and Labor Committee,*

*United States Senate, Washington D. C.*

MY DEAR SENATOR MURRAY: As your telegram of March 29, 1946, indicated that time probably would not permit verbal testimony of the American Association of Medical Social Workers, we are submitting the association's statement of principles relating to medical social aspects of a national health program. We hope this statement may be written into the hearings of your committee on S. 1606.

The focus of the statement has been on the essential social needs and a plan which would ensure their consideration. The statement has four sections:

1. Purpose of the statement.
2. Need for a national health program.
3. Objectives of such a program.
4. The essentials of such a program.

We believe that these principles are desirable goals for the future as they provide for a planned service which assures continuity and integration of medical and social aspects of a national health program, and which safeguards the rights and dignity of individuals. We recognize that gains may be a matter of a series of intermediate steps. Timeliness and other factors will be involved in this progress, the question of personnel alone being a tremendous problem.

We would like to bring your attention particularly to—

Page 3, B: "Even where medical services and facilities exist many persons are unable to make effective use of them \* \* \*"

Page 5, 1B: Scope of services and facilities.

Page 6 and 7, II A: A single responsible health agency is a fundamental requisite to effective administration at each level, Federal, State, and local. The Federal Government should participate in costs through grants to the States with special help to those States whose financial resources are inadequate to meet their needs.

We trust your committee will find our statement of some value in discussing the social aspects of a national health program, and we would be happy to answer any questions you might have about the statement.

Sincerely yours,

MARGARET K. LUMPKIN, *Executive Secretary.*

## STATEMENT OF PRINCIPLES RELATING TO MEDICAL SOCIAL ASPECTS OF A NATIONAL HEALTH PROGRAM

### PURPOSE OF STATEMENT

This statement is a guide for members of the American Association of Medical Social Workers in the evaluation of the medical social aspects of medical care programs under public auspices, Federal, State, or local. Moreover, it is to assist members in appraising proposed legislation or plans for the extension and improvement of health and medical services, to determine whether these plans take into consideration the many social factors which are essential to sound program development. The principles cited represent guides to be used by the association and its constituent units for the formulation of a policy for action.

Other professional groups and organizations have presented convincing evidence of the need for medical care. They have also submitted principles expressing the desirable content of a comprehensive health program, and have made recommendations regarding the provision of extended services and facilities.<sup>1</sup>

The purpose of this statement is to indicate principles and criteria related to the social aspects of health and medical care, to cite gaps in community services and in community planning, and to present recommendations regarding ways of solving some of the social needs and problems which interfere with good medical care. The concepts expressed are based on experience with health and medical services under public and private auspices and in both hospital and extramural settings. Consideration of these concepts by those concerned with future developments and planning is necessary to assure the availability of services and facilities to persons who need them and to provide for their proper utilization.

<sup>1</sup> Interim Report of the Subcommittee on Wartime Health and Education to the Senate Committee on Education and Labor, U. S. Senate, Pursuant to S. Res. 74 (78th Cong., 2d sess., Subcommittee Rept. No. 3). Washington, D. C.: U. S. Government Printing Office, 1944.

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Principles of a Nation-Wide Health Program: Report of the Health Program Conference. New York: Committee on Research in Medical Economics, November 1944.

Bulletin and Special Supplements of the Physicians Forum, 510 Madison Avenue, New York 22, N. Y. (1939-46).

Statements of the Committee of Physicians for the Improvement of Medical Care, Inc., 789 Howard Ave., New Haven, Conn. (1938-46).

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## THE NEED FOR A NATIONAL HEALTH PROGRAM

Numerous studies have revealed that prompt and accurate diagnosis and comprehensive medical care are not readily available to all the people. Extensive amounts of neglected ill health, chronic disease, and major physical defects which need medical attention, are uncovered whenever representative groups of the population are examined.

Some of the inadequacies which necessitate a national health program are:

A. Professional services and care in hospitals and related facilities are not financially available to everyone everywhere. The striking advances of medical science, with its specialization involving complex services and facilities, have greatly increased the costs of medical care of good quality and reduced its availability.

Illness and its costs fall unevenly and unpredictably upon the individual and upon individual families. Low-income families have more than average amounts of illness. Although they spend a proportionately larger share of their incomes on sickness than the well-to-do, the percentage of illness without medical attendance rises steadily as income declines. A major or prolonged illness frequently brings economic disaster to many families of all income groups except the very wealthy. Denial of the basic necessities of life, in an attempt to pay for the catastrophic illness of one member, can endanger the health of other members of the family group. Thus illness creates poverty and poverty in turn creates more illness.

Because the ability to pay governs the use and availability of medical services, there is often serious delay in seeking early diagnosis and medical treatment. Frequently, people are reluctant to apply for medical care because the circumstances under which free medical care can be secured imperil their dignity and self-respect. As a result, many do not receive care at a stage when prevention of serious illness is possible, nor do they receive the full range of services needed.

Present voluntary prepayment plans for medical and hospital services meet only a small proportion of the total medical need. They are limited in the types and extent of care provided and the groups served.

B. Professional services and medical care facilities are limited in scope and quality, their distribution is uneven, and little emphasis is given to their social aspects.

The ratio of physicians and hospital beds to population varies from State to State and among urban and rural areas within States. The lowest ratio is found in less prosperous and in rural or sparsely populated areas. Some communities do not have any qualified physicians or medical institutions. Specialists in particular are concentrated in large cities and wealthy communities. Not only is there a lack or a maldistribution of physicians but also of dentists, nurses, medical social workers, nutritionists, and other professional personnel essential for adequate medical care. Personnel for psychiatric services are limited in all areas.

Services and facilities available to Negroes and other minority groups are even more inadequately and unevenly distributed than are those available to other groups in the population. The quality of these services, or the manner in which they are made available, often discourages their utilization.

Even where medical services and facilities exist many persons are unable to make effective use of them because of (1) lack of understanding and knowledge of resources; (2) emotional factors; and (3) socio-economic factors. Some persons can profit fully from medical care if information or advice is given to them and they are helped to make use of community resources. The needs of other sick persons can be met only when social study and treatment are provided as an integral part of medical services. Persons are disabled not only as a result of impairment of function by organic disease, but also as a result of impairment of function by deprivations, and equally important, by fears, anxieties and dissatisfactions which affect the degree, extent and duration of disability, as well as the individual's reaction to medical care. The ability of individuals to utilize medical services and facilities is affected also by social and environmental problems, such as family responsibilities, poor housing, insufficient food, inadequate clothing, unsatisfactory working conditions, and difficulties of transportation.

C. Recruitment, funds, educational facilities and instructors for the training of professional personnel for State and local health and medical services are inadequate.

The need for planning and supporting programs for recruitment exists in relation not only to persons to be trained but also to persons to participate in the

training. Educational programs established for the various professional groups involved are in need of financial support as well as assistance with the development of content of the curriculum.

The present teaching in public health and medical schools regarding the social, emotional, and environmental factors in medicine, and in schools of social work regarding the social aspects of public health and medical care programs is recognized as being unsatisfactory.

D. The amount and scope of preventive health services, including medical social services, are inadequate.

Many communities are without basic public health services and others provide only limited services. Individual preventive services, best exemplified in maternity clinics and child health conferences, are not generally available to all communities or to all members of a community. Disease must be recognized early in its course and treated promptly and effectively, in order to shorten the period of illness and to decrease the prevalence and extent of disability. Social factors which might lead to illness must also be recognized and treated early.

People lack information regarding good public health measures and the benefits of modern medical care. Health education alone, however, does not assure the actual availability of services to and utilization by those who need them.

All measures for the protection and improvement of health and the prevention and treatment of disease need to be coordinated in a unified program. A sufficient number of full-time, organized, and adequate public health departments are needed to give Nation-wide coverage in carrying out a broad program which includes medical care as an integral part of public-health services.

E. Services and facilities for care of the chronically ill are especially inadequate, both as to quantity and quality.

The problems of chronic disease affect all age groups but will inevitably become more extensive and more serious with the increase of aged persons in the population. Persons with chronic conditions usually need protracted and expensive care. Lack of such care has tended to increase the amount of disability, to precipitate social and economic dependence and insecurity among the individuals and their families, and to multiply the ultimate costs of care for the community. Failure to provide resources for the chronically ill has also led to overburdening facilities for the acutely ill. Plans for the chronically ill must recognize the varying needs of different diagnostic groups and must make appropriate provision for care in the home, as well as in hospitals and other institutions, specifically designed to serve these groups.

#### OBJECTIVES OF A NATIONAL HEALTH PROGRAM

The welfare of a nation depends on the health of its people. Health, therefore, is a concern of government. The success of a democracy is measured by the extent to which all its citizens attain the fullest possible measure of self-realization, for the common good. A national health program is essential if each citizen is to be assured the opportunity to remain or to become a participating member of his community. The objectives of such a program are:

A. To make readily available the benefits of modern medical and public health science to all persons everywhere. Medical care of good quality should be available as a right to all of the people, irrespective of age, race, creed, residence, economic status or type of medical or health need.

B. To provide the range of services and continuity of care needed within the preventitive, diagnostic, and treatment aspects of medicine.

C. To support and stimulate further developments in medical, public health, and medical social education.

D. To promote research in the medical sciences, including the social and economic aspects of illness and medicine.

#### ESSENTIALS OF A NATIONAL HEALTH PROGRAM

A national health program must provide for organization of professional services, construction of medical care facilities, organized payment for the use of professional and institutional services, sound administration, maintenance of high standards of service and professional education and research. In each of these social consideration must be brought to bear.

*I. Provision of professional services and construction, maintenance and use of medical facilities for care.*

A. A Nation-wide program should be planned to make health and medical services available for all people in all areas. The plan should provide for sound professional leadership, the effective utilization and correlation of existing services and facilities, for their improvement, and for their expansion, under appropriate auspices, on the basis of unmet needs.

B. Full and comprehensive health and medical services should be made available to include adequate preventive, diagnostic, and treatment services. The services available should include—

1. Public-health services, general medical care, and all specialty services. Particularly should provision be made for increasing psychiatric services and dental services.
2. Care in general and special hospitals.
3. Itinerant diagnostic and therapeutic clinics.
4. Medications, medical supplies and appliances, and prosthetic devices.
5. Services and facilities for care of the chronically ill, including comprehensive diagnostic and treatment services.
6. Services and facilities for convalescents, including sheltered care for adults and foster home care for children. There will often be need for continuing such services during periods of prolonged treatment.
7. Nursing services including institutional, public health, and home nursing.
8. Medical and psychiatric social services for the study and treatment of social problems incident to illness and medical care.
9. Nutrition services.
10. Physical therapy.
11. Occupational therapy.
12. Recreation and diversional activities.

C. The construction of additional facilities where needed should be planned to assure to people in all parts of the country accessibility of facilities for preventive and curative care.

Social consideration should be given to the proper size, location and type of facility to ensure its best possible use to provide care for the patient.

There should be provision for maintenance as well as for construction of needed hospitals, health centers and related institutions.

D. Provision should be made for social study and treatment as an integral part of the medical care of individuals.

Both the provider and the user of medical services need increased recognition of the social, emotional, and environmental factors which affect illness, and of the effect of illness on the socio-economic conditions of the family and community. Such recognition would improve the quality of medical services offered and the individual's ability to profit fully from such services. Increased consideration should be given to the social problems of persons with mental and psychiatric disorders as well as of persons with physical disabilities.

Social services should be available to assist individuals in gaining insight into the social problems incident to medical care and disability, and in modifying or correcting those situations which interfere with the maximum benefit from medical services. Individuals also require assistance in the use of health and medical facilities and in accepting and carrying through the medical recommendations.

E. Provision should be made for extensive informational programs, designed to acquaint the people with the types of services which the community offers, and with the circumstances under which they may be used.

Such programs will contribute both to a wider, as well as a more discriminating, use of facilities. Prevailing methods of health education should be extended and modified to include specific information about the location, admission policies, costs and kinds of service available, as well as the circumstances under which it is important to seek medical care.

*II. Administration and financing*

A. A satisfactory national health program should be planned with Federal, State, and local participation.

A single responsible health agency is a fundamental requisite to effective administration at each level, Federal, State, and local.

1. The Federal Government should—

(a) Provide leadership in developing a broad program which correlates the activities of public and private agencies and facilities for preventive and treatment services.

(b) Establish standards for personnel administering the programs and for professional personnel, hospitals, and other medical facilities rendering services.

(c) Participate in the costs through grants to the States with special help to those States whose financial resources are inadequate to meet their needs. It should be recognized that Federal grants to States are essential to ensure an adequate national health program, whatever the principal plan for financing (i. e., compulsory health insurance, general revenues).

2. State agencies should—

(a) Develop plans designed to assure the availability of services in each area of the State to all persons, irrespective of age, race, creed, residence, economic status, or type of medical or health need.

(b) Provide for methods of administering or supervising the administration of local agencies which will carry out the plan.

(c) Establish and maintain standards for personnel administering the programs and for professional personnel, hospitals, and other medical facilities rendering services.

(d) Develop agreements or cooperative arrangements with other State or local public or private agencies which provide health, welfare, and educational services.

(e) Provide opportunity for a fair hearing to any person denied health or medical care, or to any physician, professional person, or medical institution participating, or desiring to participate, in furnishing services.

(f) Protect the right of persons to select, from among physicians and medical institutions meeting acceptable standards and participating in the program, the physician, hospital, clinic or health service agency of their choice.

3. Local agencies should administer services in accordance with State plans, with supervision from the State health agency and with suitable correlation of health, welfare, and educational activities in the community.

B. Professional bodies and technical experts should be used in consultant and advisory capacities, in the formulation of policies and standards, by Federal, State, and local agencies.

C. Qualified professional staff chosen on the basis of a merit system of selection, including medical social workers, should be employed to assist in carrying out the purposes of the program.

D. Emphasis should be given to the social aspects of administration in the formulation of operating policies and procedures which affect the care of individuals.

Care should be offered under conditions which encourage fullest use of services and facilities. Channels to care must be clear and free of unnecessary procedure. Services should be offered under conditions which respect the freedom and dignity of the individual. Diagnostic, treatment, convalescent and rehabilitation services should follow with no interruption in continuity of care.

Medical and psychiatric social workers on the staff of the health agency should participate with other personnel in the formation of policies, standards, and procedures; in their interpretation to staff and in their modification on the basis of experience.

E. A national system of reporting on the volume, kinds and costs of medical services provided, including medical social services, is essential to sound administration. Adequate data collected on a comparable basis are needed to plan and carry out a national program and to enable administrators to estimate the volume, type and cost of services needed, in order to secure legislation, develop a plan of administration and interpret the program to the community.

F. Effective use of community resources in the fields of welfare, education, rehabilitation and recreation, is essential to meeting the total needs of individuals in order that they may benefit fully from medical care. Assistance to the patient in the use of these resources is the responsibility primarily of the medical social worker. Development of necessary resources under appropriate auspices should be stimulated to fill the gaps in a community health and welfare program.

### *III. Maintenance of high standards of professional personnel.*

A. High standards of professional services and facilities should be developed and maintained through the use of competent, qualified personnel.

B. In the interest of good administration and quality of care, administrative agencies should plan for extensive and continuing staff training programs for all the staff, including physicians, dentists, medical and psychiatric social workers, public health nurses, and others.

C. Medical and psychiatric social work personnel are essential in the extension of public health and medical care programs. Provision should be made for expanding the teaching facilities and personnel, and for recruiting and assisting persons to secure the necessary training.

The Federal Government should make funds available for these purposes. It should assume responsibility for assisting in the development of method and content for the teaching of the social aspects of public health and medical care.

State or local agencies likewise should assist schools of social work by offering consultation in regard to curriculum, help in conducting lectures, and by offering the opportunity for students to have field work in State and local health agencies.

D. In accordance with the recommendation of many medical and public health authorities, the social, emotional, and environmental factors in medicine and public health should receive greater emphasis in the education of the physician and the health officer. The participation of medical social workers in the teaching of medical and public health students should be extended, in cooperation with the medical profession and the schools of medicine and public health. Further initiative should be taken by the professional field of medical social work in developing the method and content of this teaching. Similar consideration should be given to the content of education for other personnel in the medical team.

#### IV. Research

A. Provision should be made for the advancement of medical research and for the advancement of the scientific knowledge of social, economic, and psychological factors in the prevention and care of illness.

B. Provisions should be made for the conduct of broad studies related to the social and economic aspects of health to form the basis for National, State, and local planning.

C. Special emphasis in research is needed in those areas of illness or disability having particular social implications and in which relatively little research has been done, e. g., convalescence, chronic disease, geriatrics.

D. Studies of the administration of medical care programs, especially the social aspects of administration, are needed to help Federal, State, and local agencies determine what methods are most effective and least costly.

Committee on medical care: Edith M. Baker, Dora Goldstine, Barbara B. Hodges, Louise Meyer, Rose Segal, Lucille M. Smith, Marian E. Russell, chairman.

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AMERICAN FEDERATION OF LABOR,  
Washington 1, D. C., April 16, 1946.

HON. JAMES E. MURRAY,

Chairman, Senate Committee on Education and Labor,  
United States Senate, Washington 25, D. C.

DEAR SENATOR MURRAY: This is written in response to the request for the full record of the negotiations between representatives of the American Federation of Labor and representatives of the American Medical Association with respect to consultations on health insurance legislation made during President Green's appearance before your committee this morning.

Early in January 1945, Miss Florence Thorne, director of research and information for the American Federation of Labor and I were invited to meet with the council on medical service and public relations of the American Medical Association at the Mayflower Hotel in Washington. During the course of this meeting we were asked if representatives of the American Federation of Labor would meet with representatives of the American Medical Association to discuss health insurance and specifically the provisions of the Wagner-Murray-Dingell bill relating thereto which was then in the drafting stage. We replied immediately that we would be glad to meet with representatives of the American Medical Association for that purpose at any time to suit their convenience either in Washington or Chicago, and left with the understanding that we would hear from this committee as to the time and place. To this date we have not heard anything further. It appears that the American Medical Association though they repeatedly complain that they were not consulted about the provisions of the bill in question fail to respond when the opportunity is presented.

There is enclosed a copy of a letter from Dr. Carl M. Peterson who is secretary of the council on industrial health and I believe either chairman or secre-

tary of the council on medical service and public relations. You will note that this letter refers in the first paragraph to the meeting which Miss Thorne and I attended. The references in the remainder of the letter are to another meeting which was canceled as a result of wartime travel restrictions.

Sincerely yours,

NELSON H. CRUIKSHANK,  
*Director, Social Insurance Activities.*

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AMERICAN MEDICAL ASSOCIATION,  
COUNCIL ON INDUSTRIAL HEALTH,  
*Chicago, February 9, 1945.*

MR. NELSON H. CRUIKSHANK,  
*Director, Social Insurance Activities,  
American Federation of Labor, Washington 1, D. C.*

DEAR MR. CRUIKSHANK: Many thanks for your letter of January 23. I had the pleasure of meeting you in Washington recently when you and Miss Thorne met with our council on medical service. I hope that it is going to be possible for us to get better acquainted promptly.

I am a little doubtful whether it will be possible for us to organize a "convention by mail" respecting the contributions of the people who had expected to participate in the congress on industrial health—especially those who were members of panels. I expect that it will probably be better for us to hold these contributions in abeyance in the hope that at some later time this year the regulations regarding meetings may be relaxed and that at such time we can reorganize the meeting.

However, if there are a sufficient number of manuscripts received to justify the publication of a "proceedings" I shall be sure to let you know.

Sincerely yours,

C. M. PETERSON.

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THE AMERICAN PUBLIC HEALTH ASSOCIATION,  
*New York 19, N. Y., April 17, 1946.*

HON. JAMES E. MURRAY,  
*Chairman, Committee on Education and Labor,  
Senate Office Building, Washington, D. C.*

DEAR MR. MURRAY: The American Public Health Association welcomes the opportunity to present to you and the Senate Committee on Education and Labor an official statement of the American Public Health Association which outlines some principles having a bearing on the current hearings on S. 1606.

A reprint of this declaration on medical care in a national health program is attached which we should be glad to have inserted in the record, as the considered opinion of this professional society of public health workers.

Faithfully yours,

REGINALD M. ATWATER, M. D.,  
*Executive Secretary.*

[Reprinted from American Journal of Public Health, vol. 34, No. 12, December 1944, published by the American Public Health Association, 1790 Broadway, New York, N. Y.]

#### MEDICAL CARE IN A NATIONAL HEALTH PROGRAM

An Official Statement of the American Public Health Association  
Adopted October 4, 1944

At the annual meeting of the committee on administrative practice of the American Public Health Association, October 9, 1943, the committee directed its subcommittee on medical care to draft a set of principles expressing the desirable content of a comprehensive program of medical care, the methods of its administration, and the part which public health agencies should take in its operation. In pursuit of this assignment, the subcommittee completed a tentative draft, which was considered and adopted by the committee on administrative practice at its meeting, October 1, 1944. The report was then transmitted to the governing council of the association where, after certain revisions, it was adopted as a statement of association policy.

Because of its composition and charge, the subcommittee has limited its considerations to one sector of a comprehensive national health program, namely, medical care.

In preparing the report, the subcommittee has considered:

- A. The needs for a national program for medical care.
- B. The objectives of such a program.
- C. Recommendations for immediate action.

The American Public Health Association through its national organization and its constituent societies stands ready to collaborate with the various professional bodies and civic organizations which may be concerned with either the provision or receipt of medical service with a view to implementing the following general principles:

#### A. THE NEEDS

I. A large portion of the population receives insufficient and inadequate medical care, chiefly because persons are unable to pay the costs of services on an individual payment basis when they are needed, or because the services are not available.

II. There are extensive deficiencies in the physical facilities needed to provide reasonably adequate services. Such facilities include hospitals, health centers, and laboratories. The needs are most acute in poor communities, in rural areas, and in urban areas where the population has increased rapidly or where the development of facilities has been haphazard or the financial support inadequate.

III. There are extensive deficiencies in the number and the distribution of personnel needed to provide the services. Here again, the needs vary according to categories of personnel and to characteristics of communities.

IV. There are extensive deficiencies in the number and categories of personnel qualified to administer facilities and services.

V. Many communities still are not served by public health departments; others inadequately maintain such departments. Thus, some communities have never utilized organized health work to reduce the burden of illness, and others share its benefits only in part. In these communities especially, people lack information on the benefits of modern medical care.

VI. Expansion of scientific research is urgently needed. Despite past and current scientific advances, knowledge as to the prevention, control, or cure of many diseases is lacking.

Each of the six conditions defined above can be broken down into many component parts representing specific needs. In general, however, solutions of these broad problems require simultaneous attack on four fronts: namely, the distribution of costs, construction of facilities, training of personnel, and expansion of knowledge.

#### B. THE OBJECTIVES

I. A national program for medical care should make available to the entire population all essential preventive, diagnostic, and curative services.

II. Such a program should insure that the services provided be of the highest standard, and that they be rendered under conditions satisfactory both to the public and to the professions.

III. Such a program should include the constant evaluation of practices and the extension of scientific knowledge.

#### C. RECOMMENDATIONS

The recommendations presented in this report represent guides to the formulation of a policy for action. It is believed that study of these recommendations by the professions and others concerned in the States and localities will produce new and more specific recommendations for the attainment of the objectives of a national health program.

##### *Recommendation I. The Services*

(a) A national plan should aim to provide comprehensive services for all the people in all areas of the country. In light of present-day knowledge, the services should include hospital care, the services of physicians (general practitioners and specialists), supplementary laboratory and diagnostic services, nursing care, essential dental services, and prescribed medicines and appliances. These details of content must remain subject to alteration according to changes in knowledge, practices, and organization of services.

Because of inadequacies in personnel and facilities, this goal cannot be attained at once; but it should be attained within 10 years. At the outset, as many of the services as possible should be provided for the Nation as a whole,

having regard for resources in personnel and facilities in local areas. The scope of service should then be extended as rapidly as possible, accelerated by provisions to insure the training of needed personnel, and the development of facilities and organization.

(b) It is imperative that the plan include and emphasize the provision of preventive services for the whole population. Such services include maternity and child hygiene, school health services, control of communicable diseases, special provisions for tuberculosis, venereal diseases, and other preventable diseases, laboratory diagnosis, nutrition, health education, vital records, and other accepted functions of public health agencies, which are now provided for a part of the population.

(c) Insofar as may be consistent with the requirements of a national plan, States and communities should have wide latitude in adapting their services and methods of administration to local needs and conditions.

#### *Recommendation II. Financing the Services*

(a) Services should be adequately and securely financed through social insurance supplemented by general taxation, or by general taxation alone. Financing through social insurance alone would result in the exclusion of certain economic groups and might possibly exclude certain occupational segments of the population.

(b) The services should be financed on a Nation-wide basis, in accordance with ability to pay, with Federal and State participation, and under conditions which will permit the Federal government to equalize the burdens of cost among the States.

#### *Recommendation III. Organization and Administration of Services*

(a) A single responsible agency is a fundamental requisite to effective administration at all levels—Federal, State, and local. The public health agencies—Federal, State, and local—should carry major responsibilities in administering the health services of the future. Because of administrative experience, and accustomed responsibility for a public trust, they are uniquely fitted among public agencies to assume larger responsibilities and to discharge their duties to the public with integrity and skill. The existing public health agencies, as now constituted, may not be ready and may not be suitably constituted and organized, in all cases, to assume all of the administrative tasks implicit in an expanded national health service. Public health officials, however, should be planning to discharge these larger responsibilities, and should be training themselves and their staffs. This preparation should be undertaken now because, when the public comes to consider where administrative responsibilities shall be lodged, it will be influenced in large measure by the readiness for such duties displayed by public health officers and by the initiative they have taken in fitting themselves for the task.

(b) The agency authorized to administer such a program should have the advice and counsel of a body representing the professions, other sources of services, and their recipients of services.

(c) Private practitioners in each local administrative area should be paid according to the method they prefer, i.e., fee for service, capitation, salary, or any combination of these. None of the methods is perfect; but attention is called to the fact that fee for service alone is not well adapted to a system of wide coverage.

(d) The principle of free choice should be preserved to the population and the professions.

(e) State departments of health and other health agencies are urged to initiate studies to determine the logical and practical administrative areas for a national medical care plan.

#### *Recommendation IV. Physical Facilities*

(a) Preceding, or accompanying, the development of a plan to finance and administer services, a program should be developed for the construction of needed hospitals, health centers, and related facilities, including modernization and expansion of existing structures. This program should be based on Federal aid to the States and allow for participation by voluntary as well as public agencies, with suitable controls to insure the economical and community-wide use of public funds. The desirability of combining hospital facilities with the housing of physicians' offices, clinics, and health departments should be stressed.

(b) Federal aid to the States should be given on a variable matching basis in accordance with the economic status of each State.

(c) Because of its record of experience and accomplishment in this field the United States Public Health Service should administer the construction program at the Federal level, in cooperation with the Federal agencies responsible for health services and construction.

(d) Funds available under this program should be granted only if:

(1) The State administrative agency has surveyed the needs of the State for hospitals, health centers, and related facilities, and has drawn up a master plan for the development of the needed facilities (taking account of facilities in adjacent States); or, in the absence of a State plan, the project is consistent with surveys of construction needs made by the United States Public Health Service;

(2) The proposed individual project is consistent with the master plan for the State; its architectural and engineering plans and specifications have been approved by the State agency and/or the United States Public Health Service; and there is reasonable assurance of support and maintenance of the project in accordance with adequate standards.

(e) State health departments are urged to conduct studies to develop State plans for the construction of needed hospitals, health centers, and related facilities. Such studies should be made in cooperation with official health agencies, with State hospital associations, and other groups having special knowledge or interests.

#### *Recommendation V. Coordination and Organization of Official Health Agencies*

(a) The activities of the multiple National, State, and local health agencies should be coordinated with the services provided by a national program. There is no functional or administrative justification for dividing human beings or illnesses into many categories to be dealt with by numerous independent administrations. It is difficult to reorganize agencies or to combine activities, and this cannot be accomplished hurriedly. Therefore studies and conferences should be undertaken without delay at the Federal level, and in those States and communities where the health structure is already unnecessarily complex.

(b) The Federal and State governments should provide increased grants for the extension of adequate public health organization to all areas in all States. Increased Federal grants should be made conditional upon the requirement that public health services of at least a specified minimum content shall be available in all areas of the State.

#### *Recommendation VI. Training and Distribution of Service Personnel*

(a) Within the resources of the program, financial provisions should be made to assist qualified professional and technical personnel in obtaining postgraduate education and training.

(b) The plan should provide for the study of more effective use of auxiliary personnel (such as dental hygienists, nursing aides, and technicians), and should furnish financial assistance for their training and utilization.

(c) Professional and financial stimuli should be devised to encourage physicians, dentists, nurses, and others to practice in rural areas. Plans to encourage the rational distribution of personnel, especially physicians, should be developed as quickly as possible, in view of the coming demobilization of the armed forces. Such plans should be integrated with the whole scheme of services and the establishment of more adequate physical facilities.

#### *Recommendation VII. Education and Training of Administrative Personnel*

(a) Education and training of administrative personnel should be encouraged financially and technically, especially for those who may serve as administrators of the medical care program, for hospital and health center administrators, and for nursing supervisors.

(b) State health departments should utilize those funds that may be available to train personnel in such technics as administration of health and medical services, and hospitals. Such a training program may contribute more than any other single activity to the future role of the official public health agency. As a corollary, the attention of schools of public health is directed to the importance of establishing the necessary training courses.

#### *Recommendation VIII. Expansion of Research*

(a) Increased funds should be made available to the United States Public Health Service and to other agencies of government (Federal, State, and local), and for grants-in-aid to nonprofit institutions for basic laboratory and clinical research and for administrative studies and demonstrations designed to improve the quality and lessen the cost of services.

(b) The research agencies and those responsible for making grants-in-aid should be assisted by competent professional advisory bodies to insure the wise and efficient use of public funds.

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AMERICAN VETERANS COMMITTEE,  
THOMAS JEFFERSON CHAPTER,  
Bronx, N. Y., April 17, 1946.

Senator JAMES E. MURRAY,  
*Senate Office Building, Washington, D. C.*

DEAR SENATOR: The Thomas Jefferson Chapter of AVC believes that the vast majority of the people in the United States are not able to afford the benefits of medical service as evinced by the high proportion of draft rejectees. We believe that in a country as advanced as we are in medical science, the average citizen should not fear illness and hospitalization as a financial burden, which may throw him into debt for years. We are all entitled to a chance at good health; death does discriminate between the rich and poor.

The Wagner-Murray-Dingell bill is a good step forward in the betterment of public health. It allows a majority of the public, by small pay-roll deduction, to be able to afford medical treatment of practically all physical affliction. We do not believe that any professional association, such as the American Medical Association, has either the moral or the ethical right to prevent the propagation of the benefits of its science.

The provisions of the bill are not new to the world. Other countries have proven the bill to be necessary to the welfare of the people.

We believe, therefore, that the Wagner-Murray-Dingell bill deserves the support of the people, and the Thomas Jefferson Chapter of American Veterans Committee will support the bill.

BILL KAPELMAN,  
*Chairman,*  
MONROE KAUFMAN,  
*Corresponding Secretary.*

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AMERICAN SOCIETY FOR RESEARCH IN PSYCHOSOMATIC PROBLEMS,  
*New York, April 17, 1946.*

Senator JAMES E. MURRAY,  
*Senate Office Building, Washington, D. C.*

DEAR SIR: In response to your telegraphic invitation, we have prepared a statement embodying the position of this society on the National Health Act and beg to enclose it herewith.

If the opportunity should arise, we should be glad to present testimony at the hearings of your committee through a personal representative.

Faithfully yours,

EDWARD WEISS, M. D.,  
*Committee on Psychosomatic Factors in Health Insurance.*

STATEMENT OF THE AMERICAN SOCIETY FOR RESEARCH IN PSYCHOSOMATIC PROBLEMS  
ON NATIONAL HEALTH ACT OF 1945 (S. 1606, H. R. 4730)

This is a national scientific society for the study of the relations between emotions and bodily illness. It is composed of physicians skilled in internal medicine, psychiatry, pediatrics, and numerous other medical specialties, as well as of economists, sociologists, social workers, and others qualified in the social sciences. As a scientific and educational organization, it is not concerned with advocating or opposing the passage of legislation. It therefore expresses no opinion concerning the desirability of enacting the present bill. It is, however, deeply concerned with public health and the nature of medical practice, and therefore wishes to take this opportunity of placing on the record some of the considerations which it believes should receive attention if this bill should become a law.

The psychosomatic approach to medical problems is not a new medical specialty, but a recognition that when a person becomes sick, he must be understood and treated as an organic unit and not as if the only problem were a particular symptom which may affect the heart, the stomach, or some other part of the body. It may be just as necessary in preventing or curing ill-health to devote attention to the individual's emotional processes as to administer drugs or other kinds of standard medical treatment. Psychosomatic medicine, therefore, con-

centrates attention on the interrelationships of the various functions of the body and mind, and takes care to diagnose the personality as well as the particular symptoms. It excludes no recognized scientific medical discovery or method, but seeks to bring them all into proper relationship with one another. In the course of doing this, it must naturally take account of the important role played by environmental factors, including early training, education, and adult experience.

By way of illustration, it has become widely known that emotional factors are prominent in gastric ulcers, asthma, and hay fever, high blood pressure and many types of heart trouble, gastrointestinal disorders and allergies. Medical authorities in the armed services have estimated that a high percentage of the illnesses of soldiers fall in the categories where emotional factors are significant in diagnosis and treatment—commonly called the psychoneurotic and psychosomatic illnesses. This conclusion is of great importance for the future care of veterans, whether or not their disabilities arise from war service. In regard to the latter point, when the emotions enter into illness, insurance becomes a double-edged sword, sometimes helping to perpetuate illness, as demonstrated in the "pensionitis" problems that complicate the medical care of veterans. The remedy is not, of course, to withhold treatment, but rather to see that it is of such a sort that the will to get well replaces the immature desire to be dependent.

New interrelationships between physical symptoms and emotional disorders are continually being discovered. The psychosomatic approach will probably be proved of general value for public health. It has a distinct bearing on preventive medicine and child training, as well as upon the treatment of those who have already become sick.

It has been established by research in this field that the incidence of illness in adult life is closely correlated with the type of personality of the patient—the sort of problems that are important to him, and the means which he takes to deal with them. Personality structure in turn is closely connected with the experience of infancy and childhood, and particularly the influences exerted by parents, other members of the family and nurses. Although medicine has long recognized the role of the physical aspects of environment in causing or preventing disease, such as the sanitary precautions and nutrition, it is just as important that attention be paid to the human environment of the child and the emotional stimuli which it gives to his plastic personality.

For this reason, this society is particularly interested in those section of title I of the bill which are designed to promote physical and mental health of mothers and children through maternal and child-health services, which are to be administered by the States and approved by the Chief of the Children's Bureau. The society notes that the Children's Bureau is directed to make and aid the financing of studies, investigation, and research to promote the efficient operation of these services. It sincerely hopes that this clause, if the bill becomes law, will be broadly interpreted so that studies may be made of the most desirable means of assisting mothers to provide the best possible emotional environment for their children in order to safeguard their future mental and physical health. The implications of preventive medicine in this field are extremely broad, and have scarcely been touched by public-health measures and preventive medicine, although they have received recognition in educational circles. No adequate program exists, and the formulation of such a program would require extensive study and careful consideration.

Other aspects of the public-health program as well are important from the psychosomatic point of view. We have in mind particularly the training of personnel and health education.

Though this society takes no position on whether or not health insurance should be established, in accordance with the provisions of title II of the bill, it must of course recognize the important influence which would be exerted on medical practice by the manner of administration of health insurance, if it were enacted. Good administration would leave the door open for improved methods of medical practice, for research, and for advances in medical education. It is not sufficient merely to assure everyone of medical service of whatever kind happens to be available. It is necessary also to improve the quality of medical service, as the science and art of medicine advance. The bill appears to offer scope for flexible and progressive administration, for competent professional advice, and for extension of research and training. If it is enacted, we hope that full advantage will be taken of this opportunity.

We have particularly in mind the fact that there are only a relatively few diseases for which specific cures are known. Application of improved techniques

for treating these diseases has greatly reduced their importance as causes of disability and death. The bulk of illness, as well as of the expense for medical care, now results from the so-called chronic diseases, concerning which medicine knows far less. It is in the study and treatment of these very diseases that the psychosomatic approach offers its greatest promise. Why is it, for example, that one individual with high blood pressure is totally incapacitated while another with an equal degree of high blood pressure is a useful citizen? Often the difference is in the personality make-up and depends on factors that may be adversely affected by paying the man for remaining sick, or sending him to an unskilled practitioner who makes him worse by suggesting that his condition is grave, rather than by dealing with the emotional roots of his incapacitation.

The Chief of the Division of Public Health Methods of the United States Public Health Service stated in 1945 that chronic diseases caused nearly a million deaths and a billion days of disability every year. About 750,000 hospital beds are occupied by sufferers from these diseases, who receive the equivalent of full-time services from at least one-third of the Nation's physicians. More than 25,000,000 persons in the United States have some chronic ailment. It is not true, as is generally supposed, that the chronic diseases are chiefly a problem of old age. While the morbidity rate is high in later years, more than half of all the persons with known chronic diseases are less than 45 years old and 16 percent of them are under 25.<sup>1</sup>

The relative importance of the chronic diseases is indicated by the fact that while in 1900 they were responsible for 30 percent of the deaths in the death-registration area, in 1940 they were responsible for 64 percent of all the deaths in the United States.

These facts not only indicate the serious nature of the diseases which cannot be controlled by specific remedies, public-health measures of the usual type, or medicine as it is generally practiced today. They also show the enormous expense to the community of chronic disease, an expense which will under any health-insurance plan necessarily be borne largely by the insurance fund.

While the extension of benefits of health insurance and hospitalization to sufferers from these diseases may be thought advisable for numerous reasons, this step would offer no final solution of a health problem which must in the end be attacked by scientific research and improved methods of medical practice. Any plan for health insurance which resulted in freezing the methods of treatment of chronic diseases at the present level might even make the situation worse, both from the point of view of the patient and from the point of view of the burden on the community.

We must be careful not to repeat in civil medicine the mistake we made in the pension problems arising from World War I when we failed to evaluate the emotional factor in determining disability. As a consequence we doomed thousands of unfortunate men to long hospitalization when, with early and adequate treatment of the right sort they might have been returned to society as producers, rather than remaining a burden to the community and themselves.

For these weighty reasons, this society notes with special interest section 211 (B) of title II of the bill, which makes the Surgeon General and the Social Security Board jointly responsible for studying and for making reports and legislative recommendations, not less than 3 years after the bill is enacted, as to needed services and facilities for the care of the chronic sick and of individuals afflicted with nervous or mental disease, and of needed provisions for the prevention of chronic physical diseases and of mental and nervous diseases. While recent advances in this field offer great promise for the future, it is a lamentable fact that much remains to be done before medicine will have dependable techniques for dealing with major chronic illness. It is a still more lamentable fact that those who have the training requisite either for research or for practice in this field—a training which should include psychiatry as well as general medicine—are far too few in number. We therefore wish to emphasize the importance also of section 213 of the bill, which authorizes the Surgeon General to make grants in aid for research and professional education. If the bill becomes a law, we hope that this activity will be carried on with due regard for the importance of the major chronic diseases and for the relevancy of the psychosomatic approach in seeking greater knowledge and better methods.

<sup>1</sup> Perrott, George St. J., *The Problem of Chronic Disease* (New York: The American Society for Research in Psychosomatic Problems, Inc., January 1945), *Psychosomatic Medicine*, vol. VII, No. 1.

LA SALLE, ILL., March 19, 1946.

Senator JAMES E. MURRAY,  
*Chairman, Senate Committee on Education and Labor,  
 Senate Office Building, Washington, D. C.*

DEAR SIR: At the regular meeting of Central Trades and Labor Council, representing over 35 organizations and well over 5,000 workers in this area, we went on record favoring the Wagner-Murray-Dingell bill, S. 1606 and urge you grant as many requests as possible to supporters of this bill to be heard at your hearings. Thanking you in advance and urging your support for this bill I am  
 Yours truly,

GEORGE R. FREITZ,  
*Secretary, Central Trades and Labor Council.*

CITIZENS POLITICAL ACTION COMMITTEE,  
 New York, N. Y., April 3, 1946.

Senator JAMES E. MURRAY,  
*Senate Committee on Education and Labor,  
 United States Senate, Washington, D. C.*

DEAR SENATOR MURRAY: As chairman of the committee holding hearings on the Wagner-Murray-Dingell bill, we wish you to know that the National Health Act has the complete backing of the community organizations of the New York Citizens Political Action Committee.

It is of vital importance that this bill be passed. We hope you will continue the hearings until all necessary information pertinent to this bill is obtained.

Social security has been successful since its inception in giving security to a certain portion of the people, but this security should be extended not only to a greater number of people but in increased benefits as well. The inclusion of health protection is necessary and should not be deleted.

We are wholeheartedly for bill S. 1050 and feel that you will do all in your power to insure its acceptance.

Sincerely,

J. R. WALSH,  
*For the Council of Community Organizations.*

CITIZENS' PUBLIC AFFAIRS COMMITTEE,  
 Brookline, Mass., March 15, 1946.

CHAIRMAN, SENATE LABOR AND EDUCATION COMMITTEE,  
 United States Senate, Washington, D. C.

DEAR SIR: The Citizens' Public Affairs Committee, numbering more than 600 alert and civic-minded citizens who are vitally interested in the general welfare as a prerequisite to national well-being and prosperity, takes this means of requesting that this organization be recorded as favoring the Wagner-Dingell-Murray bill as a broad national health and social security measure.

We respectfully urge that thoughtful consideration be given our imperative health needs and that this bill be reported upon favorably. We are convinced that a national measure of the scope and purpose of the Wagner-Dingell-Murray bill is imperatively demanded to spread the costs of adequate medical care more equitably, and to bring the impressive achievements of medical science to the aid of low-income groups now suffering needlessly from a continuous drain upon their potential economic resources. Improved national health is a self-liquidating investment.

Respectfully yours,

HARRISON L. HARLEY, *Chairman.*

CONNECTICUT INDEPENDENT CITIZENS' COMMITTEE  
 OF THE ARTS, SCIENCES AND PROFESSIONS,  
 New Haven 15, Conn., April 5, 1946.

The Honorable JAMES E. MURRAY,  
*Chairman, Senate Education and Labor Committee,  
 Senate Office Building, Washington, D. C.*

DEAR SENATOR MURRAY: The Connecticut Independent Citizens' Committee of the Arts, Sciences and Professions believe that prevailing methods for the dis-

tribution of medical care do not serve their purposes effectively. The vast majority of our people are victims of substandard hospital facilities and health care. The report of the Subcommittee on Wartime Health and Education proves the unquestioned need to organize medical services to bring the advances of medical services to the public.

We believe this can be developed around the Wagner-Murray-Dingell bill, which applies the principles of compulsory insurance and taxation to the problem of meeting the cost of medical care, and can bring such services to the people. Through grants in aid to the States it offers care for the needy sick together with expansion of public health services and the Maternal and Child Health program. It also provides for the support of medical education and research which are vital to scientific advancement. To complete the President's program provisions for rehabilitation, for increased unemployment insurance, and for liberalizing old age and survivors' benefits by amendment of the Social Security act are essential.

We therefore urge that after the hearings on the bill now in progress in the Senate the Wagner-Murray-Dingell bill be brought to the floor of the Senate and we shall urge our Senators to vote for it.

Very truly yours,

(Mrs.) CHARLOTTE H. PETERS, *Secretary.*

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BOWLING GREEN, OHIO, *March 18, 1946.*

Senator JAMES E. MURRAY.

DEAR HONORABLE SIR: I am secretary of the Farmers Educational and Cooperative Union of America, Bowling Green Local 22, which now has a roll call of 72 voting members. At our meeting held March 8, 1946 a resolution was passed unanimously that I should write to you concerning some health legislation pending in Congress at the present time.

We urge you as chairman of the Senate Committee on Education and Labor to hold hearings on both bills—the Maternal and Child Welfare Act of 1945, S. 1318 and the National Health Act of 1945, S. 1606, at the same time. We are emphatically in favor of both these bills. No one can measure the good to the entire Nation which will be derived from such sorely needed legislation.

We wish to thank you for anything you may be able to do in the way of securing the passage of these bills.

Sincerely,

Mrs. JOHN J. STEIN,

*Secretary of the Bowling Green Local 22 of the Farmers Union.*

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THE GIRLS' FRIENDLY SOCIETY, U. S. A.,  
*New York, N. Y., April 2, 1946.*

Senator JAMES E. MURRAY,

*Chairman of the Committee on Education and Labor,  
Senate Office Building, Washington, D. C.*

DEAR SENATOR MURRAY: The executive committee of the Girls' Friendly Society, U. S. A., has endorsed S. 1318, the Maternal and Child Welfare Act of 1945, for the following reasons:

1. As a church organization, concerned with children and young people, we recognize health as a fundamental asset for character development.

2. From our experience, we realize how many mothers and children are denied this because of the lack of adequate services and facilities.

3. In a democratic country, we believe the Government should assume as its responsibility making such services available to all mothers and children.

We urge that the Senate Committee on Education and Labor, in its hearings on S. 1606, give consideration to these points and report the bill favorably. We also urge that title I, section B of this bill (S. 1606), be strengthened by the inclusion of the more specific provisions in regard to services and facilities, services to crippled children, and standards for professional personnel, as provided in S. 1318.

Sincerely yours,

FRANCES P. ARNOLD,  
*Program Adviser.*

THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA,  
*April 17, 1946.*

The Honorable JAMES E. MURRAY,  
*Chairman, Committee on Education and Labor,  
 United States Senate, Washington, D. C.*

DEAR SIR: The six doctors of medicine proposed by the Medical Society of the State of Pennsylvania (9,500 members) as witnesses to appear before your committee during the current hearings on S. 1606 unite in submitting for your committee's consideration the following comments and observations based on years of study and practical experience in the distribution of medical care and the equitable division of its costs.

We consider title I of S. 1606 superfluous since S. 191, as it has recently passed the Senate, provides admirably for the building of hospitals and public health centers where needed. It has the approval of the American Medical Association and the American Hospital Association.

The provision of other needed facilities and of personnel may readily be accomplished when the Congress is ready to appropriate sufficient funds to expand the public health work under existing title VI of the Social Security Act. The same is to be said of the maternal and child health and crippled children's services under title V of the Social Security Act. An amendment to the original Social Security Act providing for grants-in-aid to States for their public-assistance recipients, when proven necessary, would provide for this section of title I of S. 1606.

Adequate Federal subsidization of medical education will be provided for in the pending Magnuson bill creating a national science foundation, which bill has the support of the organized medical profession and the American Association for the Advancement of Science.

Title II of S. 1606 provides for prepaid personal health services. Inasmuch as title I is not necessary, the section providing for cooperation with the Children's Bureau in title II becomes unnecessary. (See sec. 203 (d) of S. 1606.)

On behalf of the 9,500 members of the Medical Society of the State of Pennsylvania, a constituent of the American Medical Association, we write herewith in opposition to compulsory health insurance, whether it be known as federalized medicine, socialized medicine, political medicine, regimented medical service, or any other term which is popularly used in reference to governmental control over the delivery of individualized medical services, as proposed in title II of S. 1606.

We oppose it for the following specific reasons:

1. In the provisions of S. 1606, there is no guaranty that the patient will have absolute free choice of physician under all conditions. While there are some alluring statements in the bill regarding free choice of physician, yet these statements are definitely limited by other statements in the bill. (See sec. 205 (e), (k).)

2. In spite of all the statements in the bill regarding attempted means to improve medical services the ultimate result will be a deterioration in the quality of medical services rendered. This has followed the introduction of such governmental plans throughout the world.

3. The centralized control of individual medical service as provided for in this bill will irresistibly develop its great part in the totalitarian trend which, unless halted soon, will eventually and inevitably destroy our democratic form of government.

4. There is no specific mention in the bill of the cost of the program or of the raising of the revenue to provide for these services. Yet, if enacted, its heavy cost must be met—doubtless by a pay-roll deduction plan supplemented by direct taxation. It seems rather strange to propose such all-inclusive and comprehensive services without indicating how they will be underwritten or proffering an estimate of its total cost.

Those of us who have had experience in the administration of voluntary prepaid medical care plans know that the amount indicated in S. 1050—8 per cent of the Nation's payrolls—will not be sufficient, and we publicly express the opinion that it will cost the people of the United States anywhere from \$10,000,000,000 to \$14,000,000,000 annually to attempt delivery of the proposals of this bill. Wherever introduced, utilization of the service, much of it wasteful due to malingering, has rapidly increased administrative and professional costs to three or four times that originally anticipated.

5. From the statements in S. 1606 (see sec. 210 (a), (e)) that the patient may be charged a fee for the first services in any spell of sickness or course of treatment, or that the service may be limited, it is evident that the originators' knowledge as to the costs of this colossal program is very limited.

It has been the experience in Pennsylvania and many other States that unless blueprints made in Washington, D. C., for the maternal and child health, crippled childrens', and public health services as provided for in the original Social Security Act are adhered to in minute detail by the local State agency, the promised Federal funds are withheld. This same procedure will apply in the program authorized by title II of S. 1606.

The Surgeon General will make the blueprints as to fees, rules, regulations, and interpretations of the laws, pass them down through the State bureaus and community committees, and enforce his decisions by withholding the funds. "Whoever pays the fiddler calls the tune" will again prove a truism should S. 1606 be enacted.

7. In Pennsylvania we have had for 7 years one of the best tax-supported medical-care programs in the United States for the medical care of the indigent. This program is administered by the Pennsylvania Department of Public Assistance and by an active State Healing Arts Advisory Committee which represents the State organizations of medicine, dentistry, nursing, pharmacy, and the hospitals. There are similar advisory committees in each county.

In Pennsylvania the medical society is cooperating with the Farm Security Administration in a program of procedure with farm groups for rural health activities, and more recently with the Veterans' Administration and the State rehabilitation service for those unemployed because of physical disability. For the low-and average-income groups we have a voluntary insured medical care program, the Medical Service Association of Pennsylvania. All of these activities can be expanded and under the Pennsylvania law creating the medical service association we can provide on a voluntary and democratic basis any type of service that is proposed by the Wagner-Murray-Dingell bill.

In conclusion, we point with pride to the part played by our profession in the reduction throughout the years in human morbidity and mortality, and promise progress through further scientific experimentation and voluntary cooperation between (1) those who practice the healing arts (2) Governmental agencies, and (3) the people both serve. If not interfered with by centralized Governmental bureaucratic control with its red tape and all other objectionable features, we will be able by democratic processes to supply all that is necessary for the people in the way of health service, hospital service and medical care.

Respectfully submitted.

WILLIAM BATES, M. D.,  
*Philadelphia, Pa.*

LEWIS T. BUCKMAN, M. D.,  
*Wilkes-Barre, Pa.*

WALTER F. DONALDSON, M. D.,  
*Pittsburgh, Pa.*

ELMER HESS, M. D.,  
*Erie, Pa.*

RICHARD A. KERN, M. D.,  
*Philadelphia, Pa.*

C. L. PALMER, M. D.,  
*Pittsburgh, Pa.*

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MINNESOTA STATE FEDERATION OF LABOR,  
*St. Paul, April 16, 1946.*

SENATOR JAMES E. MURRAY,  
*Chairman, Committee on Education and Labor,*  
*United States Senate, Washington, D. C.*

Dear SENATOR MURRAY: We have received a letter in response to our request to be heard on the National Health Act (S. 1606) in which it is stated that President Green, of the American Federation of Labor, will give testimony on behalf of all affiliated American Federation of Labor organizations.

We are pleased that your committee is going to hear the testimony of President Green and we appreciate the inability of your committee to hear the many witnesses who undoubtedly would like to give testimony favoring this measure.

However, we want your committee to know that the Minnesota State Federation of Labor has been on record for this type of legislation for some time. Experience in Minnesota has demonstrated that the present methods of handling health matters are inadequate to take care of the needs of individuals in the lower income brackets. Even during so-called periods of high wages such as we are experiencing now, the average wage earner with a family to support is entirely unable to meet emergency medical costs and expenses when they occur. We are convinced that the only solution to the problem is the establishment of a Nation-wide system of prepaid health service benefits of the kind provided for in S. 1606.

As indicated, this matter has been considered by this federation for some time. We are enclosing for your further information a resolution passed at our 1944 convention at St. Cloud, Minn., in September 1944. This action was reaffirmed by the 1945 convention.

Trusting that your committee will act favorably on S. 1606 we are,

Very truly yours,

MINNESOTA STATE FEDERATION OF LABOR,  
R. A. OLSON, *President*,  
GEO. W. LAWSON, *Secretary*.

#### RESOLUTION

Whereas figures showing that to date over 4,000,000 men have been rejected from the armed services as unfit for military service, 8 of 10 of whom have at least one physical defect, indicate a lowering of the national health standards; and

Whereas further proof of the decline of our national health may be found in testimony given before a subcommittee of the Senate Committee on Education and Labor calling attention to the fact that there are 23,500,000 Americans with chronic diseases or physical impairments, thousands of which could be cured even if minimum standards of health were set up; and

Whereas this condition was attributed mainly to the absence of adequate hospital and medical services a relationship was traced between low incomes and poor health, substantiating the belief that the average workingman is financially unable to meet the added burden of sickness or hospitalization; and

Whereas Dr. Parran, Surgeon General of the United States Public Health Service, confirms the fact that a third of the American people are handicapped by ailments that might have been prevented in the first place and which could now be corrected by proper health policies, and calls for the encouragement of group medical practice and more rather than less "socialization" of medicine; and

Whereas there is before the Senate Committee on Finance S. 1161, more commonly known as the Wagner-Murray-Dingell bill, which sets up a system of Federal medical and hospitalization benefits which would encourage the raising of national health standards by not only providing for beneficiaries in case of illness or hospitalization but by indulging in preventive medicine to such an extent that many diseases and impairments might be eliminated: Now, therefore, be it

*Resolved*, That the Minnesota State Federation of Labor in convention assembled at St. Cloud, Minn., September 19, 1944, does go on record as favoring the enactment at the earliest possible moment of the health and medical and dental care provisions contained in the Wagner-Murray-Dingell bill, S. 1161, and calls for its immediate enactment into law, properly amended to make its benefits available to Government employees as well as those in private industry; and be it further

*Resolved*, That the delegates to the national convention of the American Federation of Labor be instructed to present a similar resolution at that convention, that our representatives in Congress be furnished with copies of this resolution and urged to support this legislation and that the national officers of the American Federation of Labor be advised of this action and asked to use their efforts toward obtaining prompt action on the Wagner-Murray-Dingell bill.

## STATEMENTS FROM INDIVIDUALS

BOSTON, MASS., April 3, 1946.

Committee CHAIRMAN MURRAY,  
*House of Representatives, Washington, D. C.*

MY DEAR MR. MURRAY: The public health bill that is being brought before Congress is one of the greatest issues in Congress for the poor American people. To defeat this bill is one of the most serious of its kind at issue. It is a wonderful thing, even though the American Medical Association is teeth and toe against it. Why? Because it gives to the medical men of the big clinics and institutions of medicine, their best way to make all the money that they can. They fear that it would take away their special privileges, and give to the poor doctor and the poor people a chance to gain a living in the field of medicine and survey.

I hope that this bill will be fought out, and passed, for it will be one of the best things that can happen for the poor. As for it being a socialistic or communist policy that is absurd and foolish.

For goodness sake fight to get this bill through. I have seen in medicine, and the way things are carried out, that it is a great danger to those who want to be independent, and the poor sucker pay for a lot of bunk, and only accrues to the business medicine, money. Public health service, without a doubt, is to be encouraged to the latter.

I hope to hear from you on this matter, and if I can I will write you further.

Most sincerely yours,

W. RANDOLPH ANGELL, M. D.

BROOKLYN 29, N. Y., April 10, 1946.

DEAR SIR:

I have read and studied your Murray-Wagner-Dingell health bill very carefully. This bill appears to me to be to a great advantage to our country. Many people today can't afford on the proper medical care that they need. But I see that your bill will provide for their medical care. Though this bill isn't favorable to large doctors with big practices, I think that your bill should be passed. I know that if I couldn't afford the proper medical care that I needed, I would be grateful if a bill like this was in existence. This bill can prevent many deaths in our country due to inadequate medical help. Therefore I urge that your Murray-Wagner-Dingell health bill becomes a law.

Yours very truly,

MALCOLM BERGER.

COLUMBUS 7, OHIO, April 6, 1946.

COMMITTEE ON EDUCATION AND LABOR,  
*United States Senate, Washington, D. C.*

HONORABLE GENTLEMEN:

I wish to state here that I support S. 1606 and that it should be reported favorably on the floor of Congress.

Our country is too great to tolerate any health record of which we cannot be proud. And the high percentage of physical rejects by Army and Navy doctors indicates a faulty medical record. *If poor people are freely asked to fight wars, then it is your duty to provide benefits for them.* S. 1606 would be especially beneficial for people in our low income groups, and today, sirs, there are plenty of us.

Furthermore, gentlemen, *health citizens add more strength to an already strong Nation.*

Sincerely yours,

CARL BERKE, JR.  
 JOSEPHINE A. BERKE.

MELVIN BRUCKER, 1260 EAST EIGHTY-NINTH STREET,  
Brooklyn 12, N. Y., April 5, 1946.

Senator MURRAY:

I am taking this opportunity to let you know my opinion on the health bill, now in the Senate. I am all for the bill and I believe it will obtain and be what it stands for, the health and good medical care for all.

The system envisaged in the health bill is the only one which could effectively meet the Nation's health needs. Medical service under the present private fee-for-service system bear only a casual relationship to health needs. A highly inequitable cash barrier now keeps needed medical care from millions of people. But the 3 percent pay-roll tax, little enough for the individual, would be adequate for all the benefits under the bill.

In conclusion, I think you are doing a grand job and do continue to fight for the passing of this bill.

Respectfully yours,

MELVIN BRICKER.

BROOKLYN 26, N. Y.

Senator WAGNER,

*United States Senate, Washington, D. C.*

HONORABLE SIR:

National Health Act, S. 1606.

I support this measure, I am not afraid of the words "Socialized Medicine."

This is the way to show Russia how democracy can work and help the less privileged in the United States of America.

Sincerely yours,

BEATRICE A. DONALDSON.

PHILADELPHIA 2, PA., April 11, 1946.

Senator WAGNER:

I fully endorse your health bill in spite of the falsehoods that the National Physicians Committee is spreading. More power to you and Senator Murray.

E. FINKELSTEIN.

PITTSBURGH 13, PA., March 14, 1946.

Senator JAMES E. MURRAY,

*Chairman, Senate Committee on Education and Labor,  
Senate Office Building, Washington, D. C.*

DEAR SIR: This letter is to add one more voice to the support for the National Health Act, S. 1606. I feel very strongly that public provision for the health of the people should be provided, to meet the needs of the very large percentage of our people who otherwise, for financial reasons, will continue to be hesitant and negligent in seeking medical care. I believe that this kind of care for the Nations health will in the long run greatly reduce the cost of ill-health to the Nation in terms of physical fitness for military service, of hours of work which were formerly lost due to this cause, and the general unhappiness caused by it. Health care should, like education, be a right of every individual.

Yours sincerely,

CUTHBERT G. GIFFORD.

BROOKLYN, N. Y., April 1, 1946.

Senator JAMES E. MURRAY,

*House of Senators, Washington, D. C.*

DEAR SIR: The next meeting on bill S. 1606, I want you, as chairman, to read this letter out loud:

I am a married man, father of four small children, and a wife to take care of, on a salary of \$44.45 per week. Can one of you gentlemen please advise me how I can accumulate \$250 for dental service on myself without jeopardizing their health, within 3 months' time. My only solution, outside of not going to a dentist, and poisoning my whole system, is the bill S. 1606. And I'm sure that you gentlemen all agree with me. So let it ride on a "yes" track to speed it through, so I and millions like me can live in health and enjoy life and not to live in misery.

Sincerely yours,

J. GOVERNALE.

VALLEJO, CALIF., April 1, 1946.

The Honorable JAMES E. MURRAY,  
*United States Senate, Washington, D. C.*

MY DEAR SENATOR MURRAY: In reply to your letter inviting me to make a statement of my position in regard to Senate bill 1606, known as the Wagner-Murray-Dingle bill, I have the following general remarks for the Congressional Record and for the information of your committee.

First, may I state that it is often difficult to write what may better be conveyed by the spoken word.

I wish to qualify myself in your mind so that whatever weight or wisdom is expressed may the better be evaluated. After graduation from Rush Medical College, Chicago, Ill., in June 1908, I practiced medicine with my father, William T. Green, at Albion, Ind., for a few months. He lived and died in the small town of Albion, Ind., a strictly rural locality. Feeling that a larger experience might be gotten elsewhere, I went to Iron River, Mich., where I worked in a mining hospital for a year with Doctors Libby and Brown. The Homestake Gold Mining Co., of Lead, S. Dak., was looking for a new second surgical assistant at an advance in salary and I went to Lead in 1910, remaining as assistant to Dr. John W. Freeman for 5 years. In the meantime my father had become State senator of the Thirteenth District of Indiana and needed help in his practice so I returned to Indiana in May 1915, to reengage in private practice. Father died during the session of the Indiana Legislature in January 1917. World War No. I then called medical doctors into the service of their country and I reported to Great Lakes Naval Training Station in May 1917. I served there until July 1918, and was transferred to the Officers' Training School at Pelham Bay, N. Y., in July and remained as senior medical officer until the school closed in June 1919. I was then transferred to the U. S. S. *Leviathan* and served aboard that ship until October 1919, when she was placed out of commission. My next duty was in charge of eye, ear, nose, and throat at the Naval Hospital at Newport, R. I. I remained there until January 1921, when I was transferred to Mare Island Naval Hospital, Mare Island, Calif., where I again headed the eye, ear, nose, and throat section of the hospital. I resigned from the Medical Corps of the Navy November 10, 1921, and have been in private practice in Vallejo for over 25 years. Having seen about all phases of medicine, private, military, and industrial, I feel qualified to make some recommendations concerning how the quality of medical care is best obtained. I am sure we all want the best medical service we can get. Anything or any factor which contributes to a poorer quality of medicine should promptly be ruled out.

While engaged in industrial medicine our patients contributed \$1 a month for their medical care. This is known as contract practice. The miners were never wholly satisfied and there were always private doctors in the locality to take care of those who did not take advantage of the services offered by the company doctor.

In military practice, it is common knowledge that many service people, both Army and Navy, do not use the military-doctor personnel offered them as members of the services. In other words, this service, no matter how good, does not satisfy everyone. The reason for this attitude of the patients is, that the doctors do not pay the personal attention to their illnesses that private doctors do and that the service doctor gets paid whether he serves them well or not.

There is never the stimulus while in uniform to dig in and arrive at the top of the profession early in a career because if you go too fast you tread on some officer who is senior to you and who may make trouble for you and label you as an ambitious so and so.

Sick persons really prefer, in almost all cases, to select their own doctor and hospital. Everyone knows that faith in the doctor and hospital is half the battle when striving to get well.

I believe in the Public Health Service when it comes to sanitation and allied problems. Their help in controlling tuberculosis, the social diseases, epidemics, etc., is a necessary phase of governmental medicine, but I do not believe that all the people in this United States should be cared for by a compulsory medical service, administered by the Surgeon General of the Public Health Service. I believe public-health activities have gone about as far as such are good for medicine in this country.

We now have the best national health of any country in the world. Why interfere with this situation? Medicine needs the best young men and women for training in the healing arts and if a compulsory service is provided these persons will not be attracted to medicine because of the lack of opportunity to attain

eminence and affluence in the profession. They will be regimented. Our Army and Navy medical officers recently returned from World War II wish no further regimentation. This opinion is held almost 100 percent by such medical officers.

There has been a Dr. Green in every generation (sometimes as many as three or four) since Dr. John Green practiced in Providence, R. I. in 1736. Medicine is a family tradition and a family pride. My grandfather was in practice at Crawfordsville, Ind., 100 years ago. My father practiced 45 years at Albion, Ind., and I am proud of the advances in the science and practice of medicine as a free enterprise. The results of this advance in method is shown by the number of recent war casualties who returned home. Medicine is proud of this chapter and especially so, because 90 percent of all the medical officers in the service were drawn from civil life. We welcome them back and are helping them reestablish themselves in private practice.

Twenty-five of the States are now offering a voluntary prepaid medical and hospital service. It has taken 10 years to develop California Physicians Service in California where we now have enrolled 6,200 doctors of medicine as professional members. Our doctors did not, immediately, go for this change in the type of practice, but now most are convinced that some change was necessary. Beneficiary members are now coming by the thousands and even agriculturists are being brought into the plan. The Veterans' Bureau is using California Physicians Service now. Other States in our Union who have not had plans for voluntary health and hospital service are now developing them with the aid of the American Medical Association and neighboring States who have going plans. California has helped New Mexico, Nevada and Montana in this respect.

I believe the public health can be best served under a voluntary plan, that it would not be as costly as a governmental plan with all its extravagant expense, red tape and reporting, inspections and supervision. If voluntary plans were encouraged by labor, the white-collar class with the same effort that some of the so-called leaders use in forcing political bureaucratic medicine on us, voluntary medical care could be supplied every family for a great deal less than the proposed Federal plan of 3 percent pay-roll deduction.

In conclusion it is my opinion that the people of this country would not wish Federal medical care if the relative costs and comparative systems were properly explained to them. Nor do I believe that the Congress of the United States wishes to force any such European system of medicine on Americans. Should it come to pass, I will be the last Dr. Green of this medical family to practice medicine. My son John, who has fond hopes of following the profession of our family, will no doubt prefer to become a workman in the Mare Island Navy Yard.

Sincerely yours,

JOHN W. GREEN, M. D.

PHILADELPHIA 31, PA.

Senator JAMES E. MURRAY:

I am writing to you in support of the Wagner-Murray-Dingell National Health Act, S. 1606 (H. R. 4730).

All along I have been hoping to appear before your committee in person in order to plead for this bill and my reasons for the same.

During all of the later years of my 55 years of active practice in the city of Philadelphia, I was constantly reminded of the inadequacies of the medical service as rendered by organized medicine. More, however, have I constantly seen cases of disservice during the decade of my retirement. Industrial centers are over-supplied with specialists of all kinds and an ever-present lack of real doctors. Out-of-the-way places have a lack of all medical service worthy of the name.

One county in the interior of Pennsylvania has not a single psychiatrist. No makeshift can take the place of your bill!

Yours very respectfully,

DANIEL LONGAKER.

O. D. CHEMICAL CORP., Tuckahoe, N. Y., April 16, 1946.

Senator JAMES E. MURRAY,

United States Senate, Washington, D. C.

DEAR SIR: We should like to express our wholehearted endorsement of the Murray-Wagner-Dingell National Health Act.

The tactics of Senator Taft and the medical oligarchy who oppose this bill are a disgrace to American traditions and ideals. The AMA plan is merely an effort to protect the vested interests of a few doctors who happen to control the

AMA against the interests of the rest of the medical profession and the American people as a whole. Any doctor or any ordinary citizen who falls for the red baiting of these elements is a sucker and deserves what he will get if the bill fails. Unfortunately, a lot of innocent people will also suffer with them.

Yours very truly,

S. EISENBERGER, *Plant Manager.*

S. MACHLIS, Ph. D., *Research Director.*

Copies to:

1. Senator Robert F. Wagner.
2. Senator James M. Mead.

OREGON CITY, OREG., April 16, 1946.

HON. JAMES E. MURRAY,

*Chairman, Education and Labor Committee,  
United States Senate, Washington, D. C.*

DEAR SIR: In accordance with the suggestions in your favor of March 18, 1946, I am submitting the accompanying statements regarding Senate bill 1606, which you say will be included in the record of the hearings.

Respectfully,

EDWARD H. MCLEAN.

STATE OF OREGON,

*County of Clackamas, ss:*

To the COMMITTEE ON EDUCATION AND LABOR,

*United States Senate, Washington, D. C.*

I, Edward H. McLean, being first duly sworn, state that I am a citizen of the United States, born in Klamath Falls, Oreg., October 19, 1886; that I was graduated from Columbia University College of Physicians and Surgeons in New York City in 1912; that I served as intern in St. Luke's Hospital and Sloan Hospital for Women in 1913, 1914, and 1915; that in 1916 I served as medical officer in the Oregon National Guard on the Mexican border; that in 1917, 1918, and 1919, I was a medical officer in the First World War and that since 1919 I have been engaged as a general practitioner of medicine in Oregon City, Oreg.

I have read and studied S. 1606 section by section. Part 1 of the bill is worthy in its objectives but is defective in that control of greatly variable situations is too centralized. Many of the provisions of part 1 are already in force and others are cared for by other proposed legislation.

Part 2 of the bill is revolutionary. It upsets completely an established system of practice that has been giving the best medical service in the world to the most people.

It will give practically absolute control of medical practice into the hands of one man. The powers delegated are extensive and controls indefinite. Centralized control has proven unsatisfactory in many fields and cannot be satisfactory in medicine, in which local conditions vary so widely.

By its own efforts American medicine has advanced in the past 50 years to lead the world and is still advancing.

The trend in medical practice today is to reach, by gradual evolution based on experience, the goals at which this bill aims.

While the reaching of these goals may appear to be slower than by the law proposed, it will be more orderly, less disrupting, and with less danger of destroying the values we have and injecting the dangers of a vast political system.

In countries where such systems have been tried there has been a deterioration in the quality of medical care.

The great danger lies in the future. At the present time the best young men in the United States are taking up the study of medicine. It now proposes a challenge to initiative. Under a state-controlled system there will no longer be the attractions that compensate for the length of training and other fields will be more inviting. Then will happen to medical practice what has happened to teaching. Young men and women in the numbers and type needed are no longer interested.

The arguments that this bill is not socialized medicine are specious. It offers a medical system supported by pay-roll taxation collected by the Government, and paid for by the Government through this taxation. That is socialization. The freedom of choice within the bill is deceiving, as practically all control is subject to the Surgeon General. When such a large majority of the public is com-

pelled to come under this system the freedom of the practitioner to participate of not is academic as there is nothing else he can do except not to practice.

This country has been made great by men willing to sacrifice security for liberty. Let us not reverse this action.

This statement contains pages 1 and 2, and are both signed by me.

EDWARD H. McLEAN.

Subscribed and sworn to before me this 16th day of April 1946.

[SEAL]

ANNE M. WISE,

Notary public for Oregon.

My commission expires March 18, 1950.

APRIL 5, 1946.

Senator JAMES E. MURRAY.

*United States Senate Office Building,  
Washington, D. C.*

DEAR SENATOR MURRAY: May I add my voice to the many who must be commending you for your efforts to enact a workable national health service program.

Up to December 1944 it never occurred to me that medical costs can be so high and out of reach of even the so-called better-paid white-collar workers. It was then that my wife became paralyzed from an unknown cause and steadily grew worse. At enormous expense, we did everything possible to get her well again. Unfortunately, all our efforts did not produce the desired result. Today, lacking access to the necessary places of treatment only because there just isn't enough money to handle this prolonged situation, she is without the attention she deserves and is apparently doomed to spend what time remains for her in pain and discomfort and despair.

It is most shameful that so rich a nation, so bountifully endowed with the good things of life, should neglect even the least of its citizens in so inhuman a way. We denounced the Japs and the Nazis for failure to provide adequate medical treatment to our soldiers in captivity. Shall we continue to look away while those we hold responsible for the health of our Nation fail to furnish modern facilities and implements of health except for a price few of us can afford?

The fear and doubt and utter loneliness that grip this family of four today in the shadow of the Nation's capitol, the fading hope in little children that they will yet see their mother whole again—these things are a grave reflection on the democracy and humanity of a democratic nation.

May your good fight succeed.

Very truly yours,

BERNARD PLATT.

WASHINGTON 11, D. C.

NEW YORK 28, N. Y., April 12, 1946.

Senator ROBERT F. WAGNER,

*Washington, D. C.*

DEAR SENATOR WAGNER: As a physician practicing in New York City, I wish to let you know that I am unconditionally in favor of the national health bill (S. 1006) which you are so efficiently sponsoring.

Despite the statements of the representatives of some medical associations, I know that the majority of the American physicians are ready to back the national health bill.

With respectful regards, I am,

Sincerely yours,

HECTOR J. RITEY, M. D.

STATEMENT OF SAMUEL RUBIN, PRESIDENT OF FABERGÉ, INC., NEW YORK, PREPARED FOR THE SENATE EDUCATIONAL AND LABOR COMMITTEE, ON THE NATIONAL HEALTH ACT, APRIL 10, 1946

Business has for a number of years tacitly recognized the need for health insurance for workers. Most such industrial health insurance plans have been installed to cut operating losses due to absenteeism and low levels of productivity resulting from sickness. As a businessman, I believe that all business stands to profit from the passage of national health insurance legislation.

According to the Department of Commerce, the annual cost of absenteeism due to sickness reaches something over \$4,000,000,000 a year—an amount which represents a serious loss to the national economy. More specifically, it represents debits in the ledger of every businessman—a proportionate reduction in profit.

In man-days of sickness, the loss is about 500,000,000 each year—enough to produce a sizable number of the refrigerators, radios, and houses we are impatiently waiting for.

Though many industries have adopted health insurance plans of their own, the extent of coverage has not been sufficient to make much of a dent in the losses reported by the Department of Commerce. As a matter of fact, the President of the United States recently pointed out that "Only about 3 or 4 percent of our population now have insurance providing comprehensive medical care." If health coverage were greater, business losses due to illness would unquestionably decline.

Though industry has recognized the need for health insurance in its own plans, the plans themselves fall far short of the "comprehensive medical care" advocated by the President. I have been informed by officials of the underwriting company that the health insurance plan adopted by my firm is one of the most comprehensive in all industry. It is certainly true that our plan possesses many unique features. Specifically, we have tackled the problem of doctor's bills—both for home and office calls—by providing reimbursement after the first two visits. We include substantial benefits for dependents. We provide life insurance for all employees, including total disability payments. We pay for extensive hospitalization up to 70 days. And we include part-time employees in the benefits of the plan.

In addition, we think preventive medicine is so important that we are now establishing a system of periodic check-ups which will give the employee the benefit of the best medical attention. Preventive medicine results in a higher on-the-job rate, and a higher level of production. We know now that we will catch our anemic and fatigued workers in advance, and give them a chance to build up to normal. A healthy worker is a good worker.

Finally, our plan is entirely paid for by the firm—there are no deductions from employees' wages. We feel that such an arrangement is worth our outlay many times over, in increased working efficiency and general morale. May I say, parenthetically, that our plan was worked up with the full cooperation with the union in our industry—the United Gas, Coke and Chemical Workers of America (CIO).

I cite the health insurance plan adopted by my firm as evidence merely because it is considered one of the most advanced in the country. Yet this plan falls short of the highly desirable benefits provided by the Wagner-Murray-Dingell bill. A brief comparison shows that only the national health plan would provide adequate medical service as long as needed, for any illness. Only the national plan would fully encourage early medical care during illness and the receipt of preventive service. Only the national plan would fully take care of specialists' fees. Only the national plan would provide adequate dental care, and home nursing. And finally, only the national plan would take care of dependents in a comprehensive way.

So, in essence, industrial health plans may be considered only a first step toward the kind of coverage business would find most desirable. In my opinion, health insurance is not properly a business obligation; it should be a Government obligation, like the postal system or social security.

Unfortunately, many industries have been unable to provide any health coverage whatever for employees. Most industrial health plans have been set up by large corporations. Small and independent businesses, by and large, have been in no position to afford health insurance programs. This means that the great majority of American workers have been left out in the cold. Hence small business in particular has a great deal to gain from the national health program. All businessmen will find that the National Health Act is good business for American business.

In my judgment, business profits directly reflects the degree of personal security attained by workers. Fear of high medical bills makes poor customers. For a long time, family breadwinners have recognized the importance of life insurance. Industry has recognized the importance of health insurance for company workers. National health insurance, sponsored by the Federal Government, is long overdue for every American.

A nation is as wealthy as its people are healthy.

MICHELE SARTORI, M. D., D. D. S.,  
*Brooklyn, N. Y., April 11, '46.*

DEAR SENATOR: In spite of all the screams of some of the members of my profession and the pressure brought upon other members to protest the Wagner-Murray bill, I have full confidence that the bill will pass, for it is good for the people and that is what counts most.

I am devotedly,  
 Yours,

M. SARTORI.

MARCH 25, 1946.

HON SHERIDAN DOWNEY,  
*United States Senator, Washington, D. C.*

I can't say that I approve of the mechanics of the Wagner-Murray bill (S. 1606), but I do approve of its intent.

There is no valid reason why 150,000 doctors should dictate to 150,000,000 people the solution of a social problem.

In order for you to arrive at a decision, you must divide the question into its two component parts: 1, social; 2, medical. The social problems of the people are ably administered by the Congress who has the necessary information as to the needs of all the people.

The problem of the methods of treatment and prevention of human ills is the responsibility of the medical profession and should not be subject to governmental dictation. The argument put forth by organized medicine that the people would get inferior medical care under compulsory health insurance is rather an admitted indictment of the medical profession for it has long been an accepted fact that the doctor gives his medical service to rich and poor alike.

Free enterprise in medicine does not mean the same thing that it does in business. Free enterprise to the doctor means enough minimum security so that he has opportunity to advance in the science of medicine and carry out its ideals and not be compelled to evaluate a patient on the basis of his wealth rather than his illness. The high cost of medical care is a handicap to the patient and the doctor because the diagnosis and treatment are handicapped by the patient's inability to pay.

This health bill does not set a precedent in the field of medicine. We already have State and National laws governing sanitation, public health, and workmen's compensation. I am sure no one will question their social value to the people nor the quality of the service rendered by doctors in these branches of medicine. In fact, the greatest advances in medicine have been developed in these Government agencies.

ARTHUR H. SCHWARTZ, M. D.

Copies sent to Senator Robert Wagner and Senator Murray.

NEW YORK, N. Y., *March 7, 1946.*

HON. ROBERT F. WAGNER,  
*United States Senate,  
 Washington, D. C.*

DEAR SIR: I wish to express my support for the health bill which was initiated by you in the Senate, commonly known as the Wagner-Murray-Dingell bill.

Respectfully yours,

S. SCHWARZ, D. D. S.

ART CRAFT JEWELERS,  
*Providence 4, R. I.*

COMMITTEE ON EDUCATION AND LABOR,  
*United States Senate, Washington, D. C.*

GENTLEMEN: Millions of our young men were physically unfit for military service, because and only because, they never received the medical care they could and should in a genuine democracy. Many millions more of our men, women, and children; in fact, a much larger percentage than of our men in military age, are in desperate need of medical care but never did and never will get same because of price and price alone, which is denied them in the richest country in the world.

Let's stop fooling ourselves with beautiful phrases like democracy, free enterprise, rugged individualism, and institute real legislation such as S. 1606 and then, and then only, will we have real democracy, real enterprise, and real rugged individualists, and what's more important a real healthy and happy American family.

I could cite a million reasons why this bill, S. 1606, should not pass, just like Hitler cited a million reasons why nazism is superior to democracy (real), but we know now what nazism brought to the world, and our enemies to this vital health bill, S. 1606, with their million reasons against it are endangering the health of our people no less than Hitler endangered the very lives of his people, with his beautiful phrases.

S. 1606 can mean only one thing—a better health standard for all our people. We drafted millions of our young men against their will to give their lives for a miserable pay to save our skins—and in the name of democracy, we can ask the medical profession, also, to devote their lives (not give) to save our health, for the highest pay of any profession, and also in the name of democracy.

Yours for a better health,

HERMAN H. SOHN.

NEW YORK 28, N. Y., April 3, 1946.

HON. JAMES E. MURRAY,  
*The Senate, Washington, D. C.*

SIR: I am one of those who believe deeply and sincerely that the Wagner-Murray-Dingell health insurance bill is an imperative safeguard for the American people.

As the wife of a physician and as a social worker I have had occasion to observe the lack of opportunity most people have to obtain really adequate medical care. It is a farce to speak of widespread and adequate medical care for the vast majority of people under existing circumstances. For the poor even in large cities, the hospital clinics are inimical to real human dignity. For the lower middle class group medical care is prohibitive or is secured through actual sacrifice of other necessities. It is my humble belief that every American has a basic right to not only a livelihood but to an opportunity for the best medical care and education our democracy can afford.

Incidentally, my husband is a well recognized psychiatrist with a substantial income. Both of us are heartily in favor of the bill.

Respectfully yours,

MRS. LUBA (LOUSS) WENDER.

APRIL 15, 1946.

Dear SENATOR MURRAY: This is a confidential letter written for the purpose of seeking information on the proposed Wagner-Murray-Dingell bill on compulsory national health insurance and also to express some opinions of my own. I hope that this letter, at least the name of its writer, will be held confidential. I am a doctor, am in the Army, am a member of the American Medical Association. It is too bad that I should feel that I haven't freedom of speech in the United States of America, but in writing to a Senator on a political issue seems to be a privilege reserved only for civilians. Or is it?

Personally, I would like a copy of the proposed legislation on national health insurance. In fact, I think much could be accomplished by mailing copies of the bill to every doctor in civilian life and in the Army. If these letters also enclosed a letter of information to all doctors explaining the bill, I am sure that if the bill is an honest attempt to bring good medical care to every person in the United States of America without destroying individual enterprise among doctors, without destroying initiative and the stimulus of competition, and without lowering but, instead, raising standards of medical practice, then I am sure that a large majority of the doctors would favorably endorse and urge such legislation.

It might interest you to know how the majority of doctors feel, at least those with whom I have come in contact, about the American Medical Association. We feel that the A. M. A. does not represent the opinions of American doctors. We are of the opinion that the A. M. A. is controlled by a political minority; but, as individuals, we are unable to do much about it. We are disappointed that the A. M. A. neglected to take advantage of its golden opportunity to propose a plan for the improved medical care and health of the American people but instead

seems to be encouraging "individual enterprise" for certain insurance companies with their high cost, uncomprehensive hospitalization, and medical care plans. We are aghast at the cheap, untrue propaganda being distributed by the National Physicians Committee for the Extension of Medical Service to confuse the public and the doctors too. We feel that the day has arrived when the word "charity" should be struck out of our national medical affairs. It is time that all Americans can face the future without fear of costly illness and the fear of the humiliation of accepting charity. We are disgusted with the management of countless organizations subscribing donations for the treatment, prevention, and for research of various diseases, organizations where most of the money goes for administrative purposes. An article in McCall's Magazine and reprinted in Reader's Digest for April 1946 by Albert Maisel entitled "Urgently Needed—A National Health Fund" illustrates what I mean. It might interest you to know that many doctors able to think clearly and not poisoned by concepts of "political medicine" want national health insurance to succeed.

However, we doctors are asking questions. We have had enough regimentation in the Army to last us a lifetime. We don't want more of the same in civilian life.

With your permission, I want to ask some questions and make some suggestions:

1. Will the appointments of the Federal Security Administrator and the Surgeon General of the Public Health Service be political appointments and leave office at each change of administration?

To remove the possible taint of political control over national health and the medical profession, I suggest that appointments to these important posts must be ratified by a two-thirds vote of the United States Senate and that their appointments be for 6 years, impeachment for inefficiency accomplished by a simple majority vote.

2. Will lesser workers in the administrative department of this health insurance department be selected under civil-service requirements?

3. Will seriously ill people be able to get immediate care from their physicians or will they have to go through hours of "red tape" before care is authorized?

4. What provisions will be made to pay a doctor his fees and still retain case histories, examinations, diagnosis, and treatment rendered as confidential records of the doctor or the hospital not open to public scrutiny? How will this private and secret doctor-to-patient relationship be maintained and still prevent dishonesty and cheating by both doctors and their friends to fatten a doctor's income?

5. Will the amount of treatment any one person can have in a year be limited?

6. Will the Government pay the entire bill for a patient or will the patient be classified according to his income tax and be required to pay a certain percentage of his bill based on his income bracket?

To me the latter part of the above question is a feasible answer to prevent dishonesty and to prevent daily social visits to the doctor's office.

7. Will the doctor be restricted as to the number of patients he can see in a day or the number of operations he can do in a month?

This question was raised in National Physicians Committee propaganda. If so, what will be done in epidemics, severe catastrophes, etc., when doctors to save lives may work 48 to 72 hours without sleep? Or what will happen in communities with insufficient numbers of doctors?

8. Will patient's have freedom of choice of doctors and hospitals?

9. Will only hospitals approved by the A. M. A. (or the Government) be acceptable?

10. Will hospitals not up to standard be put on the black list?

11. Can a doctor refuse to take a patient he does not care to treat?

12. Will rates of fees for services rendered be fixed to the extent that if a doctor exceeds this charge, he is subject to punishment under law, or will the rates that the Government will pay be fixed for any certain type of work, but if the doctor wants to give extra service and a patient is willing to pay more for superior, more experienced and better care, then such arrangements could be made without being labeled "black market" or unlawful?

13. Will fee rates be made flexible so as to vary with the changing purchasing value of the dollar or be fixed regardless of inflation, deflation, the laws of supply and demand?

14. Will "bonuses" or "gifts" so prevalent in today's black market rackets be condoned? If not, how can they be prevented?

If doctors can refuse to take patients, it is conceivable that in certain communities these patients will not be able to get medical care without digging up a bonus or a gift. My experience in national housing at present makes this a real threat to adequate care of patients.

15. Will specialists be able to charge more for a procedure done extra well compared to a general practitioner who does the same type of work satisfactorily but not with the perfection of a specialist?

A good example is tonsil operations which are done by many physicians. Some are done superbly well, others satisfactorily, others passably, others poorly, and other disgracefully.

16. Will there be any provisions to prevent fee-splitting among doctors?

17. Will there be any attempt to control "cuts," "bonuses" or "percentage returns" of certain laboratories to doctors referring work to those laboratories?

18. What will happen to the American Red Cross under the proposed legislation?

19. Will the burden on doctors of getting a new State license, paying big reciprocity fees, and wasting months of time whenever necessity requires them to move from one State to another State be eliminated by having a national medical examination and licensing board acceptable to every State?

To avoid overloading some States with doctors States could limit a quota of doctors based on numbers of doctors per 1,000 population.

20. Will standards of medicine in all States be raised by developing national basic science laws?

21. Will standards of medicine be raised by requiring periodic (5-year) examinations of all doctors on current developments in medicine and surgery for renewal of licenses?

22. Will the proposed legislation define the qualifications and limitations of osteopaths, chiropractors, physio-therapists, optometrists, opticians, oculists, colonic irrigationists, Chinese herb doctors, etc.?

It is well to remember that the Medical Corps of the armed forces permitted only qualified physicians and surgeons to accept commissions and treat our soldiers. Yet in many Western States, certain categories of "doctors" are permitted to do surgery, obstetrics, general medicine and other specialties without adequate training and qualifications.

These and many other questions should be thoroughly considered before any comprehensive plan of national health insurance is finally enacted into law. They are the loop-holes which if not properly provided for in advance will result in a break-down of what may be a great benefit to the American people and the American medical profession. They are meant to be helpful and not critical.

Again I wish to request a copy of the proposed Murray-Wagner-Dingell bill. Also I again request that my name be withheld in case you desire to use any of this letter in your work.

Sincerely and respectfully yours,  
[Name withheld on request.]

X