

NATIONAL HEALTH PROGRAM

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

PART 2

APRIL 17, 18, 19, 22, 23, AND 24, 1946

Printed for the use of the Committee on Education and Labor



UNITED STATES
GOVERNMENT PRINTING OFFICE
WASHINGTON : 1946

EDUCATION AND LABOR COMMITTEE

JAMES E. MURRAY, Montana, *Chairman*

DAVID I. WALSH, Massachusetts

ELBERT D. THOMAS, Utah

CLAUDE PEPPER, Florida

ALLEN J. ELLENDER, Louisiana

LISTER HILL, Alabama

DENNIS CHAVEZ, New Mexico.

JAMES M. TUNNELL, Delaware

JOSEPH F. GUFFEY, Pennsylvania

OLIN D. JOHNSTON, South Carolina

J. W. FULBRIGHT, Arkansas

ROBERT M. LA FOLLETTE, JR., Wisconsin

ROBERT A. TAFT, Ohio

GEORGE D. AIKEN, Vermont

JOSEPH H. BALL, Minnesota

H. ALEXANDER SMITH, New Jersey

WAYNE MORSE, Oregon

FORREST C. DONNELL, Missouri

CHARLES A. MURRAY, *Clerk*

PAUL SAMPLE, *Assistant Clerk*

JOSEPH P. MCMURRAY, *Special Assistant*

CONTENTS

	Page
Academy of Medicine of Cleveland.....	610
Alamance General Hospital, Inc.....	619
Association of American Physicians and Surgeons.....	853
Boas, Dr. Ernst P., chairman, the Physicians' Forum:	
Endorsement of S. 1606.....	735
Effect of the bill on doctors.....	738
Shortcomings of voluntary plans.....	740
Attitude of American Medical Association.....	741
The National Physicians Committee.....	742
Voluntary insurance.....	744
The Advisory Council.....	745
Free choice of doctor.....	756
The American Medical Association.....	760
Health insurance in Europe.....	767
Free choice of doctor.....	768
Cary, Edward H., chairman of board of trustees, National Physicians' Committee:	
Expenditures of the National Physicians' Committee.....	862
Endorsement of title I.....	874
Proposed amendments to title I.....	874
Endorsement of S. 191.....	875
Opposition to title II.....	876
Health insurance a revolutionary concept.....	876
Medical care would deteriorate under S. 1606.....	877
Support of the committee by drug manufacturers.....	877
Origin of the National Physicians' Committee.....	879
Exemption of contributions from income tax.....	882
The Linz honor award.....	900
The Blue Cross plans.....	905
Council on Medical Services and Public Relations of the American Medical Association:	
.....	670
Densford, Katherine J., R. N., president, American Nurses' Association:	
The American Nurses' Association.....	1081
Health insurance must include nursing care.....	1082
Necessary safeguards to nursing education.....	1082
Number of nurses.....	1087
Income of nurses.....	1087
Flagstad, Dr. Carl O., chairman, legislative committee, American Dental Association:	
The American Dental Association and its objectives.....	1017
The American Dental Association's attitude toward health security legislation.....	1018
The American Dental Association's concept of the basis for a dental health program.....	1019
The American Dental Association's attitude toward S. 1606.....	1020
Proposed dental health program.....	1023
Grants-in-aid preferable to compulsory insurance.....	1026
Getting, Viado A., M. D., secretary, the Association of State and Territorial Health Officers, and Commissioner of Public Health, Boston, Mass.:	
Statement on training.....	817
Objectives of the Massachusetts Medical Society.....	819
Proposed changes in title I.....	833
Grants to States for health services.....	834
Grants to States for medical care of needy.....	835
Detailed criticism of S. 1606.....	839
Proposed amendments to title II.....	842
Conclusion.....	

	Page
Goin, Dr. Lowell S., president, California Physicians Service:	
Voluntary plans can expand to meet the need.....	623
Selective service figures not convincing.....	624
Compulsory health insurance will not improve health.....	625
The costs are unpredictable.....	626
Other steps should be taken first.....	627
Voluntary plans are preferable.....	627
The California Physicians Service.....	628
Administrative costs of the plan.....	647
Goldmann, Dr. Franz, associate clinical professor of Yale University School of Medicine.....	611
Hamilton, Dr. Alice, National Consumers League:	
Resolutions adopted by National Consumers League.....	970
Unmet health needs.....	971
Title I of S. 1606.....	972
Shortcomings of voluntary plans.....	972
Advantages of universal coverage.....	973
Free choice of doctor.....	974
Doctor-patient relationship.....	976
Should low income groups be insured?.....	976
Charity medicine is not the answer.....	977
Quality of medical care.....	977
Cost of health insurance.....	978
Public demand for health insurance.....	978
Is it too soon?.....	978
Howard, Dr. Joseph H., president, Connecticut State Medical Society.....	666
Jacobs, Mrs. Beatrice F., chairman of the Health and Education Committee, The League of Women Shoppers, Inc.:	
The problem of medical costs.....	1142
Adequate medical care a Government responsibility.....	1144
Benefits from title II.....	1144
Support of Pepper amendments to title I.....	1144
The League of Women Shoppers.....	1145
Free choice of doctor.....	1150
Johnson, Dr. Victor, secretary, Council on Medical Education and Hospitals of the American Medical Association:	
The Council on Medical Education and Hospitals.....	698
A National Science Foundation preferable to S. 1606.....	700
Distribution of hospitals.....	701
Kash, Dr. R. C., Lebanon, Tenn.....	621
Kaufmann, Dr. Maurice, Dentists Committee for the Passage of the Wagner-Murray bill:	
Endorsement of S. 1606.....	1036
Suppression of free discussion by American Dental Association.....	1036
Quality of care would not deteriorate under S. 1606.....	1039
The need for dental care.....	1040
Selective-service rejections for dental defects.....	1041
Safeguards in the bill.....	1041
Shortage of dentists.....	1042
Kennedy, Dr. Walter V., president, Indiana Mutual Medical Care, Inc.:	
European standards of medical care.....	703
Low standards of living.....	704
Inferior medical training in Europe.....	705
Deterioration of quality.....	705
Newspaper clippings on British health insurance.....	707
Louisiana State Medical Society.....	783
Low, Dr. Harold T., president, Association of American Physicians and Surgeons:	
The Association of American Physicians and Surgeons.....	794
Opposition to S. 1606.....	795
Endorsement of voluntary insurance.....	796
S. 1606 would involve regimentation.....	797
Free choice is limited by S. 1606.....	797
S. 1606 makes Surgeon General a dictator.....	797
S. 1606 would be too expensive.....	798
Health insurance in England.....	799
Voluntary insurance can meet the need.....	802
A plan for national health.....	803
Statement of Dr. Frederick B. Exner.....	813

CONTENTS

V

	Page
Mannix, John R., chairman, Blue Cross commission of the American Hospital Association.....	967
Peters, Dr. John P., secretary, Committee of Physicians for Improvement of Medical Care:	
The need for integration.....	982
Cash benefits are undesirable.....	983
Payment of doctors.....	983
Bill does not affect medical practice.....	984
S. 1606 should improve quality of service.....	985
Committee of Physicians for Improvement of Medical Care.....	998
British health insurance.....	1000
Robinson, Dr. E. I., president, National Medical Association:	
Endorsement of the bill.....	787
Health problems of the Negro.....	788
Proposed amendments.....	789
Rorem, C. Rufus, director, the Blue Cross Commission of the American Hospital Association:	
Description of the Blue Cross system.....	929
Costs under the Blue Cross.....	932
Payment of doctors.....	934
Administrative expense.....	935
Administration of the Blue Cross.....	937
Recent developments in Blue Cross.....	949
Proposal for grants-in-aid to the Blue Cross.....	951
Voluntary pay-roll deductions.....	953
Voluntary plans in Europe.....	954
Sensenich, Dr. R. L., chairman, Board of Trustees, American Medical Association:	
American Medical Association report on S. 1606.....	551
National health 10-point program of the American Medical Association.....	553
Standards of acceptance for medical-care programs.....	555
Regimentation.....	557
The National Physicians Committee.....	557
British health insurance.....	557
Selective Service rejections.....	558
Loss of time through illness.....	558
Voluntary insurance.....	558
Rural health care.....	559
Medical opinion.....	559
Sleeper, Ruth, president, National League of Nursing Education.....	1094
Texas State Medical Association.....	604

NATIONAL HEALTH PROGRAM

WEDNESDAY, APRIL 17, 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, Tunnell, Smith, and Donnell. The CHAIRMAN. The hearing will come to order.

The first witness this morning is Dr. R. L. Sensenich, of South Bend, Ind.

Doctor, we are pleased to have you here this morning. Would you care to make some statement about your background, the position you occupy in the American Medical Association, and so forth? Also anything else you wish to say.

STATEMENT OF DR. R. L. SENSENICH, CHAIRMAN OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

DR. SENSENICH. I am a physician, in the practice of medicine in South Bend, Ind., and have been for a number of years; and, by the way, if you wish my name, it is Roscoe L. Sensenich, chairman of the board of trustees of the American Medical Association. My appearance here this morning is in connection with that office. Senator Murray, in the interests of your committee, who I know are very busy, I have prepared a statement which I will ask to be placed in the record. From that I will brief some of the material which I think you might care to discuss.

The CHAIRMAN. That will be satisfactory.
(The statement is as follows:)

STATEMENT BY AMERICAN MEDICAL ASSOCIATION AT HEARING BEFORE THE COMMITTEE ON EDUCATION AND LABOR, UNITED STATES SENATE, S. 1606, NATIONAL HEALTH PROGRAM, SUBMITTED BY DR. R. L. SENSENICH, CHAIRMAN OF THE BOARD OF TRUSTEES

The American Medical Association is an organization which includes more than 125,000 physicians who are members of the county and State medical societies. The policies of the association are determined by its house of delegates. The members of the house of delegates, numbering 175, are elected by the respective houses of delegates of the individual States, which in turn are elected by the members of the county medical societies. Thus the organization is democratic in its organization and in its functions.

AMERICAN MEDICAL ASSOCIATION REPORT ON S. 1606

At the last meeting of the house of delegates held in Chicago in December 1945 consideration was given to the Wagner-Murray-Dingell bill (S. 1606) and

to the national health program presented by President Harry S. Truman in his message to the Congress on November 19. The report adopted by the house of delegates follows:

"The President's program includes five features: The first is the proposal to grant Federal aid for the building of hospitals and health centers throughout the Nation. The board of trustees of the American Medical Association has approved the principles of the Hill-Burton bill, and the committee recommends that the house of delegates endorse this action of the board as being within the program of constructive action toward improving the health of the American people.

"The second recommendation of President Truman is for an extension of maternal and child-health services. The Wagner-Murray-Dingell bill would make this effective by increased grants-in-aid through the Children's Bureau to the individual States. This constitutes an insidious attempt to turn over to the Federal Government functions that are definitely those of the medical profession. The American Medical Association has always favored proper aid for the extension of maternal and child-health services where the need can be shown.

"The third feature of the President's message dealt with the development of the National Research Foundation. The Committee on Postwar Medical Service, the Council on Medical Education and Hospitals, and the board of trustees of the American Medical Association have approved the principles of the Magnuson bill, which would place the control of the National Research Foundation under a scientific board of directors rather than under an individual director to be appointed by the President. Your reference committee approves the action taken by those official bodies of the American Medical Association and urges that the house of delegates support their recommendations.

"Finally, the fourth proposal of President Truman and the main feature of the Wagner-Murray-Dingell bill is the creation of a Federal system of compulsory sickness insurance. In commenting on this proposal, your reference committee recommends that the house of delegates endorse the following statement from the editorial published in the Journal of the American Medical Association, December 1, 1945: "No one will ever convince the physicians of the United States that the Wagner-Murray-Dingell bill is not socialized medicine. By this measure the medical profession and the sick whom they treat will be directly under political control. By this measure the great system of private hospitals and community hospitals that have grown up in our country will depend for their continued operation on funds paid to them by a Federal Government agency. By this measure the philanthropic efforts for the care of the sick, which have been the pride of our Nation, will be forever deterred. Through this measure competent young men who would enter the medical profession will be forced to seek other fields of action still remaining under our democracy which still permits the exercise of individual initiative and freedom of thought and action. By this measure doctors in America would become clock watchers and slaves of a system. Now, if ever, those who believe in the American democracy must make their belief known to their representatives, so that the attempt to enslave medicine as first among the professions, industries, and trades to be socialized will meet the ignominious defeat it deserves."

"Your reference committee recommends that the house of delegates express its official disapproval of section 4 of the Wagner-Murray-Dingell bill for the following reasons:

"1. The Wagner-Murray-Dingell bill is founded on the false assumption that solution of the medical-care problem for the American people is the panacea for all of the troubles of the needy.

"2. This is the first step in a plan for general socialization not only of the medical profession but of all professions, industry, business, and labor.

"3. Positive proof exists from experience in other countries that inferior medical service results from compulsory health insurance.

"4. A program such as outlined is enormously expensive. It will result in greatly increased taxes for the entire population of the United States.

"5. Voluntary prepayment medical plans now in operation in many parts of the United States and which are rapidly increasing in number will accomplish all the objects of this bill with far less expense to the people and under these plans the public will receive the highest type of medical care."

In a meeting held by the board of trustees of the American Medical Association in Chicago in February the following health program was adopted representing the objectives of the association in improving the national health:

NATIONAL HEALTH 10-POINT PROGRAM OF THE AMERICAN MEDICAL ASSOCIATION

"1. The American Medical Association urges a minimum standard of nutrition, housing, clothing, and recreation as fundamental to good health and as an objective to be achieved in any suitable health program. The responsibility for attainment of this standard should be placed as far as possible on the individual, but the application of community effort, compatible with the maintenance of free enterprise, should be encouraged with governmental aid where needed.

"2. The provision of preventive medical services through professionally competent health departments with sufficient staff and equipment to meet community needs is recognized as essential in a health program. The principle of Federal aid through provision of funds or personnel is recognized with the understanding that local areas shall control their own agencies as has been established in the field of education. Health departments should not assume the care of the sick as a function since administration of medical care under such auspices tends to a deterioration in the quality of the service rendered. Medical care to those unable to provide for themselves is best administered by local and private agencies with the aid of public funds when needed. This program for national health should include the administration of medical care including hospitalization to all those needing it but unable to pay, such medical care to be provided preferably by a physician of the patient's choice with funds provided by local agencies with the assistance of Federal funds when necessary.

"3. The procedures established by modern medicine for advice to the prospective mother and for adequate care in childbirth should be made available to all at a price that they can afford to pay. When local funds are lacking for the care of those unable to pay, Federal aid should be supplied with the funds administered through local or State agencies.

"4. The child should have throughout infancy proper attention including scientific nutrition, immunization against preventable disease and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child care and infant welfare stations administered under local auspices with support by tax funds whenever the need can be shown.

"5. The provision 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. Where such facilities are unavailable and cannot be supplied through local or State agencies, the Federal Government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established (Hill-Burton bill).

"6. A program for medical care within the American system of individual initiative and freedom of enterprise includes the establishment of voluntary nonprofit prepayment plans for the costs of hospitalization (such as the Blue Cross plans) and voluntary nonprofit prepayment plans for medical care (such as those developed by many State and county medical societies). The principles of such insurance contracts should be acceptable to the Council on Medical Service of the American Medical Association and to the authoritative bodies of State medical associations. The evolution of voluntary prepayment insurance against the costs of sickness admits also the utilization of private sickness insurance plans which comply with State regulatory statutes and meet the standards of the Council on Medical Service of the American Medical Association.

"7. A program for national health should include the administration of medical care, including hospitalization to all veterans, such medical care to be provided preferably by a physician of the veterans' choice with payment by the Veterans' Administration through a plan mutually agreed on between the State medical association and the Veterans' Administration.

"8. Research for the advancement of medical science is fundamental in any national health program. The inclusion of medical research in a national science foundation, such as proposed in pending Federal legislation, is endorsed.

"9. The services rendered by volunteer philanthropic health agencies such as the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Inc., and by philanthropic agencies such as

the Commonwealth Fund and the Rockefeller Foundation, and similar bodies have been of vast benefit to the American people and are a natural growth of the system of free enterprise and democracy that prevail in the United States. Their participation in a national health program should be encouraged and the growth of such agencies when properly administered should be commended.

"10. Fundamental to the promotion of the public health and alleviation of illness are widespread education in the field of health and the widest possible dissemination of information regarding the prevention of disease and its treatment by authoritative agencies. Health education should be considered a necessary function of all departments of public health, medical associations, and school authorities."

At the meeting of the house of delegates held in Chicago, December 3-5, 1945, acting on several resolutions calling for the adoption of voluntary prepayment medical care plans, the house of delegates made the following report:

"All of these plans show a uniformity of desire for the immediate setting up of a national plan on a voluntary basis. In all of them the urgency of this being done is stressed. Accordingly your reference committee recommends that the house of delegates of the American Medical Association instruct the board of trustees and the council on medical service and public relations to proceed as promptly as possible with the development of a specific national health program, with emphasis on the Nation-wide organization of locally administered prepayment medical plans sponsored by medical societies."

In accordance with this action the council on medical service and public relations of the American Medical Association and its board of trustees called a conference of representatives of the voluntary prepayment medical care plans of the individual States. This conference, which was held in Chicago in February 1946, organized a corporation to be known as the Associated Medical Care Plans, a national nonprofit organization, which includes State and local medical care plans that comply with the minimum standards for medical care approved by the council on medical service and public relations and by the board of trustees of the American Medical Association.

The objects of the new corporation as set out in the articles of incorporation are broad. They embrace a variety of activities, which can be expanded as future experience and development may indicate. Specifically, the authority granted by the State of Illinois permits the new corporation "to promote establishment and operation of such nonprofit, voluntary medical care plans throughout the United States and Canada as will adequately meet the health needs of the public and preserve and advance scientific medicine and the high quality of medical care rendered by the medical profession of the two countries." Significantly, the corporation recognizes that "State and local medical care plans should be autonomous in their operation so that the needs, facilities, resources, and practices of their respective areas can be given due consideration, but that the health and welfare of the public is advanced by the coordination through the medium of this corporation of methods, coverages, operations and actuarial data."

The actual activities that are at present contemplated are indicated by the specific duties that the proposed bylaws impose on the commission of the corporation, which, in effect, is the corporation's board of directors. The commission is directed to undertake and promote:

(a) Research and compilation of statistics with special studies of experience and collection and distribution of financial and service data.

(b) Consultation and information services based on contacts with existing and contemplated plans concerning administrative policies and procedures, and the distribution of significant literature and information.

(c) Public education by interpreting the national scope and significance of the medical care plan movement under medical society auspices with publicity methods suitable to the various groups in the public and yet consonant with proper professional practices.

(d) Coordination and reciprocity among plans with reference to transference of subscribers and benefits in the development of national enrollment, among large enterprises and authoritative contacts with governmental or national agencies, such as Farm Security, welfare, and industrial groups.

The necessary details dealing with the manner in which these duties will be performed are matters that will evolve from future meetings of the commission and of members of the corporation. To expedite the initiation of corporate activities, a meeting of the commission has been called for April 26 and 27 in Chicago from which will emerge considered operational plans. These will

be presented for approval to the first meeting of the members of the corporation, now tentatively to be held in San Francisco the 2 days immediately preceding the annual session of the American Medical Association in July.

Among the more pressing of the matters on the agenda of the commission for its April meeting is the acceptance of applications for membership and the appointment of an executive director to administer the day-by-day activities of the corporation. Plans, at least temporarily, call for the establishment of an office, with necessary administrative and clerical staff, in the headquarters building of the American Medical Association, thus facilitating coordination of the activities of the new corporation and of the Council on Medical Service and Public Relations of the American Medical Association.

The following men are serving as indicated on an interim basis until the membership can elect officers at the corporation's first annual meeting:

President: F. E. Feierabend, M. D., of Surgical Care, Inc., Kansas City.

Vice president: William M. Bowman, of the California Physicians' Service, San Francisco.

Treasurer: Norman M. Scott, M. D., of the Medical Service Plan of New Jersey, Clinton.

Secretary: Jay C. Ketchum, of the Michigan Medical Service, Detroit.

Commissioners: Willard C. Marshall, Oregon Physicians' Service, Portland; Edwin M. Kingery, Iowa Medical Service, Des Moines; Arthur J. Offerman, M. D., Nebraska Medical Service, Omaha; L. Howard Schriver, M. D., Ohio Medical Indemnity, Cincinnati; Lester H. Perry, Medical Service Association of Pennsylvania, Harrisburg; Herbert H. Baucus, M. D., Council, Medical Society of State of New York, Buffalo; Raymond L. Zech, M. D., Seattle, Council on Medical Service and Public Relations of the American Medical Association; A. W. Adson, M. D., Rochester, Minn., Council on Medical Service and Public Relations of the American Medical Association, and Edward J. McCormick, M. D., Toledo, Council on Medical Service and Public Relations of the American Medical Association.

The council on medical service and public relations has established standards for prepayment medical care plans which propose to insure to the sick a high quality of medical care by incorporating the fundamental principles which the medical profession believes to be necessary in maintaining such medical service. These principles include free choice of physician, free choice of hospital, the maintenance of mutual responsibility between doctor and patient and the avoidance of political interference between doctor and patient. The text of the standards follows:

STANDARDS OF ACCEPTANCE FOR MEDICAL CARE PLANS APPROVED BY THE BOARD OF TRUSTEES AND BY THE COUNCIL ON MEDICAL SERVICE OF THE AMERICAN MEDICAL ASSOCIATION

Development of plans affecting the distribution of medical care, in accordance with the principles adopted by the house of delegates, is one of the principal functions of the council on medical service and public relations. First in importance in the development of plans affecting the provision of medical care is the utilization of the prepayment method to help spread medical and surgical costs.

The council on medical service and public relations suggests that special recognition be granted to plans organized and operated in accordance with standards which adequately protect the interest of the public and the medical profession.

In granting this recognition the council will consider each prepayment medical care plan in the light of established knowledge and authoritative opinion, and according to standards adopted from time to time by the council in the interest of the public. Plans that conform with the requirements thus formulated will be accepted by the council.

Under the conditions defined in the following paragraphs, the council grants the right to print its seal on all official papers of accepted plans and in any promotional literature or display material used by these plans.

This official seal should appear without comment on its significance unless such comment has been previously approved by the council. A statement proposed for such use follows: "The seal of acceptance denotes that (name of plan) has been accepted within the standards set forth by the council on medical service of the American Medical Association."

The acceptance of a plan and the seal of the council are intended to signify that the plan conforms with or meets the following standards or requirements:

(1) The prepayment plan must have the approval of the State medical association—or if local, of the county medical society in whose area it operates.

(2) The medical profession should assume responsibility for the medical services included in the benefits; the medical profession is qualified by education to accept responsibility for the character of the medical services rendered.

(3) Provision should be made for a medical director acceptable to the county or State medical society, or a committee appointed by either of these groups, to adjust difficulties and complaints. The medical director or committee members may be paid on a per diem basis for the time involved in handling such matters.

(4) There should be no regulation which restricts free choice of a qualified doctor of medicine in the locality covered by the plan who is willing to give service under the conditions established.

(5) The method of giving the service must retain the personal, confidential relationship between the patient and the physician.

(6) The plan should be organized and operated to provide the greatest possible benefits in medical care to the subscriber. Honesty of purpose and sincere consideration of mutual interests on the part of the subscribers, the physicians and the plans are presupposed as necessary considerations for successful operation.

(7) The duties from subscribers through premium rates should be adequate to provide for the benefits offered and the risks involved.

In determining such factors the council will utilize the experience of those plans that are and have been operating successfully, but will not discourage experiments in other types of coverage provided such experiments are limited in scope and capable of scientific evaluation.

(8) These benefits may be in terms of cash indemnity or service units. Where benefits are paid in cash to the subscriber it must be clearly stated that these benefits are for the purpose of assisting in paying the charges incurred for medical service and do not necessarily cover the entire cost of medical service, except under specified conditions.

(9) Subscribers' contracts must state clearly the benefits and conditions under which medical services will be provided or cash indemnities paid. All exclusions, waiting periods, and deductible provisions must be clearly indicated in the promotional literature and in the contracts.

(10) Promotional activities must be reasonable without extravagant or misleading statements concerning the benefits to the subscribers. In approving promotional material the council will endeavor to indicate the type of statements which are acceptable and the nature of those considered objectionable. It is not the function of the council to edit all copy word for word and sentence for sentence, but rather to indicate the general type of revision required in any given piece of literature. It expects the spirit and intent of such objections to be observed in the remainder of the copy not specifically criticized. Promotional activities will include any devices for informing the public or the profession.

(11) Enrollment practices shall be based on sound actuarial principles such as will not expose the plan to adverse selection. Group enrollment is recommended until further experience warrants the acceptance of individuals.

(12) It is understood that the plan of organization will conform with State statutes and that the plan will operate on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs, and reserves for contingencies and unanticipated losses. Supervision should be under the appropriate State authority.

(13) Each accepted plan must submit periodic reports of financial and enrollment experience in the manner prescribed by the council.

Acceptance of plans by the council will be for a period of 2 years or until revoked (provided they comply with the standards during this period) at the end of which all contracts and financial statements be reexamined. A shorter period of approval may be granted at the discretion of the council. Any changes in contracts or literature during the period of acceptance must be submitted to the council for review.

The representatives of the American Medical Association have reviewed the statements made to the Senate Committee on Education and Labor by the Senators and Congressmen who present this legislation and by representatives of Federal Government agencies that support it. We should like to answer specifically some of the points made by those who support this legislation and to cite the evidence in support of our statements.

Regimentation.—Senator Wagner has said, “There is no foundation for the charges that a compulsory health-insurance program would involve regimentation of doctors and patients, lowered standards, or political medicine.” Nevertheless, physicians in countries which have compulsory health-insurance systems have been regimented. The standards of medical care in all such countries, we contend, are lower than those that prevail in the United States, which at this time does not have any such system. This was admitted by Mr. Altmeyer and there is evidence submitted which will prove it.

Senator Wagner has asserted that, “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.” Under questioning of Senators Donnell and Ellender, Mr. Altmeyer, of the Social Security Board, and Dr. Joseph Mountin, of the United States Public Health Service, admitted that the choice of doctor is not free choice but is a restricted choice. The bill itself indicates that the administrator of medical care under this bill would have the right to designate hospitals and specialists entitled to cooperate under the act.

The National Physicians Committee.—In his testimony before this hearing, Congressman John D. Dingell characterized the National Physicians Committee as a satellite organization of the American Medical Association. The National Physicians Committee is not connected with the American Medical Association. The American Medical Association does not exercise any supervision over its financing or its operations. The house of delegates has voiced approval of its work.

Congressman John D. Dingell asserts that the National Physicians Committee was “formed specifically to preserve the American Medical Association’s tax-exempt status under the income-tax laws.” The representatives of the American Medical Association wish to say that the American Medical Association did not organize the National Physicians Committee; rather that the National Physicians Committee was organized by a group of physicians independently and without the sponsorship of the American Medical Association.

Congressman John D. Dingell asserted that the American Medical Association has a “monopoly which it exercises over the health of the American people.” The questioning of Mr. Altmeyer by Senator Ellender brought out that there are more than 60,000 physicians in practice who are not members of the American Medical Association. This is true. Furthermore, the American Medical Association does not exercise any type of control over physicians or over the health of the American people, other than the will of either to follow voluntarily advice which the American Medical Association may give in the pages of its publications. The councils of the association set up standards of medical education, hospitals, drugs, foods, and physical devices. Those who wish to do so voluntarily may accept these standards.

British health-insurance plan.—Congressman Dingell referred to alleged false information which the American Medical Association issued concerning the British health-insurance system and which he stated “has been repudiated by the secretary of the British Medical Association.” The secretary, Dr. Anderson, to whom he refers has been dead for several years. The present secretary of the British Medical Association, Dr. Charles Hill, has issued a statement to the effect that the presently proposed expansion of compulsory sickness insurance in England will be opposed by the medical profession, since the proposals would “lead sooner rather than later to doctors becoming whole-time salaried servants of the state.

The health of the Nation.—In his statement to the Senate committee, Senator Pepper presented what he called a series of facts showing the gravity of the Nation’s health problem. The Nation’s health problem is not grave, since the United States now has the lowest sickness and death rates of any large nation in the world. Here are the statistics, as published in the Encyclopaedia Britannica Book of the Year (1943), of the comparative death rates of the large nations :

United States	10.5	Sweden	11.2
England	12.9	Chile	19.8
Germany	12.3	Japan	17.6
Bulgaria	12.5	New Zealand—European	9.8

The rate for the United States is lower than that of any other great nation. New Zealand, which is not a large nation but which has a lower death rate, limits its sickness and death statistics to its European population.

The Selective Service rejections.—Senator Pepper and others emphasize that over 40 percent of the Nation's selectees were found unfit for military duty. These statistics are fully discussed in the presentation by Dr. L. Goin. Senator Pepper pointed out that only one-sixth of these had defects which were remediable. A pilot study made under the auspices of the Selective Service System during the war at the request of President Franklin Delano Roosevelt failed to show that the application at Government expense of everything that scientific medicine had to offer yielded a sufficient number of corrected defects to make the project worth while. This pilot study was carried on under the auspices of General Hershey and Colonel Rowntree of the Selective Service System and was conducted in Maryland and Virginia.

Senator Pepper points out that more than 23,000,000 people in the country have some chronic disease or physical impairment. He fails to indicate how the establishment of a compulsory sickness-insurance system such as is proposed would in any way improve the care of those with chronic disease or provide for correction of these physical impairments.

Loss of time through illness.—Senator Pepper said that he wished "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." The actual figures show that the amount of time lost from work by absenteeism due to illness is greater in every foreign country in which a compulsory sickness insurance system prevails than it is in the United States. The figures for Germany before the war and Great Britain as compared with the United States follow:

According to statistics of the United States Public Health Service, the average annual duration of absence from work because of illness is about 9 days. These figures are based on a 5-year average, from 1938 to 1942. In the report on health insurance in England in 1938 appears a statement that the average duration of absence from work per year because of illness was 14 days. In the report on German sickness insurance on the duration of illness in Germany it is established that the number of days between the onset of illness and date of recovery increased from 1885 to 1934 until the period was almost twice as great as it was when the insurance system was established; namely, from 14.7 in 1885 to 24.6 in 1934. These figures appear in the book by Goldman and Grotjahn and in figures cited in the Berlin letter in the Journal of the American Medical Association, January 16, 1937, page 218.

Voluntary insurance.—Senator Pepper and others object to voluntary prepayment medical care plans on the grounds that they could never become sufficiently widespread to meet the Nation's need. Nevertheless the United States is today the best insured Nation in the world from the point of view of life insurance, and strictly on a voluntary basis. There is no reason to believe that American initiative applied to the development of voluntary prepayment medical care plans could not bring about an equally favorable result with medical care insurance. The phenomenal growth of the Blue Cross plan once the basic principles had been established and of the voluntary prepayment medical care plans—both private and nonprofit mutual State plans—is an indication that similar growth may be expected once standards are established and suitable State legislation developed to insure scientific and economic operation. Removal of a portion of the costs from the American worker and his family—by hospital insurance, surgical fee insurance, and so forth—in a Nation which has the highest standard of living in the world often meets the entire need of the family for protection.

In his presentation Senator Pepper listed nine reasons why voluntary plans could not meet the need. Not one of the reasons to which he refers is incapable of control. Senator Pepper's subcommittee on health apparently reached the conclusion 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 financed by required contributions to the Social Security Board and by payments from income-tax revenues.

Senator Smith pointed out that he had never been asked to attend any meeting or discuss any of these measures with the subcommittee, although he himself is a member of that subcommittee. In this connection, as far as we know, representatives of the medical profession have never been given opportunity, either at public or at private hearings, to present evidence to the subcommittee on the points under consideration. Senator Pepper admitted that the report had not been formally adopted as the formal report of his committee.

In his testimony Mr. Altmeyer referred to the concealed rates in analyses of our health and death statistics. Our principal problems in medical care are the

control of certain diseases in certain segments of the population. Improvement applied specifically to the problems in these diseases and addressed to these segments of our population would bring about a vast general improvement in sickness and death rates for the Nation as a whole. An analysis of the statistics regarding such diseases as diphtheria and typhoid fever, for instance, reveals that these diseases can be eliminated from a population such as ours once research has established the cause, the method of dissemination, the method of prevention and the method of treatment. Without such knowledge progress in the control of such diseases is costly and inefficient. The Nation has spent many millions of dollars over many years attempting to control the dissemination and incidence of venereal diseases. Such attempts have been relatively ineffective until recently when scientific research established new methods of treatment of gonorrhea with penicillin and the sulfonamide drugs so that this condition can now be cured in more than 95% of the cases in 24 hours. Now it is possible to say that gonorrhea may be eliminated from our population, or at least made as infrequent as typhoid fever and diphtheria, within the next generation. On the contrary, even a billion dollars applied to the treatment of arthritis would not be effective in controlling that condition until research establishes its cause.

Rural health care.—Mr. Altmeyer suggested that the rural population was not covered by any of the voluntary prepayment medical care plans. The first national rural health congress was held under the auspices of the American Medical Association in Chicago in March 1946. Three of the largest farm organizations in the United States—the Grange, the American Farm Bureau Federation, and the Farm Foundation—cooperated in this conference. All have stated their opposition to compulsory sickness insurance as a means of meeting the problem of health for rural areas. Through a cooperative effort of these organizations with the American Medical Association in establishing voluntary prepayment medical care plans, and by the extension of medical facilities to rural areas through the passing of the Hill-Burton bill, rural health needs can be met in this country.

Mr. Altmeyer's testimony on the meaning of the bill.—In his testimony, under the questioning of Senators Ellender and Donnell, Mr. Altmeyer admitted that under the Wagner-Murray-Dingell bill as written, the Government would regulate the terms of medical arrangements and the fees paid physicians. He admitted that freedom of choice is not really freedom of choice. He indicated that under this proposal the Blue Cross would cease to be a private agency and would act merely as a Government agent in paying hospitals for services. He indicated his belief that failure of any community to cooperate would lead the Surgeon General of the United States Public Health Service to send physicians into a community to take over medical care.

Medical opinion.—Mr. Altmeyer asserted his belief that a majority of the physicians of the country would favor this bill if given opportunity to express their opinion. A poll conducted by the Opinion Research Corp. gave the following results:

“Are you familiar with the Wagner-Murray-Dingell bill which proposes to set up a Federal medical care program to be paid for out of increased social security pay-roll deductions?”

Total doctors:	<i>Percent</i>
Yes.....	86
No.....	14

“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?”

	<i>Percent</i>
Good thing for the public.....	13
Bad thing.....	75
Some ways good; some ways bad.....	10
No opinion.....	2

The American Medical Association sent a questionnaire to 3,000 medical officers, selecting every fifteenth name from the list of 45,000 physicians in the armed forces, including officers on duty with the Army, Navy, Public Health Service, and Veterans' Administration on September 30, 1943. Only 5 percent indicated any wish to participate in Government medical service. Only 9 percent stated they would wish to practice on a full time salary basis.

Finally, as has already been shown, the house of delegates of the American Medical Association and that of every State medical society in the United States individually has expressed itself as opposed to this bill.

Dr. SENSENICH. The statement has frequently been made that the action of the American Medical Association represents only a very small group, a portion only of the association, and it has been variously and ungraciously referred to as a clique, and comment has been made that it does not represent the attitude of the American medical profession, for that reason.

The CHAIRMAN. At the outset, I would wish to say that the committee does not recognize that at all, and we recognize the American Medical Association as representing the profession in this country almost completely, and we are satisfied with that fact.

Dr. SENSENICH. In that connection, I wish to state that the membership of the association exceeds 125,000 physicians, and that its policies are determined by its house of delegates, which numbers 175. This group is elected by the various State societies, and the representatives to the State organizations are from the county and local component societies. So that we do make the effort to have—

Senator PEPPER. I do not like to interrupt you, Doctor, except that you were speaking about the organization of the American Medical Association.

Dr. SENSENICH. Yes, sir.

Senator PEPPER. You say it starts with the county association?

Dr. SENSENICH. That is right.

Senator PEPPER. And the next is the State association?

Dr. SENSENICH. Yes, sir; Senator.

Senator PEPPER. And the next is the national house of delegates, composed of representatives of the State associations?

Dr. SENSENICH. That is right, sir.

Senator PEPPER. Now, I was interested in the parliamentary procedure which prevails in the organization. Suppose that a county medical society, we will say in my county in Florida, desires to come out in favor of a particular form of health insurance, and they pass a resolution to that effect, in my county in Florida, that is the county medical association. How long would it take before that resolution of this county medical association would come before the house of delegates in the regular order?

Dr. SENSENICH. That resolution might come first to the State house of delegates, the State association, and from that group to the house of delegates of the American Medical Association. However, there would be nothing preventing that county society from directly approaching delegates to the house of delegates of the American Medical Association and presenting to them this resolution or this action of the local component society.

Senator PEPPER. I got the impression from somebody, and I wanted you to advise me about the accuracy of the impression, that it took something like 3 years to get a matter of that sort finally before the house of delegates and to get its decision upon it.

Dr. SENSENICH. I am glad to discuss that, Senator Pepper, because the house of delegates in each State meets at least annually, and on special occasion they may have extra sessions, and the house of delegates to the American Medical Association meets at least one time annually. At the present time, there is much discussion as to the advisability of meeting regularly two times a year, but we are subject to call at any time.

Senator PEPPER. There is no rule about any length of time that has to elapse, and there is no executive committee that has to give final approval of it?

Dr. SENSENICH. There is no screening, there is nothing to prevent or even discourage any county society from taking any action that it wishes, and that action may then be taken to the governing body of the American Medical Association.

Senator PEPPER. All right.

Senator DONNELL. May I ask the doctor one question, too, at this time?

Doctor, what proportion in percentage would you say the 125,000 physicians who are members of the American Medical Association represent with respect to the entire practicing profession of medicine and surgery in this country?

Mr. SENSENICH. There are probably as many as 50,000 or 60,000 graduate physicians that are not members of the American Medical Association. Now, as to how many of them are actually in practice, it is impossible to say. There are men who graduate and then take executive positions in various life insurance companies, or in this or that group, but there are this number who are of themselves independent and are licensed to practice, and who can, as frequently as they wish, express their wishes and their ideas and their positions on medical matters.

Senator DONNELL. Thank you.

Dr. SENSENICH. On page 2 of the statement which has been prepared for you, I will not take the time to read that, but that is the action of the house of delegates with reference to the legislation that is presently under discussion. I would go to page 3 in the report and simply come to the report of the reference committee, which recommends that the house of delegates express itself, its official disapproval, and I am sorry there is an error there in the matter of section 4.

Section 4 is not the Wagner-Murray-Dingell bill, but section 4 of the President's message. However, under No. 1, the Wagner-Murray-Dingell bill is founded on the false assumption that solution of the medical-care problem of the American people is the panacea for all of the troubles of the needy.

No. 2 from the reference committee, this is the first step in a plan for general socialization not only of the medical profession, but of all professions, industry, business, and labor.

No. 3, positive proof exists from experience in other countries that inferior medical service results from compulsory health insurance.

No. 4, a program such as is outlined is enormously expensive, it will result in greatly increased taxes for the entire population of the United States; and No. 5, voluntary pre-payment medical plans now in operation in many parts of the United States and which are rapidly increasing in number, will accomplish all the objects of this bill with far less expense to the people, and under these plans the public will receive the highest type of medical care.

Now, that was the report of the reference committee to the house of delegates which was acted upon by the house.

Senator TUNNELL. Could you tell us about the countries where this has been tried? Positive proof exists from experience in other countries, you say, that inferior medical service results from compulsory health insurance?

Dr. SENSENICH. Personally I have visited Germany, France, and England, and have had some opportunity to observe the operation of the plans. However, I should prefer, if you will, Senator, a little later Dr. Walter Kennedy will go into that in some more detail.

I will be glad to have the question asked again, if you wish. That way, we will not take so much of your time.

Senator TUNNELL. All right.

Dr. SENSENICH. On page 4 of the brief, there is the national health 10-point program of the American Medical Association. It is to be regretted that for some reason or other, this action of the American Medical Association and the effort that has preceded this statement of program, throughout many, many years, has not received the general recognition to which it is entitled, and too often the American Medical Association has been charged with being obstructionist and not in any way willing to accept any innovations or any changes in the matter of the provision of medical care.

Without taking your time and reading the program you have before you, I would simply brief it to this extent, that the American Medical Association urges a minimum standard of nutrition, housing, clothing, and recreation fundamental to good health. That is first of all. The responsibility for the attainment of this standard should be placed as far as possible on the individual, but the application of community effort compatible with the maintenance of free enterprise, should be encouraged by governmental aid where needed. That is the background of the position that the American Medical Association has taken with reference to the Hill-Burton bill and other legislation which is pending.

Senator PEPPER. You would not think it would be socialistic for the Federal Government to aid in maintaining minimum standards of nutrition, housing, clothing, recreation and so forth?

Dr. SENSENICH. No, I think not, if there is need and the community is unable to do that for itself, I think, Senator Pepper, that after all your legislative effort, and I want to say that to you, sir, that I believe that your legislative efforts have been directed toward improving general standards of living, and I think the Senate has expressed itself again and again in that connection.

Now, of course, the manner in which that shall be attained is the point which determines whether or not it is socialistic or what it is.

No. 2, the provision of preventive medical services through professionally competent health departments, and that goes on with the development of adequate public health service in each local community.

No. 3, is the procedures established by modern medicine for advice to the prospective mother and child. We are very much interested that every mother and child shall have the service that they should have, preferably through local and State agencies. Where that need cannot be met from the local level, then there would be no objection to some aid from Federal sources.

No. 4, the child should have throughout infancy proper attention, including scientific nutrition and immunization.

Senator PEPPER. You say that you would like to see every mother and child get the care that they should have?

Dr. SENSENICH. Yes, sir.

Senator PEPPER. And that would carry with it the provision of hospital care for every mother at childbirth?

Dr. SENSENICH. I think so, sir.

Senator PEPPER. And prenatal care, also, for the mother and the child?

Dr. SENSENICH. Yes, sir.

Senator PEPPER. And then the necessary care that the child should have after birth, in its health?

Dr. SENSENICH. Yes, sir.

Senator PEPPER. And you would recommend that wherever a mother is not financially able to purchase the needed medical and hospital care in such cases, that the Government could properly and should properly make those things available to them?

Dr. SENSENICH. Yes, sir. However, I would distinguish there, Senator Pepper, as between the local government and local units, and Federal Government. I should dislike to have that made the basis of an over-all government policy, which disregarded the responsibility locally, from the individual on up.

Senator PEPPER. Obviously there would have to be some more hospitals built to give that much care to the mothers and children.

Dr. SENSENICH. Yes, sir.

Senator PEPPER. And probably some more physicians and nurses and so on?

Dr. SENSENICH. But that should be determined upon local need. That is the point which has been developed.

Senator PEPPER. And you think the local government could afford all of that needed service without Federal aid?

Dr. SENSENICH. In most instances it could. Out in my own city, I happened to pick up the statement of the board of health for last year, and out of some 2,600 and some births, I think if I am correct, there were only 20 that were not born in a hospital, and that is a mixed population, including negroes, foreign, and industrials.

The CHAIRMAN. Are you familiar with the conditions in poorer States, in the South, Doctor, where they claim that they have not the means to build and maintain hospitals? Even if the hospital was built by the Federal Government, they would not be able to maintain it and support it through lack of sufficient means.

Dr. SENSENICH. I think that that is no doubt true in areas. Of course, Senator Murray, we must not lose sight of the fact that there are other things which will enter into the situation outside of the actual construction of hospitals. You cannot have a community in good health that is not decently fed and clothed and cared for. The attitude of the American Medical Association and the physicians locally has always been that the need should be determined.

Now, many communities that now do not have hospitals, are ready and not only ready, but actually have built up funds looking toward their contribution in part at least to the creation of local medical facilities.

Senator PEPPER. Taking the country as a whole, what percentage of the children are born in hospitals, do you recall?

Dr. SENSENICH. I do not have that. We will have later in the day some statistics from Dr. Joseph Howard, who was to have appeared on this program, and unfortunately had a coronary, and we have his report for you.

Eighth, research for the advancement of medical science is fundamental. That is something that is removed from the simple provision of some kind of insurance or local contribution to medical care.

Ninth, we are close to the individual, medical care is an individual service, and we have not lost faith in the individual as an individual or collectively in the local community, and we feel that the activities and the interests of the community in its own welfare and in setting up its mechanisms for dealing with problems locally and in the larger units nationally, should be encouraged.

Senator PEPPER. You say that you have not lost faith in the individual. That does not mean that all doctors render service on credit, however, does it?

Dr. SENSENICH. I do not know of any.

Senator PEPPER. There are a lot of poor people that have told me that they do not get a doctor if they do not pay the cash on the barrelhead when he comes to render the service.

Dr. SENSENICH. That I could not argue, because I do not know all of your doctors. I would only insist upon this, and I think that you would agree to it, Senator Pepper, that after all that is not the attitude of most physicians.

Senator PEPPER. I think a lot of this charity service that is talked about is a lot of hooey, and I think a lot of poor people can prove it.

Senator DONNELL. I would like to be recorded as supplementing what Senator Pepper has said, that a good deal of talk about charity is the exact fact, because I have a profound respect for the charity and generosity of the medical profession.

There may be instances to which the Senator refers in which he is quite correct, but my observation has been, and my view is that the medical profession has been characterized by generosity and charity.

Senator SMITH. I would like to record the same view. I just heard this as I came in. I want to protest against the suggestion anywhere in these hearings that the medical profession has not been a profession of out-giving service to the people of this country. I lived in a medical atmosphere from my childhood up, and I have been inspired all of my life by what the doctors have done for the people. That does not mean that there are not big gaps to be filled, but I do not like the suggestion that the doctors, as a whole, have not had the spirit of giving to the people of this country.

Senator TUNNELL. I do not see how they live if they do not collect, that is a practical side of it.

The CHAIRMAN. I think we are all in accord that the medical profession has been most generous and charitable, but at the same time, there is a limit beyond which it would be impossible to expect the medical profession to furnish medical care, that is, proper medical care and hospitalization to people in various sections of the country. I am sure there is no doubt about that.

I think that the doctors would be willing to do what they could, but they simply cannot handle the whole problem and it would be unfair to ask them, because the average income of the medical profession is pretty low. There are some parts of the country where they

do not make enough money to continue in practice, and they have to leave. I know of cases of that kind. You cannot expect a doctor to raise a family, and maintain his family in a community where he cannot make a living. That situation exists, there is no doubt about that. That is no reflection on the medical profession at all.

Senator PEPPER. I would like to say by way of clarification of my remark, that I happen to have been delivered by an old country doctor, and in my youth on a little Alabama farm I had a chance to see the character of the country doctor, and as I grew up later I had a chance to see the family doctor, who is the typical doctor in the American mind, but I have also seen as I have grown older, and talked to more people, and I have heard of more pathetic cases of where the specialization and the general commercial tendency that has invaded all of our life, and the demands of the doctor, of course, for his own survival, have made it more and more common for the doctor not to come unless he knows he is going to get a fee for coming to visit the patient.

I have been in the homes of too many Negro servants that have worked in my house, and I have talked to too many others, and have them tell me that the doctor will not come unless he knows he is going to get the cash to take home with him when he makes his visit.

Now, I am not complaining about that, and I do not think that he owes medical service free to the community any more than the lawyer or the merchant owes it to give his goods to the humble. I do not think it is the problem of the grocer in a community to feed the hungry of the community. If the hungry exist, it is the community's obligation to feed them. What this bill proposes is to take the individual out of the ranks of charity so that it will not be a beneficence if the doctor comes to see him, but to make it possible for the poor to provide in an honorable way for their medical and hospital care. But when time and again the proposition is made, in opposition to legislation like this, that the poor of this country can get medical care by charity, the statistics do not bear it out.

Dr. SENSENICH. Senaor Pepper, if I may ask you a question, how would you provide for this low-income group other than on a charity basis, if the income is insufficient to pay its reasonable proportion of the premium?

Senator PEPPER. I think the Wagner-Murray-Dingell bill would be the foundation of the answer to your question, and that would cover everybody who is in the pay-roll class, and they would pay probably a certain percentage of their pay roll and the employer would pay a certain percentage of his pay roll, just as they do now in respect to unemployment compensation. Then those who were not employed, so that they could not pay through the pay roll tax as this bill eventually contemplates, would be provided for by grants of Federal funds, and those grants would be contributed by the Federal and the State and the local governments, in my opinion, if you were to make the proper arrangement.

And it is certainly not socialized medicine, and it is not, as you suggest here, anything that is sinister in character for a person to have an opportunity through a cooperative insurance system to provide in an honorable way for his own care, without being the beneficiary of charity.

Dr. SENSENICH. There are two reasons for discussing the matter of the Wagner-Murray-Dingell insurance provisions. One of them is

that the insurance is not cheap, from the estimates. Of course, I admit that there are no figures that have been given, but according to the testimony of Mr. Altmeier, if the individual even of a low-income family, with three earners, would contribute 3 times 27, or 81, and 3 earners, it is no small contribution.

Senator PEPPER. You will admit that the more people in the system, the cheaper it will be, is that not a fact, actually?

Dr. SENSENICH. It should be; yes, sir.

Senator PEPPER. And the only way you can get the price down so that the low-income group of people can participate, is to have the largest possible number of people in the system, is it not?

Dr. SENSENICH. Yes, sir.

Senator PEPPER. And the fewer the people in the system, the higher the rate will have to be, is that not true?

Dr. SENSENICH. It depends.

Senator PEPPER. Is not one of the basic principles of this compulsory insurance to bring in by public requirement the largest number of people so that we will have the lowest possible rate for the people who participate on ordinary actual principles?

Dr. SENSENICH. The point in question there, Senator Pepper, and I think you and I have discussed this at other times, is the fact that there is a tremendous concentration of poor insurance risks in this lower group, which means that the rest of the contributors to the insurance fund will pay out of proportion to their own risk, in order to support a very large number of those who are not good risks.

The CHAIRMAN. Are you discussing a voluntary system?

Dr. SENSENICH. I am discussing any system in which you introduce into the picture a low-pay risk that goes in bad health and who will continue to contribute \$27 a year and will be under continuous medical care and support, because the burden of that falls upon the others.

Senator PEPPER. Have you not disclosed the real weakness of the voluntary plans. Just as I say, the major risk is among the poorest category of the people.

Dr. SENSENICH. They are not risks, they are burdens.

Senator PEPPER. I mean the poorest health risk, the greatest health needs are among the people of the lowest income groups.

Dr. SENSENICH. That is right.

Senator PEPPER. Now, then, they are a burden, as you say, if you put them into a system, so is it not the tendency of the voluntary plans, in order to avoid that burden of the category of the poorest of the poor, to attract primarily those in the upper income groups who are the best health risks? That emphasizes the inherent weakness and failure of the voluntary plan. That leaves all of the people at the bottom of the ladder who need health care most with the least ability to provide, so this compulsory insurance plan budgets them all in together, and, yes, it does make the well-to-do and those who need health care least come into the same system with those who are least able to pay and need the most. But is not that the only way that you are going to make it possible for those who need the most and are least able to pay, to get adequate care?

Dr. SENSENICH. Senator Pepper, the individual who does not have sufficient income, and this very low group that you refer to, should not and cannot properly be included in any insurance plan, and we have advocated for all time that they should be properly taken care

of. In your own area, Senator Pepper, you discussed a moment ago the individual who could not receive medical care because he did not have funds. Actually that reflects upon the local government, which should provide for everyone who is unable to secure otherwise, but they are not properly an insurance plan.

Senator PEPPER. Is not public education on the same basis? There have always been throughout history a few wealthy or well-to-do people who could send their children to private schools and have tutors in their homes. Your reasoning would have closed the doors of public education to the masses of the people. I remember when I was a boy hearing a lot of well-to-do people complain about having to pay to educate their neighbors' children, as they would have the power to do in the case of their own children.

Yet we live in a democracy here, where we say not only the rich man who could educate his own child by tutor or in a private school, but the man who has no children shall pay according to his ability to pay to educate the children of America. And I do not see any difference between that principle and the principle of compulsory insurance where we bring in those most able to pay, and those least needy of health care, into a national insurance scheme so that the poor will be able to get not only education but health care.

Dr. SENSENICH. The condition is not comparable, because the people in the school require a comparable amount of care and education and expense, whereas the group that we are talking about who are continuously sick are not on the same basis, comparable with the other individuals.

Senator PEPPER. The bachelor who has no children at all, he does not have any children to get the same amount of care, and yet he pays taxes on it.

The CHAIRMAN. When you say "the group that are continuously sick," what do you mean by that? You do not mean that they are sick all of the time?

Dr. SENSENICH. Virtually so, there are many who are chronically ill.

The CHAIRMAN. There are many; yes, sir, I know.

Dr. SENSENICH. And those individuals, they are the recipients of charity when you make public contribution to a fund or they are the recipients of charity contributed by other members of the same insurance plan, if they are not fair and average risks.

The CHAIRMAN. But we have a vast segment of our population that are not as poor as you indicate this group who are continually sick, that cannot afford the modern costly medical care and hospitalization, is that not true?

Dr. SENSENICH. Yes; in that case.

The CHAIRMAN. You would not want to put them on the basis of having to accept charity, and to be classified as charity cases?

Dr. SENSENICH. Is the charity any different, Senator Murray, for those individuals than it is when you contribute to the care of crippled children or for rehabilitation, or for any of the other special funds that are set up for individuals?

The CHAIRMAN. Yes. We have people in this country who are employed and working and raising good families, and they should not be put in the position of having to be classified as paupers and unable

to get proper medical care. I think that there should be some way of bringing adequate medical care within their reach, so that they can maintain their dignity as American citizens, I think if you will investigate, as our subcommittee has investigated, you will find that in a great majority of the cases where people do become perpetual paupers, they started on that road through illness in their family and through debts which were accumulated as a result of their efforts to take care of themselves.

Dr. SENSENICH. There are a great many who are mentally deficient and who never could get on well in competition with the average, normal individual. There are many factors that enter into that and I think that we can state this definitely and all agree upon it: That we are all seeking as an objective the best medical care for everyone, and we are now discussing the means of accomplishing it, and it seems that it is hardly fair to include the entire group of individuals, the entire population in a plan that will in the end bring about a lowering of standards and deterioration of service in order to take care of a smaller group to whom we feel that whatever assistance is given them should be given in a manner not recognizable.

Senator PEPPER. You do not mean that the people who need the most and are least able to pay it are the smallest group? There are more of those people than there are the well-to-do people.

Dr. SENSENICH. It depends on what you mean by well-to-do.

Senator PEPPER. What do you consider it? How much income do you think a family head should have a year, in order to purchase the kind of medical and hospital care that would be available to the beneficiaries under this Wagner-Murray-Dingell bill?

Dr. SENSENICH. Senator, may I answer that this way. I recall when that statement came out purely on a matter of income. Let us be realistic and see the other side.

Senator PEPPER. I think that you would not mind giving me an answer to that. What income for the head of a family would be necessary in order to purchase for that family the medical care that would be available under the Wagner-Murray-Dingell bill, to the persons covered?

Dr. SENSENICH. May I answer that in this way, that income buys varying quantities of service in various communities, and that after all, I must insist that you have to look at the reality, and not the idea.

We have to be realistic and recognize that, after all, the major portion by far of the American population, and I mean the population of the United States, have had sufficient funds to get good medical care, and they have enjoyed a better standard of health than any other country in the world.

Senator PEPPER. Now, you do not mean to say, Doctor, that the majority of the American people have been able to buy in the past the medical and hospital care that they ought to have, do you?

Dr. SENSENICH. They have had enough to be well.

Senator PEPPER. Do you think the American people have all been well?

Dr. SENSENICH. Yes; I know that they have.

Senator PEPPER. Very well. Now, how about my figure? I wanted to ask you how much income you think the head of a family should have in order to buy in the private channels that are existing today,

the kind of hospital and medical care which is extended to the people covered by the Wagner-Murray-Dingell bill?

Dr. SENSENICH. There is no figure available.

Senator PEPPER. What is your opinion of the figure?

Dr. SENSENICH. The one that is quoted, and I could not off-hand say, it would be foolish for me to make an estimate, that should be studied.

Senator PEPPER. Could they buy it on \$500 a year?

Dr. SENSENICH. Of course not.

Senator PEPPER. \$1,000 a year?

Dr. SENSENICH. In some areas, they not only can, but do and have, but I personally think that that is not enough.

Senator PEPPER. You think if the head of a family has an income of \$1,000 a year, that he can buy in any community in America, the kind of hospital and medical care that this bill would provide to the covered people?

Dr. SENSENICH. When those figures came out, Senator Pepper, as a matter of fact they included a number of people who live on small farms and derive almost all of their living off the farms.

Senator PEPPER. They do not derive their hospital and medical care off the farm, they do not grow that, do they?

Dr. SENSENICH. No; but they are not always in need of that much medical care. They may have their money available for that service to a much greater degree than the other individual that is on a salary.

Senator PEPPER. If they need hospital care and medical care of a sick child or sick mother or sick man in the country, as distinguished from the town or the city, is there a difference in that?

Dr. SENSENICH. There is a difference in charges, but that is not the point. If the individual has \$1,000 to spend on those things, money on the side, obviously he can buy service that the individual in the city cannot buy if that is his total income, and he has to pay rent and other things. There is no figure on that available which determines exactly what is necessary and could be determined only over a study of years and the average incidence of illness, confining it to those individuals.

Senator TUNNELL. I would like to ask a question here. As I understand your position, Doctor, you admit that there is an obligation somewhere, and you place it on the local community?

Dr. SENSENICH. That is possible; yes, sir.

Senator TUNNELL. I was protesting that it was not the duty of the doctor, I do not think the physician has the obligation to look after the health necessities of a community free.

Dr. SENSENICH. That is right.

Senator TUNNELL. That is too much of a burden.

Dr. SENSENICH. That is right.

Senator TUNNELL. It is just a case of where that obligation is.

Dr. SENSENICH. That is right.

Finally, the house of delegates in December of 1945, acting on several resolutions, adopted a resolution setting up the machinery of coordinating and developing to a greater degree the voluntary insurance plans in the various States, and that is incorporated in this report.

The CHAIRMAN. Your judgment is, Doctor, that all of the proper medical care and service can be obtained by the American people through these voluntary systems that you have mentioned?

Dr. SENSENICH. What is that, all that need it?

The CHAIRMAN. Yes, sir.

Dr. SENSENICH. There are some who will never be incorporated in those plans.

The CHAIRMAN. How many will be incorporated in those plans?

Dr. SENSENICH. That I cannot say, they have not had a sufficient time to develop.

The CHAIRMAN. The American Medical Association always opposed those plans in the past?

Dr. SENSENICH. No, they have favored them for some years past, on an experimental basis, but there has been no actuarial experience, and it would be folly to have promoted or encouraged the establishment of a great many plans that would ultimately fail, because there was not sufficient actuarial experience.

The CHAIRMAN. Would it be possible in any length of time to develop these voluntary systems to such a degree that they would be capable of furnishing proper and complete medical care and hospitalization to the people of this country? I mean to say outside of those who are in the indigent classes, unable to contribute anything?

Dr. SENSENICH. Well, in fact, not everyone would subscribe to any kind of insurance, and not everyone whom you included in the compulsory plan would utilize the service that was obtainable under that plan. Just as long as you have individuals, and a free government, of course they will do as they like. However, a sufficient amount of education would stimulate interest.

Now, we are the most insured nation in the world. I think that we have some 80 million people covered by some kind of insurance. There is nothing like it anywhere, and with a little encouragement and more facilities available, there is no question that that would grow and continue to grow. However, there would be some who would not be included, but after all, we cannot control every individual.

The CHAIRMAN. But these plans do not give adequate coverage in the way of medical care and hospitalization. For instance, would you describe some of the medical plans that you know of which you believe would be complete as an answer to this question?

Dr. SENSENICH. Some of the plans cover catastrophic illnesses only and surgery.

The CHAIRMAN. Give me the name of some of them.

Dr. SENSENICH. I cannot give that off-hand, I would be glad to furnish that for the record.

The CHAIRMAN. Well, you are familiar with the Michigan Medical Service?

Dr. SENSENICH. Yes, sir; you have a report on that.

The CHAIRMAN. How does that compare with the coverage of the Murray-Wagner-Dingell bill?

Dr. SENSENICH. It does not include as much as the Murray-Wagner-Dingell bill.

The CHAIRMAN. It only provides surgical care and a partial maternity care.

Dr. SENSENICH. And also partial medical care, as I understand it. However, there are areas in which it covers everything.

The CHAIRMAN. I do not understand that it gives anything except the surgical care and the partial medical care.

Dr. SENSENICH. There are some of the plans, Senator Murray, that cover hospitalized illnesses and some others in which they are extending the service out to calls in the home. And there are some of those that are not included in these plans, but there are commercial plans that pay for service in the homes.

The CHAIRMAN. But none of them cover complete service such as the bill before us?

Dr. SENSENICH. Not at this time, sir.

The CHAIRMAN. And all of them have qualifications which make it available only to selected groups, people of selected groups?

Dr. SENSENICH. They were dependent in their early experience, while they were attaining some actuarial knowledge, upon some kind of selection, and therefore they had to limit it to people who were employed. Assuming the fact that they were employed meant some reasonable measure of health, and so on. Those things have all obtained, but they are expanding now as their information increases.

The CHAIRMAN. But none of them are getting away from those restrictions which were mentioned here?

Dr. SENSENICH. Yes; they are.

The CHAIRMAN. My understanding is that most or all of these 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, and some are limited to particular occupational or other groups, and then the services are all limited, so that a person might be insured in one of those organizations for years and yet when he suffers a severe illness, he would not get any benefit, because the coverage is so narrow in scope that he would not be able to take advantage of his position as a member of one of those groups.

Dr. SENSENICH. That is all in process of development, Senator Murray. If you turn back to page 10 on my report, if you wish, there are certain standards of acceptance for medical-care plans, and they will be encouraged.

The CHAIRMAN. What page is that?

Dr. SENSENICH. Page 10, Senator Murray. It goes into the matter of provision, subscriber contracts, and they are all operating under State law. They must be financially dependable, and as time goes on and experience and funds permit, why the benefits are increased to cover additional risks and additional time of hospitalization, and so on.

Senator PEPPER. Is it not a fact, following Senator Murray's inquiry, that only about 3 percent of the people of the country are given, under the voluntary plans, anything like the comprehensive coverage that the Wagner-Murray-Dingell bill would extend?

Dr. SENSENICH. I cannot give you at the moment the exact percentage, I can give you that later. I will be glad to give that to the committee.

Senator PEPPER. Now, a minute ago, you said that maybe a family head with \$1,000 annual income—

Dr. SENSENICH. Money income, may I say.

Senator PEPPER. All right. What is that; that is a little over \$80 a month, is it not?

Dr. SENSENICH. That is right.

Senator PEPPER. You think that a family head can pay rent, buy food, clothes, and the other necessities of life, and at the same time be able to pay the doctor his fee, and pay the hospital its fee and pay the nurse her fee, and pay for the incidentals required in hospital care—you think that that could be done under the private system?

Dr. SENSENICH. Senator Pepper, when the \$1,000 was mentioned, I was talking about the farmer who paid no rent, the individual who had most of his living from other sources, and he had \$1,000 clear money to pay out on these things, and not every year has an illness, and not every illness requires a nurse. There are many variations there.

Senator PEPPER. When they do, then what happens?

Dr. SENSENICH. If they do, then they usually have some postponed payment or they—

Senator PEPPER. Or they go into debt.

Dr. SENSENICH. Well, 52 percent of the purchases are on a time basis, they go into debt for other things to much greater degree than they do for medical services.

Senator PEPPER. You think many people in that category buy many of the things that require them to go into debt. Doctor, do you not know as a matter of fact they just do not get, except in rare cases, the kind of medical care that the man who can pay for it gets for his family?

Dr. SENSENICH. Senator Pepper, I think that we are not thinking about the same communities at all. I know communities where they can get just as much medical care when they do not have anything.

Senator PEPPER. By charity you mean?

Dr. SENSENICH. By charity or they postpone payment. We have that kind of machinery in my own community. I admit that there are areas in some of the Southern States where nothing is available to them, and part of that is due to the Government.

Senator PEPPER. I have some statistics which show that in the family-income group from nothing to \$449, 6.9 percent get any kind of charity in respect to health care, whereas 13.9 percent of rural nonfarm people get some charity and medical care in that group, and 17.3 percent in the cities. Practically, only one-third as many people in the country in that income group get any kind of charity in the medical field as get it in the urban areas.

In all of the categories under \$3,000 a year, in a group that was examined, only 6.4 percent got any kind of charity medical care, dental or otherwise, and 12.5 percent in the other areas got some kind of charity. So that that shows that it is very probable that relatively few of the people who needed medical care and were unable to pay for it, got it by charity.

Dr. SENSENICH. But, Senator Pepper, you are assuming the probability that they needed the care, and, as a matter of fact, we explored some years ago a number of those areas and found, much to our surprise, that even though they had no charity and they had very small incomes, they enjoyed very good health and their incidence of impairment was no greater than it was in urban communities with plenty of facilities available.

Senator PEPPER. Your position is that the people of the United States need relatively little more hospital and medical care than they are now getting?

Dr. SENSENICH. In many areas it is true, and in many areas they need a great deal.

Senator PEPPER. What about the areas where it is not true?

Senator DONNELL. Would you pardon me just a moment; may I make a point of order, Mr. Chairman, with due respect to the Senator and to the Chairman, I think the doctor should be permitted to answer the question fully without interruption, and I know the Senator from Florida admits that, too.

Senator PEPPER. Had you finished that yet? I wanted to ask you about the many areas in which it is not true.

Dr. SENSENICH. Then provision should be made, first of all, with facilities, and secondly, it should be determined what they need, and if they need medical men, and then the means to be provided. The thing that I do not like, and the profession generally does not, is that the entire population should be regimented into a plan simply to care for a relatively much smaller group. Now, I realize that you will say there are more than I say there are, but the best information available is the factual data which we had back in 1940, which was a much more extensive survey than anyone else had made.

The CHAIRMAN. What did that show generally, without going into detail?

Dr. SENSENICH. I really cannot answer the question without going into some detail.

The CHAIRMAN. It showed there were good health conditions?

Dr. SENSENICH. Yes.

The CHAIRMAN. How does that correspond with the reports of the Selective Service Commission which found that as a result of ill health and defective conditions, that 40 percent of the boys examined had to be rejected?

Dr. SENSENICH. Senator Murray, we have a witness following me, Dr. Goin, who will go into detail on the draft situation.

The CHAIRMAN. I merely wanted to point that out now, because that is in conflict with the statement that you just made.

Dr. SENSENICH. The assumption of 40 percent is subject to considerable variation and also some correction, and if you will permit me, we will have Dr. Goin tell you about that later.

Senator PEPPER. If you will permit me to call attention to some of the disclosures of our subcommittee's report:

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. 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 (spatic paralysis) victims.

It was our opinion that the people of the United States are not getting the medical care that they should be getting.

Dr. SENSENICH. That involves a good many things which will be covered by witnesses later, with reference to the distribution of hospitals and charity.

The CHAIRMAN. You are not prepared to discuss with us the medical-service plans that we have mentioned here? You have not made an exhaustive study of the different plans for prepaid medical care that are being advocated?

Dr. SENSENICH. We have a statement here from the director of our prepayment plan insurance group, and if I may have permission to have it included in the record, and that copy will be available to you.

The CHAIRMAN. Will he appear here for cross-examination?

Dr. SENSENICH. He is not able to.

The CHAIRMAN. We would like to, if we could, discuss with someone representing your profession the voluntary plans that are proposed and which you say are being developed. We think that it will be impossible to ever develop them to the degree that they will provide the American people with adequate modern medical care and hospitalization.

Senator DONNELL. I take it that the chairman does not mean to be expressing the opinion of all of the members of our committee in that statement. I say that with all due respect. I realize the chairman is of that opinion, but the committee itself has not yet passed upon that question.

The CHAIRMAN. I shall modify it to that extent, but I am satisfied that when they hear the evidence, they will recognize it.

Senator DONNELL. I mean no discourtesy to the chairman in the slightest, but the committee has not acted upon that question.

The CHAIRMAN. But I am satisfied that when the committee hears all of the evidence, that they will agree with me, that it is impossible under any voluntary system in the United States to furnish the American people with a system of prepaid medical care and hospitalization. I am so convinced of that, that I was led into the mistake of including all of the members of the committee in support of the statement. I will withdraw it now, and merely say that that is my judgment, and that is the judgment I think of everyone who has made a study of these plans, and I am sure the testimony will convince you.

Dr. SENSENICH. It was not possible to put on someone on all of these phases, in the time allotted to us.

The CHAIRMAN. But this is the most important phase. It seems to me someone from the American Medical Association should come here prepared to convince the committee that we can take care of this problem in the United States by a voluntary system. I do not know of anything more important than that.

Dr. SENSENICH. If the chairman will permit, we have three other witnesses. One will deal especially with the matter of statistics as to

need. We think first of all need is the most important thing to discuss. The second will deal with the hospitals and medical facilities, and the third will deal with operations of plans of this type, and we have added the record from the head of our department of prepayment insurance, for a part of your record, also. May I say at this time that we will be happy to assist the committee in any way that we can in the consideration of the legislation.

Senator DONNELL. May I ask the doctor just a few questions, please?

Doctor, I take it that all parties, physicians, and laymen as well, generally realize the importance of improving health conditions to as practicable an extent as possible, that is correct, is it not?

Dr. SENSENICH. Yes, sir.

Senator DONNELL. And the American Medical Association has been keenly alive to that problem, has it not?

Dr. SENSENICH. That is right.

Senator DONNELL. And as pointed out in your statement at page 6, at a meeting of the house of delegates of the American Medical Association held in Chicago December 3 to 5 of last year, the house of delegates made a report, a paragraph of which is quoted in your report as follows:

All of these plans—

That is, referring to voluntary prepayment medical-care plans—

All of these plans show a uniformity of desire for the immediate setting up of a national plan on a voluntary basis. In all of them the urgency of this being done is stressed. Accordingly your reference committee recommends that the house of delegates of the American Medical Association instruct the board of trustees and the council on medical service and public relations to proceed as promptly as possible with the development of a specific national health program, with emphasis on the Nation-wide organization of locally administered prepayment medical plans sponsored by medical societies.

That was passed?

Dr. SENSENICH. Yes, sir.

Senator DONNELL. And there was a conference held in Chicago in February of this year at which time there was organized a corporation to be known as the Associated Medical Care Plans, a national non-profit organization, is that correct?

Dr. SENSENICH. Yes, sir.

Senator DONNELL. And the details of the objects of the new corporation are set forth in your statement which is being filed with the committee?

Dr. SENSENICH. That is right.

Senator DONNELL. The point I desire to make, Doctor, is this: That the American Medical Association is approaching this problem with what it deems to be the utmost of speed, consistent with efficiency in the solution of it; is that right?

Dr. SENSENICH. Yes, sir.

Senator DONNELL. I want to take this opportunity of concurring with our distinguished chairman in the importance of the American Medical Association presenting to this committee its views and its reasons for thinking that voluntary methods can be adopted, and I join thoroughly with him in the hope that the medical association will give to us the benefit of all such evidence as it can.

Doctor, I would like to ask you one question at this moment, arising out of a comment made by Mr. Green, of the American Federation

of Labor, yesterday in his very interesting testimony. He suggested, in substance, that the source of the funds of various organizations which are opposing the plan embodied in S. 1606 be made the subject of inquiry, and in response to a question asked him, he at that time indicated that he thought the American Medical Association was one of those organizations, the funds to support which should be inquired into. May I ask you if you would be kind enough to state to the committee the source from which the funds which finance the American Medical Association are derived?

Dr. SENSENICH. I will be very happy to, sir. There is no secret about it. We have dues from the fellows of the American Medical Association, and we receive no dues from the members of component societies. We publish certain medical publications from which there is advertising income, and that is the source of our income.

Senator DONNELL. Do you have income from advertisements in your American Medical Journal which is published?

Dr. SENSENICH. Yes, sir.

Senator DONNELL. Do you know about the proportion of the annual income which is derived from advertising?

Dr. SENSENICH. I could not say that offhand. I would be glad to give you that information. The point is that the journal is furnished to each Fellow for \$8, and the journal costs more than that to publish. Now, there is some coverage from the advertising income, but it would not be possible to publish the journal at that income per year if there were not some advertising from it. We have no other sources of income.

Senator DONNELL. I was doing the very thing that Senator Pepper was doing, breaking in on your answer, but would you be kind enough to furnish for our files a brief compilation of the sources of income of the American Medical Association during the year 1945?

Dr. SENSENICH. I would be very happy to; it is published each year in the journal and I will be very glad to.

(The information is as follows:)

AMERICAN MEDICAL ASSOCIATION,
South Bend 5, Ind., June 4, 1946.

The Honorable JAMES E. MURRAY,
Committee on Education and Labor,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: In compliance with the request made of me at the time of my appearance before the Senate Committee on Education and Labor, I am enclosing herewith a complete auditor's report of the finances of the American Medical Association for the year 1945.

You will note that the last few pages of the report consist of a break-down of the expenditures made by the various councils, bureaus, and committees of the association. The work performed by these subdivisions is largely in the interest of scientific advancement and protection of the public health.

During the war the number of employees of the American Medical Association was reduced by approximately 300 so that the amount expended for wages and salaries during 1945 was much less than it normally is or will be during the present year as these employees are gradually returning or being replaced.

I should like to invite your attention to an entry in exhibit B entitled "Employees' group annuities" amounting to \$133,492.16. Several years ago the association established an annuity retirement fund. This is employee and employer participation. There is also an entry in schedule 1 of \$11,001.53, which was expended for group hospital and life insurance for employees.

May I again take this opportunity to offer our services to you in any way that might be helpful?

Very truly yours,

R. L. SENSENICH, M. D.,
Chairman, Board of Trustees, American Medical Association.

REPORT OF THE TREASURER AND OF THE AUDITORS, AMERICAN MEDICAL ASSOCIATION, 1945

TREASURER'S REPORT

Report of the treasurer of the American Medical Association for the year ended Dec. 31, 1945

Investments (at cost) as at Jan. 1, 1945.....	\$4, 596, 850. 47	
Bonds purchased (at cost).....	2, 304, 955. 36	
Total	6, 901, 805. 83	
Less: Bonds called, matured, or sold.....	1, 312, 537. 36	
Investments as at Dec. 31, 1945.....		\$5, 589, 268. 47
Balance for investment Jan. 1, 1945.....	67, 065. 86	
Interest received on investments year 1945.....	123, 125. 90	
Total	190, 191. 76	
Transferred to general fund.....	63, 367. 40	
Uninvested funds Dec. 31, 1945		126, 824. 36
Invested and uninvested funds as at Dec. 31, 1945.....		5, 716, 092. 83
Davis memorial fund:		
Balance in fund Jan. 1, 1945.....		\$7, 806. 15
Interest earned on bank balance year 1945.....		97. 86
Funds on deposit as at Dec. 31, 1945		7, 904. 01

JOSIAH J. MOORE, *Treasurer.*

AUDITOR'S REPORT

JANUARY 29, 1946.

To the Board of Trustees, American Medical Association, Chicago, Ill.:

DEAR SIRS: We have examined the balance sheet of the American Medical Association, Chicago, Ill., as of December 31, 1945, and the statement of income for the year ended on that date, have reviewed the system of internal control and the accounting procedures of the association and, without making a detailed audit of the transactions, have examined or tested accounting records and other supporting evidence, by methods and to the extent we deemed appropriate except as hereinafter stated regarding confirmation of receivables and observation of the inventory taking.

The cash and bank balances have been confirmed by count or by certificates from the depositories. The United States Government and other marketable securities were confirmed by an acknowledgment from the Continental Illinois National Bank & Trust Co. of Chicago where the securities are held for safe-keeping.

We did not independently confirm the accounts receivable by communication with the debtors. The accounts receivable were reviewed as to age and collectibility and, in our opinion, the balances are fully realizable. We reviewed the plan and system of control adopted for inventory taking but we did not observe the taking of the inventories nor did we make tests of the physical existence of the quantities recorded.

Expenditures charged to property and equipment accounts during the year, in our opinion, were properly capitalized as representing additions or improvements. The provision for depreciation for the year appears to be adequate.

We have received a letter from Messrs. Loesch, Scofield, and Burke, attorneys for the association, stating that the Supreme Court of Illinois has affirmed, in January 1946, the judgment of the circuit court that the association is required to make contributions under the provisions of the Illinois Unemployment Contributions Act. The amount of the contributions payable by the association for the period involved (1937 to date) is approximately \$260,000, of which \$37,000 is applicable to 1945, plus whatever interest and penalties may be imposed. The liability referred to has not been included in the accounts payable at December 31, 1945, and no charge in respect thereto has been made against the income of the period involved. The management considers that the accounts reflect ample

provision for the liability, in the association reserve and its related fund. The attorneys state that no other litigation is pending against the association.

In our opinion, subject to the exceptions set forth in the preceding paragraphs, the accompanying balance sheet and related statement of income present fairly the position of the American Medical Association at December 31, 1945, and the results of the operations for the year, based on the accounting procedures employed by the association regarding which the following observations are submitted:

(a) In accordance with the established practice of the association, the accounts as stated do not include (1) unrecorded assets in respect of accrued interest on bond investments and membership dues unpaid; and (2) provision for accrued property taxes for the year 1945, and sundry unpaid bills and wages.

(b) Subscriptions paid in advance are stated at an estimated amount which is based on cash received in December 1945 on account of 1946 subscriptions. This procedure conforms to the method used in prior years.

(c) Advance payments on publications include an estimated amount (\$186,552.42) for prepaid subscriptions to Hygeia, and the amount (\$118,933.83) received in advance for January 1946 advertising, directory information sales, and service.

Fidelity insurance is carried against the undermentioned officers and employees in the amounts stated:

Dr. Olin West, secretary and general manager.....	\$10,000
Dr. Josiah J. Moore, treasurer.....	10,000
E. A. Hoffman, cashier.....	10,000
J. E. Hartigan, assistant cashier.....	2,000
Joseph T. O'Connor, accountant.....	2,000
Sundry employees (15, \$1,000 each).....	15,000
Total fidelity insurance.....	49,000

We have pleasure in reporting that the books are well maintained and that every facility was afforded us for the proper conduct of the examination.

Yours truly,

PEAT, MARWICK, MITCHELL & Co.

INDEX TO STATEMENTS

Balance sheet as of Dec. 31, 1945.....	<i>Exhibits</i>	A
Income account for the year ended Dec. 31, 1945.....		B
	<i>Schedule</i>	
Publications (periodicals), costs and expenses for the year ended Dec. 31, 1945.....		1
Expenses of councils, bureaus, and committees for the year ended Dec. 31, 1945.....		2

EXHIBIT A. Balance sheet as of December 31, 1945

Assets:		
Property and equipment, at cost:		
Land.....		\$328,773.98
Buildings.....	\$1,375,349.31	
Machinery and printing equipment.....	518,343.32	
Office and laboratory equipment.....	203,611.71	
	<u>2,097,304.34</u>	
Less reserve for depreciation.....	1,086,313.33	
		1,010,991.01
Type metal (book inventory) at average cost.....		<u>23,003.53</u>
Total, property and equipment.....		1,362,768.52
Marketable securities, at cost (valuation based on market quotations, \$5,725,958.77):		
United States Government securities.....	\$3,986,419.11	
Railroad, municipal, public utility, and industrial bonds.....	1,602,849.36	
		<u>5,589,268.47</u>

Assets—Continued

Marketable securities, at cost—Continued

Representing investments of—

General fund-----	\$2,414,268.47
Depreciation reserve fund-----	1,100,000.00
Association reserve fund-----	350,000.00
Building reserve fund-----	450,000.00
Retirement reserve fund-----	675,000.00
Equipment modernization reserve fund-----	600,000.00

Cash held by treasurer for investment-----		\$126,824.36
Cash in banks and on hand-----		232,930.93
Accounts receivable:		
Advertising-----	\$222,145.33	
Reprints-----	2,546.20	
Directory report service, eighteenth edi- tion-----	2,153.13	
Miscellaneous accounts receivable-----	3,390.76	
		230,235.42
Inventories of materials, supplies, work in progress, and publications-----		86,412.03
Expenditures on publications in progress-----		157,959.85
Prepaid expenses, deposits, and advances:		
Insurance, etc-----	\$2,756.81	
Deposits and advances-----	8,997.15	
		11,753.96
Total-----		<u>7,798,153.54</u>

Liabilities:

Accounts payable:

Cooperative medical advertising bureau-----	42,874.55
Miscellaneous-----	72,834.66

Total, accounts payable-----	115,709.21
Subscriptions paid in advance-----	23,068.85
Advance payments on publications-----	305,486.25

Net worth:

Association reserve-----	\$350,000.00
Building reserve-----	450,000.00
Retirement reserve-----	675,000.00
Equipment modernization reserve-----	600,000.00

Capital account:

Balance at Dec. 31, 1944-----	\$4,738,180.42
Add net income for the year ended Dec. 31, 1945-----	990,708.81

Total----- 5,728,889.23

Deduct amounts transferred dur- ing year to re- tirement reserve (\$150,000) and to equipment modernization reserve (\$300,- 000)-----	450,000.00
	<u>5,278,889.23</u>

Net worth, Dec. 31, 1945----- 7,353,889.23

Total----- 7,798,153.54

EXHIBIT B.—Income account for the year ended Dec. 31, 1945

Income:			
Fellowship dues	-----		\$62, 617. 00
Income from investments	-----		116, 840. 21
Miscellaneous receipts and other income	-----		20, 535. 71
Total	-----		199, 992. 92
Publications—periodicals:			
Subscriptions	-----	\$1, 332, 631. 22	
Advertising	-----	1, 920, 465. 58	
Total	-----	3, 253, 096. 80	
Costs and expenses, schedule 1	-----	1, 808, 381. 36	
			1, 444, 715. 44
Books, pamphlets, and reprints sold	-----	107, 440. 99	
Less printing and other costs	-----	64, 696. 56	
			42, 744. 43
Total income	-----		1, 687, 452. 79
Expenses:			
Conducting councils, bureaus, and committees, schedule 2	-----	\$537, 611. 66	
Legal and investigating	-----	20, 230. 55	
Employees' group annuities	-----	133, 492. 16	
Miscellaneous	-----	5, 409. 61	
			696, 743. 98
Income in excess of expenses	-----		990, 708. 81

SCHEDULE 1. Publications (periodicals) costs and expenses for the year ended Dec. 31, 1945

Wages and salaries	-----	\$872, 540. 79
Paper stock	-----	298, 666. 07
Engravings and illustrations	-----	45, 326. 28
Ink	-----	20, 994. 52
Factory and mailing supplies	-----	19, 647. 60
Repairs and renewals, machinery	-----	2, 886. 99
Express and cartage	-----	11, 851. 48
Power and light	-----	14, 713. 79
Building expense	-----	45, 993. 07
Fuel	-----	6, 255. 89
Insurance and taxes	-----	34, 626. 68
Editorials, news, and reporting	-----	16, 034. 43
Postage:		
First class	-----	48, 022. 07
Second class	-----	60, 479. 69
Commissions—subscriptions and advertising	-----	109, 195. 49
Discounts	-----	75, 623. 54
Exchange	-----	1, 649. 24
Subscription promotion expense	-----	12, 278. 74
Office supplies	-----	7, 439. 96
Telephone and telegrams	-----	4, 763. 80
Office printing	-----	22, 317. 54
Binding	-----	4, 053. 80
Miscellaneous operating expenses	-----	25, 446. 43
Group hospital and life insurance	-----	11, 001. 53
Estimated cost to complete November-December 1945 issue of special journal publications	-----	15, 418. 22
Bad debts and recoveries, net	-----	(168.28)
Loss on metal dross sales	-----	515. 83
Total	-----	1, 787, 575. 19

Depreciation (based on estimated remaining life):	
Buildings-----	\$23, 133. 80
Machinery-----	14, 862. 45
Type and factory equipment-----	1, 579. 81
Furniture and equipment-----	7, 552. 32
	\$47, 128. 38
Total-----	1, 834, 703. 57
Deduct proportion of overhead expense charged to other publications and departments-----	26, 322. 21
Total publications (periodicals) costs and expenses-----	1, 808, 381. 36

NOTE.—Total wages and salaries for year 1945 amounted to \$1,342,149.45. Of this amount \$872,540.79 is included above, \$328,699.82 is shown in schedule 2 (expenses of councils, bureaus, and committees), and the remainder, \$120,908.84, was disbursed on the maintenance of records which will be used in connection with the next edition of the American Medical Directory and with the printing of books, reprints, and pamphlets, and printing in process at the close of the year.

Schedule 2. Expenses of Councils, Bureaus and Committees for the year ended Dec. 31, 1945

Salaries and wages-----	\$328, 699. 82
Office printing-----	16, 286. 22
Office supplies and repairs-----	7, 161. 18
Express, telephone, and telegraph-----	6, 679. 66
Postage-----	13, 796. 41
Binding-----	463. 75
Books and periodical subscriptions-----	1, 378. 18
Legislative services-----	2, 971. 91
Educational material distributed-----	6, 854. 20
Travel-----	21, 044. 05
Radio broadcasting-----	23, 985. 84
Inspection of hospitals and medical schools-----	3, 706. 93
Association exhibits-----	7, 188. 27
Trustees' meeting expenses-----	9, 206. 83
Consultations, investigations, tests, and honorariums-----	19, 672. 62
Section secretaries' conference and honorariums-----	2, 688. 51
Council and bureau conferences-----	23, 082. 00
Committee on scientific research-----	2, 977. 13
Other committee expenses-----	15, 223. 84
Miscellaneous-----	24, 544. 31
	537, 611. 66
Total expenses of councils, bureaus, and committees-----	537, 611. 66

NOTE.—The above expenses are spread over the following councils, bureaus, and committees as indicated: Association account, \$141,413.86; Bureau of Health Education, \$56,241.70; Council on Pharmacy and Chemistry, \$49,547.06; Chemical Laboratory, \$21,102.14; Council on Physical Medicine, \$24,261.78; Council on Foods, \$16,583.50; Committee on Therapeutic Research, \$13,358.97; Council on Medical Education and Hospitals, \$60,948.84; Bureau of Legal Medicine and Legislation, \$33,145.67; Bureau of Investigation, \$9,164.90; Bureau of Medical Economics, \$6,309.26; Council on Industrial Health, \$21,152.22; Association and Bureau of Exhibits, \$22,795.12; Council on Medical Service and Public Relations, \$50,342.97; Committee on Medical Preparedness, \$11,243.67.

EXPLANATORY NOTES AND BREAK-DOWN OF SCHEDULE 2 FOR YEAR ENDING,
DEC. 31, 1946

Association account-----	\$141, 413. 86
--------------------------	----------------

This includes such items as selective retirement salaries for individuals too old to participate in our pension retirement fund, salaries of the secretary's office, honorariums for trustees and section secretaries, etc., who meet at odd intervals during the year, and the expense of certain committees not included in other break-downs (rural medical service, medical motion pictures, American health resorts, war participation committee, etc.).

Bureau of Health Education.....	\$56, 241. 70
<p>This bureau serves the public either directly or through component county and constituent State medical societies. Its principal functions are broadcasting network radio programs, supplying scripts and electrically transcribed recordings for local radio programs, cooperating in radio broadcasts by other organizations, furnishing reprints and pamphlets in the field of health education for general distribution, attending and addressing various meetings of lay groups, and answering through correspondence questions on matters of health. This bureau also cooperates with governmental and voluntary public health and lay organizations that have interests in the field of health education.</p>	
Council on Pharmacy and Chemistry.....	49, 547. 06
<p>This council consists of 17 specialists in the field of science, each one being a leader in his particular specialty. The council was organized in 1905 with the primary object of protecting the public against fraud, undesirable secrecy, and objectionable advertising in connection with proprietary medicinal articles. The council at the present time also functions as an adviser to the medical profession concerning the status of medicinal articles the profession is importuned to use. Reports on claimed advances in the use of drugs and standards for the control and identity of these drugs are published. The council has recently established a therapeutic trials committee as a standing committee of the council, whose fundamental objective is to stimulate progress in the control and treatment of disease through facilitating investigations to establish the usefulness and limitations of diagnostic, preventive, and therapeutic agents.</p>	
Committee on therapeutic research.....	13, 358. 07
<p>This is a standing committee of the Council on Pharmacy and Chemistry, which is interested in the development, promotion, and advancement of diagnosis and in the prevention and treatment of disease with special emphasis on therapeutics.</p>	
Chemical laboratory.....	21, 102. 14
<p>This laboratory was established in 1906 to aid the council on pharmacy and chemistry in the evaluation and standardization of medicinal products. The laboratory also supplies chemical data for the bureau of investigation. It performs no commercial work or work for individual physicians but limits its activities to investigation of products of general interest to the medical profession.</p>	
Council on physical medicine.....	24, 261. 78
<p>This council was established with the primary purpose of gathering and disseminating such information as will assist the medical profession in determining the therapeutic and diagnostic value of certain devices and methods employed in the practice of medicine. The membership of the council is composed of pathologists, surgeons, clinicians, physicists, physiologists, and radiologists.</p>	
Council on foods and nutrition.....	16, 583. 50
<p>This council was organized to evaluate nutritional claims for food products. It is composed of 11 persons selected because of their knowledge of those branches directly concerned with food composition, nutrition, and health. Voluntarily submitted foods, accompanied by complete advertising data and information on ingredients, manufacturing processes, bacteriologic examinations, etc., are appraised. Only those foods are considered at present which are offered as special-purpose foods and a few generally used foods of particular importance to the public health. This council has caused extensive changes in food advertising in order to protect the public and has also sponsored publication in the Journal of the American Medical Association of authoritative and informative reports on various nutritional subjects.</p>	

Council on medical education and hospitals----- \$60, 948. 84

This council has brought the standards of medical education in America to such a high level that they are recognized throughout the world. Through the council's activities, college entrance requirements have been raised to a reasonable point, college sessions have been lengthened, courses reorganized, better buildings and laboratories secured, better equipment provided, including libraries and museums, more and better teachers employed, better clinical material obtained, and more improved methods of teaching adopted. The council acts as a guard to keep the medical field from being overrun and discredited by the unfit. The council also collects and disseminates information about hospitals, including listings of hospitals approved for internships and for residences in the specialties. It also lists recognized schools for the training of occupational physical therapy, X-ray and laboratory technicians as well as medical record librarians.

Bureau of legal medicine and legislation----- 33, 145. 67

This bureau keeps in touch with court decisions, legislation, and other matters of medico-legal significance. The information acquired is available on request, and important matters are frequently published in the Journal of the American Medical Association. The bureau does not undertake to give legal advice to physicians concerning specific problems of purely personal interest.

Bureau of investigation----- 9, 164. 40

This bureau acts as a clearing house of information on patent and proprietary medicines, all forms of quackery, medical fads and fakes. Thousands of letters are received annually by the bureau relative to these matters. These letters come from physicians and laymen, including many from students.

Bureau of medical economics----- 6, 309. 26

This small bureau is really a statistical organization which collects, tabulates, and studies data pertaining to the economics of the practice of medicine. Reports of studies are published from time to time.

Council on industrial health----- 21, 152. 22

This council was organized to improve standards in the field of industrial medical practice. Its principal functions are to inform the profession of developments in the industrial field of a medical or medico-social nature, to foster research and stimulate training in this special field, and to employ all available means to protect the health of working people against illness and injury.

Bureau of exhibits----- 22, 795. 12

This bureau promotes graduate medical instruction and disseminates health education. It functions under the committee on scientific exhibit of the board of trustees. It cooperates with constituent State medical societies and other scientific groups in the presentation of exhibits on medical subjects at various meetings through the country. Certain motion pictures are supplied to county medical societies, hospitals, and medical schools on request. In the field of health education both exhibits and motion pictures on health subjects are shown at fairs, expositions, and other public gatherings.

Council on medical service and public relations----- 50, 342. 97

This council was authorized in June 1943 and its functions are to make available facts, data, and medical opinions with respect to timely and adequate rendition of medical care to the American people, to inform constituent associations and component societies of the activities of the council, and to investigate matters pertaining to the economic and social aspects of medical care for all of the people. The council sets up standards for the acceptability of nonprofit medical care plans. The public relations functions of the council is limited to the dissemination of information largely to medical groups.

Committee on medical preparedness..... \$11, 243. 67

This committee was organized to be of service to the Government during the present war emergency. It furnished information as to the availability of the medical profession and as to the special qualifications of individual physicians. It was on the basis of this committee's recommendation that the procurement and assignment service was established. The committee has served its purpose and has been discontinued. Its place has been taken by the committee on postwar medical service, which has members representing hospital associations, various scientific groups, and governmental agencies all working to aid the returning veteran in his reentry to medical practice.

Senator DONNELL. Another matter that I would like to ask you about is this: You spoke of the comparative health in the United States and other countries. Has there been a compilation of statistics on that question prepared and does it appear in your testimony?

Dr. SENSENICH. There has been one prepared insofar as the information is now available in war-torn countries. The information that we have we can depend upon is of a little earlier date. I am under the impression that we had it in this report. Just excuse me for a moment, and I will see if I can find that.

The CHAIRMAN. While you are looking for that, I would like to call attention to the fact that Dr. Fishbein declares in his editorials in the Journal of the American Medical Association that health conditions and standards of medical service are higher in the United States than anywhere else in the world. But at the same time it is found from investigation that the United States is not the healthiest country in the world. Take for example, the infant and maternal mortality rate. In 1942, 40 babies died at birth for every 1,000 born. In one State the rate was 98, and 80 in another, and we find similar conditions in many parts of the country. My understanding is that a study of comparative health conditions in this country with some other countries of the world shows that the United States is not the healthiest country in the world.

Dr. SENSENICH. Senator Murray, I think that that is included in the presentation of Dr. Howard. When you compare health statistics, you must know all of the facts. When it comes to children, for instance, I picked up the report of the health department in my own city the day before leaving, and I regret I did not bring it along, and the lowest rate quoted as I understand is Sweden which is 2.9 per thousand, and South Bend was 2.6 and a half. The rate is very much better in Sweden than it is a good many other places. But you must remember when you are dealing with infant mortality that there are many ways in which the information is gained. I have it on good authority that the English do not judge their infant mortality on the same basis that we do. I am letting others go into that in more detail, but the figures themselves are somewhat misleading.

We have and we do maintain that we have the best health, and I think that we can judge that. For instance, in New Zealand the figures given refer only to the European population, the white population. We include everybody in our statistics.

The CHAIRMAN. Of course, when we discuss this problem which is the healthiest nation of the world, we overlook the fact that even in the healthiest nations in the world and in our country here, notwithstanding the fact that it is comparatively better than other countries,

there are thousands of people every day going without medical care because they are unable to pay for it.

There is no dispute on that. It is a fact that throughout the country people in fairly moderate conditions fail to avail themselves of medical care because of the high cost. A man at the head of a family, with children going to school, and earning a fair income of say \$2,000 or \$3,000 a year, is afraid to incur the expense of medical examinations, and medical treatment because of the high cost of such services. There is no question about that. It seems to me that some way must be found to make it possible for everyone in this country to overcome these barriers and have access to the best possible modern medical care and hospitalization. We do not have it, and the country suffers severely. As a result of ill health in this country, we lose millions of dollars every year. Nothing could be better for the welfare of our country than to have some system whereby every family can get this care without hesitation.

Dr. SENSENICH. Senator Murray, I would not deny that there are people who should have medical care who are not getting it. From my own experience as a practicing physician for a good many years, and I do my turn on the staff duty on the hospitals as well, I can say definitely that the number of people who come to me or appear as charity patients in the wards, or with whom I come in contact who are ill, who have not had medical care because they have neglected the case, or because they feared the expense, is negligible as compared to the individuals who did not have medical care because they neglected it. That is our principle difficulty.

I admit that there are areas and there are individuals where education, public health education and many things are lacking, and the whole problem is a little more complex than simply the provision of an insured medical service. I would be glad to go into that.

Senator PEPPER. Doctor, further referring to the report of the subcommittee made on page 3, we have compiled the data to show that between the ages of 15 to 64—this is from the National Health Surveys—the data on the group between the ages of 15 to 64, in the category of less than \$1,000 annual income show that they had 11.6 days of illness a year. In that group they received 2.2 doctor's calls. There is 11.6 days of illness and only 2.2 doctor's calls in the year in the group receiving \$1,000 or less.

In the group receiving \$1,000 and less than \$2,000, the same age group, they had an average of 7.9 days of illness a year, and they also got substantially the same number of doctor's calls.

In the group below \$4,000, they had 6.7 days of illness a year, and they received three doctors' calls a year.

But when you get up in the highest group, above \$10,000 a year annual income, you had less than 7 days illness a year, and yet they had 5.5 doctor's calls.

So as you go from the bottom up in the economic scale, down at the bottom you find more days of illness and less doctor's calls. As you go up the ladder to the income group of \$10,000 or more you find fewer days of illness and more doctor's calls.

That obviously had a relationship to the ability to purchase the medical care.

Dr. SENSENICH. I am glad to discuss that with you. If that information was taken from the Public Health Service a few years ago

you must recall that the individual who had one leg off was ill so far as the record was concerned. He was counted, although obviously he needed no medical attention. The individual who had permanent impairment of any kind was counted as ill.

Senator PEPPER. Excuse me a minute. I do not want to interrupt you.

Dr. SENSENICH. Certainly.

Senator PEPPER. Leaving out the differences in the bases of the calculations, would you not say that is a basically correct principle, that as you said a while ago, the need is greatest in the income groups least able to pay?

Dr. SENSENICH. Senator Pepper, we have a witness following me whom I think will be able to show that in every insurance system in the world the period of illness increases, and the increase is very, very great.

Senator Pepper. I was getting at the basic thing you wanted to tell us. Of course, we have not given you very much chance to tell us, but the basic thing you started off to say was that you admitted that the lowest income groups of the Nation have the greatest need for medical and hospital care?

Dr. SENSENICH. That is right.

Senator PEPPER. Yet you felt it unsatisfactory to blanket into the same insurance system the people in those categories with the people in the higher income groups where the need for medical care was not so great, as I understood you.

Dr. SENSENICH. Because you are going to increase the rate to the rest of the people. If this person is medically indigent, we will say, then he should be frankly so treated. I do not like to mislead the rest of the group, who do not have such large incomes, to carry the burden of this group here. I think if they need assistance they should have assistance. We have said that again and again, but we object to the manner of assistance, because we feel it will cause the deterioration of the quality of medical care and service to the rest of the people.

Senator PEPPER. I believe you also said a while ago in response to a question of mine that you did believe that the people unable to pay for the kind of medical and hospital care they needed should have it?

Dr. SENSENICH. That is right.

Senator PEPPER. If they are unable to pay for it and they should get it, by hypothesis then the funds with which they shall get that care will have to come from some public source or out of the charity of the medical profession?

Dr. SENSENICH. That is right.

Senator PEPPER. If the funds come from a public source, will that not be raised from taxation?

Will not the people that pay the most of the tax be the people in the highest income group?

Dr. SENSENICH. But in this insurance plan you are not doing that.

Senator PEPPER. I am asking you, will that not be so?

Dr. SENSENICH. But the kind of tax at so much per head to the individual is not an even distribution.

Senator PEPPER. What I am asking is this: If we do not have an insurance system, you provide out of the public treasury, Federal, State, or local, the medical care needed by the people who cannot buy

it in the regular way. That money will have to be raised by taxation?

Dr. SENSENICH. That is right.

Senator PEPPER. And will not the people that pay the tax principally be the people in the higher income group?

Dr. SENSENICH. But they will not under this plan.

Senator PEPPER. I am not talking about the plan.

Dr. SENSENICH. If you are going to confine it to that, to the insured group, then the insured group are going to pay the tax. Now, not the group above. After all, if you are going to support it from taxation, the whole group ought to pay it.

Senator PEPPER. Then, if the whole group is going to pay it, do you want to put a sales tax or some other tax, and make the full payment into the Federal Treasury of the funds that will be donated out later to make up this medical service? If they do, it is the same as the insurance principle.

Dr. SENSENICH. I think not. I believe the taxes are set up to include everybody, and individual people according to ability to pay.

Senator PEPPER. You tax also according to ability. It is contemplated to be a percentage of pay roll up to \$3,000 a year.

The CHAIRMAN. \$3,600.

Senator PEPPER. The figure I have heard is that the worker pays $1\frac{1}{2}$ percent and the employer pays $1\frac{1}{2}$ percent and the self-employed pay 3 percent up to \$3,000 a year. The fellow who made \$600 a year would pay on the basis of what he made. The fellow who made \$3,000 a year would pay on the basis of what he made. That affords the central part of the funds out of which these services would be provided.

Dr. SENSENICH. May I say this, Senator Pepper: that after all the man who is insured and employed will pay once, but if he has two other earners then they pay three times. You are going to put the burden upon one group, this insured group, in proportion to the number of earners in the family to accumulate a fund to carry the indigent and those in between indigency whose burden should fall upon the whole group.

Senator PEPPER. If you provided funds out of the Federal Treasury by ordinary taxes, would not the earning members of a family pay the larger part of the taxes?

Dr. SENSENICH. But not to the same degree.

Senator PEPPER. They would pay it in to the Federal Treasury.

Dr. SENSENICH. They would not pay that amount of tax.

Senator DONNELL. May I ask a few questions, please, Mr. Chairman?

The CHAIRMAN. Yes.

Senator DONNELL. It seems to me, Mr. Chairman, that there is a very fundamental point that perhaps we have not emphasized in the questioning as much as we should have. As I understand the doctor's views, he inclines certainly toward the correctness of the statement referred to at page 3 of his testimony, in which he quotes from the reference committee as follows:

Positive proof exists from experience in other countries that inferior medical service results from compulsory health insurance.

Senator Tunnell directed a question along that line this morning.

I would like to ask a few questions along this line. I proceed with the hypothesis that everybody, all of us here in this committee, and

the doctors and the laymen alike, are interested in improving health conditions in our country. I am right in that, I believe.

Dr. SENSENICH. Definitely so, sir.

Senator DONNELL. I appreciate in your testimony, page 16, you point out statistics, as published in the Encyclopedia Britannica Book of the Year, 1943, of the comparative death rates of the large nations, that the rate in the United States was 10.5, England 12.9.

England has a compulsory system, has it not?

Dr. SENSENICH. Yes.

Senator DONNELL. Germany, 12.3; Bulgaria, 12.5; Sweden, 11.2; Chile, 19.8; Japan, 17.6; and New Zealand-European, 9.8.

Dr. SENSENICH. That is right.

Senator DONNELL. So that the comparative death rates indicated there, it would seem to me, Doctor, tend to substantiate you that the health conditions in this country are on the whole certainly favorable compared with those other nations?

Dr. SENSENICH. That is right.

Senator DONNELL. That does not limit the fundamental importance of attempting to improve the conditions?

Dr. SENSENICH. If we bring it down to 5.5, the American Medical Association would be very delighted.

Senator DONNELL. Yes, sir. May I supplement your testimony by pointing out that in addition to action of the house of delegates, in addition to the formation of the corporation to which I refer, one of the purposes of which is, by authority granted by the State of Illinois, to quote your testimony:

To promote the establishment and operation of such nonprofit, voluntary medical-care plans throughout the United States and Canada as will adequately meet the health needs of the public and preserve and advance scientific medicine and the high quality of medical care rendered by the medical profession of the two countries.

I say, in addition to that, I observe, as set forth in your statement, that a meeting of the commission to carry out these general ideas has been called for the 26th and 27th of this month.

Dr. SENSENICH. That is right.

Senator DONNELL. In Chicago. And you anticipate these plans will be presented for approval to the first meeting of the members of the corporation, now tentatively set to be held in San Francisco in July?

Dr. SENSENICH. That is right.

Senator DONNELL. Regardless of the fact that statistics seem to indicate our health conditions are perhaps better than we may realize, nevertheless the American Medical Association realizes the importance of the problem and is moving as rapidly as it can and as diligently as it deems practicable?

Dr. SENSENICH. That is correct.

Senator DONNELL. Doctor, your idea is that the experience of other nations shows that however desirable of embracing within the beneficent jurisdiction of any health insurance plan as many people as possible, that compulsory insurance has proved too defective in that it produces inferior quality of medical service?

Dr. SENSENICH. And prolongs illness.

Senator DONNELL. And prolongs illness.

The CHAIRMAN. Right there, could you have the doctor explain how he arrived at the theory that it results in the deterioration of medical care?

Dr. SENSENICH. May I look to the other witness who will follow me for that.

The CHAIRMAN. That is very confusing to the committee, to have a witness make statements of that character, and then not be able to substantiate them before the committee.

Dr. SENSENICH. They will be substantiated.

The CHAIRMAN. These hearings are very complicated, and I wish we could settle some of these questions as we go along. I think it is unfair to make a bald statement of that kind and have to wait for some other witness to prove it.

Dr. SENSENICH. The witness is waiting right here, sir. However, I can go into this much of it: immediately, when you remove responsibility and professional relationship between the patient and the physician and inject the Government between, the quality of service deteriorates.

The CHAIRMAN. Right there—

Dr. SENSENICH. Yes, sir.

The CHAIRMAN. This program does not do such a thing.

Dr. SENSENICH. It does not, sir?

The CHAIRMAN. No.

Dr. SENSENICH. When you go to the Surgeon General of the United States and give him the right to say who shall practice, who can come in, who cannot, what he shall be paid, the conditions under which he shall practice; there is no one in between the patient and the doctor?

The CHAIRMAN. He operates with an Advisory Committee.

Dr. SENSENICH. He is not held by anything. I am sorry, sir; I did not mean to interrupt you.

The CHAIRMAN. That is all right. He operates under an Advisory Committee, and that Advisory Committee works with him in determining the qualifications of these doctors and to determine who are specialists. This same practice is followed today by the medical profession, is it not, to determine who the men are who are qualified to act as specialists in the big hospitals of the country?

Dr. SENSENICH. Yes, sir.

The CHAIRMAN. Well, what is wrong, then, about the Surgeon General, with the advice of the American medical profession, specifying who the men are that are to be qualified as specialists? It is not true that under the bill the entire medical profession of the United States is placed under the direction of one man, the Surgeon General of the United States.

Section 203 of the bill, which relates to administration, is concerned not with the administration of medical practice, but with the administration of the system of paying for medical care.

I do not see how the service would deteriorate. As a matter of fact, the greatest discoveries and advances in medicine have been made by men not actually practicing medicine. They are found in laboratories. Most of the great advances that have occurred in this country and other countries throughout the world have been the work of men

on salaries in laboratories patiently studying and developing methods of cure for diseases. Is that not true?

Dr. SENSENICH. Yes. But those men are specialized in particular fields. That has nothing to do with the subject under discussion.

The CHAIRMAN. Why should a doctor, physician, or surgeon, permit his service to deteriorate merely because he is being paid out of a fund for the services he is rendering and being guaranteed that his services are going to be paid for when he performs them?

Dr. SENSENICH. Did the Veterans' Bureau develop anything in 25 years of sufficient patients, of sufficient funds, and sufficient establishment for a good service?

The CHAIRMAN. I do not think that is any comparison.

Dr. SENSENICH. But that is Government medicine.

The CHAIRMAN. And you think this is Government medicine?

Dr. SENSENICH. Yes.

Senator PEPPER. What about Walter Reed and the Naval Hospital? Do you claim Walter Reed and the Naval Hospital are inferior?

Dr. SENSENICH. I am not familiar with the work of Walter Reed and the Naval Hospital, at the moment. Like every other institution, some have good work.

Senator PEPPER. That is true of private hospitals?

Dr. SENSENICH. Yes. On the other hand, let us not forget that the work of the war was done by private physicians in the Army. They have good men in the service, but there is something about the Government service that deteriorates, and it has done so all over Europe.

The CHAIRMAN. Has the service in the Kaiser hospitals deteriorated because the physicians are being paid salaries?

Dr. SENSENICH. They have not operated long enough to know, and there are no available statistics.

The CHAIRMAN. Are you suggesting that they are not rendering efficient service?

Dr. SENSENICH. We accepted them for interne training, and after a little time we will be able to tell you whether the work is good or not.

The CHAIRMAN. You do not have that here?

Dr. SENSENICH. It would be impossible to judge from a few years under wartime.

The CHAIRMAN. Our understanding is that the Kaiser hospitals and the system he has provided out there does furnish the most modern, adequate medical care to his men, and it has worked so satisfactorily that it has been extended to the families of the workers in his plants.

Dr. SENSENICH. Senator Murray, those things take a long time to find out what they amount to. I do not mean a "long time," but operation over some time.

The CHAIRMAN. You talk about indigent people?

Dr. SENSENICH. Yes.

The CHAIRMAN. The indigent are provided for, but I am more interested in the middle class of this country, the people that earn all the way from \$3,000 or \$4,000 up to \$7,000, \$8,000, or \$10,000 a year. I find around the country, from talking to those people, that they have great difficulty meeting medical costs and hospitalization expenses. They tell me that when they go to a hospital they have their financial situation inquired into, and they are charged a very high fee some-

times. The doctors will investigate their financial situation and make them pay out of proportion to others. Does that system prevail in the country?

Dr. SENSENICH. It does not, sir.

The CHAIRMAN. You do not think so?

Dr. SENSENICH. No.

The CHAIRMAN. Have you not heard of cases where they charged \$2,500 for an operation?

Dr. SENSENICH. I have heard of that in some instances. I think that is a rarity.

The CHAIRMAN. You think so?

Dr. SENSENICH. I have had no personal contact with those big fees.

The CHAIRMAN. Is that so? Well, I have had some contact with them, and I have a very vivid recollection of it. And I have talked to other Senators about it.

Dr. SENSENICH. Perhaps, if I may interrupt, I did not investigate as well as you did.

The CHAIRMAN. Well, I will tell you that any person that goes to a modern hospital today will find that he will have his financial situation investigated and he will be charged according to what they think he is able to stand. That is the system. I do not think the system is satisfactory to the American people. I think that the great masses of the people want to find some way in which they can get modern medical care without being overcharged, and also get it without having to take a pauper's oath. I think there is nothing un-American about that, any more than the workmen's compensation laws or our present school system supported by the Government.

Senator TUNNELL. Could I ask just one question, Doctor. In your comparison of health conditions in the United States and other countries, do you think that is influenced by other things, such as hygienic conditions, including the kind of home, the standard of living, and different wage scales, so that it is hardly just a comparison of medical treatment?

Dr. SENSENICH. Very greatly, sir. In these areas of such low economic income many factors enter into the health.

Senator, may I say to the chairman, with reference to overcharging, do not mistake that. The American Medical Association does not approve of overcharging. You used that word.

The CHAIRMAN. Yes.

Dr. SENSENICH. We must not forget that the great bulk of the population in the United States lives in towns under 12,000, and if you could get a big fee, if you wanted to, out of any patient in a town of 12,000, the whole town would know it and exclude you from that time on. I have never known of that experience.

Senator TUNNELL. There are frequently differences of opinion as to what is overcharging?

Dr. SENSENICH. That is true.

The CHAIRMAN. Doctor, you were discussing a short time ago the American Medical Association and the fact that it collects a very large sum, is very strongly financially supported, and has accomplished a great deal of good for the medical profession?

Dr. SENSENICH. And for the public as well, sir.

The CHAIRMAN. And for the public as well, through their medical journals?

Dr. SENSENICH. Yes, sir.

The CHAIRMAN. Very well. Are you acquainted with the National Physicians' Committee?

Dr. SENSENICH. Yes, sir.

The CHAIRMAN. Can you tell me something about the National Physicians' Committee?

Dr. SENSENICH. I have no connection with them. The American Medical Association has no connection with them. They are a body of their own and for their own, and have been interested in various things with reference to the medical situation. There is no tie-up between the two organizations. The house of delegates has approved their objectives, but we have nothing to do with their management.

The CHAIRMAN. But they are supported largely by members of the medical profession?

Dr. SENSENICH. They would have to give you that information themselves. I do not know.

The CHAIRMAN. I see. Well, they circulate literature to the medical profession, do they not?

Dr. SENSENICH. I do not know, sir.

The CHAIRMAN. Have you not seen that?

Dr. SENSENICH. I have some, but I do not know that that is general to the entire medical profession.

The CHAIRMAN. I assume it is general, because in every part of the country I have visited I find that the medical profession there are well stocked with propaganda from the National Physicians' Committee.

In fact, on one occasion I attended a meeting of the medical profession where the speaker of the evening delivered an address which was a complete copy of a pamphlet gotten out by the National Physicians' Committee, and in which this legislation is charged with being socialized or political medicine. It misrepresents from start to finish the purposes and objects of the bill, and its provisions. Have you seen that pamphlet?

Dr. SENSENICH. No.

The CHAIRMAN. You have never seen it?

Dr. SENSENICH. I do not know the one that you speak of. I do not know the statement which you characterize as "propaganda," what the statement was.

The CHAIRMAN. It was a pamphlet which undertook to portray this legislation as socialistic and dangerous, and which misrepresented practically every provision of the bill. You have never seen that?

Dr. SENSENICH. I am not sure that I have, sir.

The CHAIRMAN. Well, it was distributed very widely across the country, and many hundreds of thousands of dollars was spent by that committee in circulating it and deceiving the profession. Medical men read that and believed it. I can see that from the fact that I received letters from them in which they quoted sections of the pamphlet to me which were entirely false.

That committee, however, is a committee which is engaged in propaganda for the purpose of discrediting this legislation. You know that, do you not?

Dr. SENSENICH. No; I do not know that, sir.

The CHAIRMAN. All right. I am surprised, because pretty nearly every person in the United States who has been following this legislation knows as a matter of fact that there is such an organization and just exactly what it is doing.

Dr. SENSENICH. Senator Murray, after all, those who disagree with us are always doing propaganda. That is the choice of the word I could not quite understand, sir.

The CHAIRMAN. Well, I have a copy of the pamphlet here.

Senator DONNELL. Has the chairman finished the immediate interrogation of the witness?

The CHAIRMAN. Yes. You may examine.

Senator DONNELL. Doctor, I thought it might be helpful if you could just give us one, two, three, four, a statement of the reasons why you are opposed to S. 1606.

I have your point that you think it would bring about a deterioration in service. And you quoted, as I take it, with implied approval at any rate, the report of this committee that positive proof exists from experience in other countries that inferior medical service results from compulsory medical insurance. That is point No. 1.

Dr. SENSENICH. That is right.

Senator DONNELL. Would you be kind enough to tell us the next point on which you oppose this bill?

Dr. SENSENICH. I would say first of all, Senator Donnell, that the important thing is that there is nothing about this plan which has anything to do with preventive medicine. That is the first thing, nothing in it which establishes any standards of preventive medicine or accomplishes what we would like to see done.

Secondly, it does bring about a deterioration of medical service because of the fact that it brings the Government in in a manner in which the profession is regimented and the public is regimented; and that is not good.

Senator DONNELL. What is your next point, Doctor?

Dr. SENSENICH. You are specifying four points?

Senator DONNELL. I did not mean just four. I want a concise statement of your general points.

Dr. SENSENICH. Senator, the second one, the statement you first quoted and in which I approved, is of course very broad. It not only tends to deteriorate the quality of service, but those who give the service; not that they deliberately choose not to give the service, but the interest is different. It is a rather intangible thing.

The third subdivision of that same point is the fact that it removes the free choice of physicians.

Senator DONNELL. May I interpolate one question?

Dr. SENSENICH. Yes.

Senator DONNELL. Have you observed from your study of conditions in other countries any effect arising from compulsory health insurance where physicians have a certain number of persons beyond which they cannot go in treating them; have you observed any effect on the initiative of physicians?

Dr. SENSENICH. Yes, indeed, sir. And that is incorporated still further in the report you will hear from another witness.

Senator DONNELL. Which witness is that?

Dr. SENSENICH. Dr. Kennedy.

Senator DONNELL. Dr. Kennedy of New Castle, Ind.?

Dr. SENSENICH. Dr. Kennedy of New Castle, Ind., who has studied and had close connection in foreign countries.

Senator DONNELL. Yes, sir.

Dr. SENSENICH. So that the deterioration of service depends on those things not so tangible, and things more tangible, in the fact that it does destroy the choice of physician. Obviously the choice is limited only to those willing to accept the plan, and in every European country there are many who do not accept the plan. And for those who do, there is a tendency to be crowded. The income is low, and they treat many more patients than the average physician would treat in a given period of time.

Whenever you standardize the control by regulation you standardize at a low level. It is not the superior, it is the low level, because it must include everybody, and as a consequence there is that constant tendency to decline.

And any time you remove the direct responsibility between the physician and patient you incur an accumulated volume, we will say, of just omissions of one kind or another. They are not intentional.

When I am called to see you, Senator, it is a responsible position, and only God and your doctor know whether you are getting good medical care or not. You cannot judge; and no one can follow up every doctor to observe his work. Therefore, it is important that the greatest responsibility exist between you and me. I must have that consciousness of the necessity and of the rightfulness of doing everything that should be done.

Now, after all, there are hair lines. Is this necessary to be done or is it not? Is this? Is this? Is this? Many possibilities must be weighed.

Senator DONNELL. Do you think the provisions of this bill, S. 1606, would tend to reduce the care and effort on the part of the physician, or the initiative of the physicians, or do you not?

Dr. SENSENICH. It diminishes the initiative, and over a period of time it tends to remove just the thing we are talking about, that responsibility. That is not so tangible, but on the other hand, you will learn more from a discussion of where these plans have operated, and what actually happened. That is the reality end of it. You cannot say what does it.

The CHAIRMAN. Senator, will you permit me to ask a question?

Senator DONNELL. Certainly, sir.

The CHAIRMAN. I notice that the Senators here avail themselves of the opportunity of going to a hospital here for medical care without having any previous contact with the physician that treats them. They go to an administrative officer of the Navy here in Washington, and he assigns them to the hospital.

Dr. SENSENICH. Yes.

The CHAIRMAN. They go to the hospital without knowing who the physicians are or anything about them, and they are very satisfied with the treatment and the care they get.

I hear the comment very frequently that this idea of relationship between the physician and patient in modern medical practice is more

or less a myth. I know of cases where people have traveled all across the continent to go to a particular doctor, and when they get there they find the doctor is too old or sick, and they have to take somebody else whom they never heard of, and the operation is entirely satisfactory in every way.

All Members of the Senate and House go to physicians they do not know. I am sure if you left it to a Congressman to select his own physician in the community, he would not know how to do it.

Dr. SENSENICH. Senator Murray—

The CHAIRMAN. Yet they talk about preserving the right to select one's own physician. In modern times the average citizen of the country is not capable of selecting his own physician. That is to say, 9 times out of 10 he might make a very serious mistake. I think that the modern group-practice system where the medical men are classified as to whether they are experts or specialists is an excellent system and the service they render, is good. A person can go to these clinics and get the best modern service. The doctor does just as good a job as if he were selected by the patient from private practice.

Dr. SENSENICH. Senator Murray, you are talking about an institution and a specialist. Let us bring that back down to the average practice that is not in the hospital itself.

You go to some supervisor who authorizes you to go to the hospital. Suppose you are ill at 2 o'clock in the morning; is the supervisor available? Does he approve of your admission? If you go to the hospital and you do not like the particular physician to whom you go, you are at liberty to change. But under this system you can change only provided the other man is included in your plan.

There are many things that make a vast difference between your relationship with your physician under existing conditions where you are entirely a free agent and can do as you like. Or, on the other hand, there is the individual who is limited in his selection to those who have approved of the plan, which in some countries has not included the better men.

Senator TUNNELL. Let me suggest something which I think the doctor means but has not spoken clearly on. Would the poor doctor get just about as much practice as the best one, under the theory you speak of?

Dr. SENSENICH. That is the way it works, because your standards must be low enough to include the whole number. They are never satisfied. The individual who is able to pay or has any means of getting outside the plan is very apt to go to some physician not included in the plan.

Senator DONNELL. I think Senator Tunnell touched upon an important point.

I would like to ask one question on it. Suppose there are 10,000 people in a community and 10 physicians. Under this plan we will say that the physicians in that community elect to adopt the per capita pay basis. Then the 10 physicians would announce themselves to be prepared to go in under the plan. We will presume that all 10 of them accept the plan.

Dr. SENSENICH. Yes.

Senator DONNELL. Whereupon there is assigned by the Surgeon General to those physicians a quota beyond which those physicians cannot go.

Dr. SENSENICH. Yes.

Senator DONNELL. There would be a very strong tendency on the part of the Surgeon General in a given community to set aside 1,000 for each physician, or some variation, but at any rate the poor physician would, as Senator Tunnell so well indicated, be apt to have about the same number of persons assigned to him as the better physician. That is probable, is it not?

Dr. SENSENICH. That is right.

Senator DONNELL. It is a matter of tact and courtesy and judgment on the part of the Surgeon General; that is correct, is it not?

Dr. SENSENICH. Yes.

Senator DONNELL. May I ask you, also, in that connection, would there not be a strong tendency on the part of the population, if they knew one doctor was much better than another, to register very quickly under that doctor, so that the fellow who was late would find himself remitted back to the inefficient doctor?

Dr. SENSENICH. That is right.

Senator DONNELL. There is that difference, also, is there not?

Dr. SENSENICH. Yes, sir.

The CHAIRMAN. Before you leave that; you admit, then, that there are a lot of inefficient doctors in the country?

Dr. SENSENICH. Some doctors are better than other doctors; let us state it that way, sir. They have to meet certain requirements as to registration.

The CHAIRMAN. They have the same fundamental education?

Dr. SENSENICH. Nearly so.

The CHAIRMAN. Some doctors have what they call better bedside manners and make themselves more attractive to the patients?

Dr. SENSENICH. I do not think that amounts to much sir.

The CHAIRMAN. It does not?

Dr. SENSENICH. No.

The CHAIRMAN. It is sometimes claimed that some doctors have personalities which attract the attention of the patients, and which probably is an advantage. I am not criticizing it.

Dr. SENSENICH. May I answer that point? I do not think a matter of "bedside manners" is anything. Of course, a gentlemen either sells himself or he does not.

But as a matter of fact the one thing greatly overlooked in the discussion of legislation is the fact that you cannot divorce a man's illness from his personality. And there is one complaint that comes again and again and again; and that is that too often at the clinics they never get people well. It is a matter of attending physical illness and a continuing kind of symptom, whereas the individual needs a sympathetic understanding. Many times he is more disappointed than ill, more worried than sick.

Many things enter into that, and the physician who can deal with that man's personality and restore him to his normal state in society as a responsible individual and someone who is at least fairly satisfactory to himself emotionally and mentally is the physician who has the patients.

Let us omit the "bedside manners" and admit that there is that difference between physicians; and that is the kind of physician we want to preserve in the picture, because he is the man who serves best.

The CHAIRMAN. Of course, men with those qualifications are favored in the community, and get the best end of the practice at the present time under the present system?

Dr. SENSENICH. That is right, sir.

The CHAIRMAN. And they cannot take care of all the people in the community?

Dr. SENSENICH. That is right.

The CHAIRMAN. The result is that people in poorer circumstances are not able to get the services of those physicians who have such qualifications as you have described.

Dr. SENSENICH. They are not necessarily excluded, sir. Their selection is not on an economic basis.

The CHAIRMAN. They are excluded if they cannot pay the fees. If they cannot come up to his requirements in the way of compensation, they are excluded.

Dr. SENSENICH. No; I think not, sir. I would not agree to that.

The CHAIRMAN. Then the system is very precarious, it seems to me. The public are not able, 9 times out of 10, to determine just who this physician is that has all these qualifications that you mention, and he just has to pick at random under the present system. It seems to me we ought to have a more definite system than that, where men are qualified in the modern medical care and methods of taking care of modern disease. It should be scientific and not so much a matter of psychology.

Dr. SENSENICH. Yes.

The CHAIRMAN. And if a doctor is properly qualified to practice medicine and has gone through the proper training, has been an interne, and has had experience, it seems to me that he can give adequate care without necessarily having some of these other personality qualifications.

Dr. SENSENICH. May I answer that this way: After all, you will admit the desirability of a certain amount of incentive, possibility of advancement, and of progressing. You must admit that even though you do have a very high percentage of physicians that are comparable in the high quality of their work and in attendance upon things I discussed with reference to personality and so on and so on, yet if you take all the competition out of it, all the incentive, and all the means of progressing and tie him down to a dead level with the rest of them, how long do you think he will continue to be the good kind of man we are talking about, as long as the Surgeon General assigns a certain number of individuals at a certain price?

The CHAIRMAN. I do not see why he should deteriorate any more than the scientists deteriorate. They sit away in a secluded spot and work out problems, such as the scientists who developed atomic energy. It seems to me that although these scientists had no contact with anybody but were sitting in there in a laboratory diligently and patiently working the problem out, they were just as competent as if they had been in a different situation where they were in contact with the people waiting for the results of their efforts.

Dr. SENSENICH. Senator Murray, you are familiar with the general exodus of scientists from Government employment to the places where they were happier than they were in Government employ?

The CHAIRMAN. I am not. I do not know that the scientists who worked out the atomic bomb were unhappy.

Dr. SENSENICH. I do not know how many were on the atomic bomb. I know the scientists in the research work have gone back to where they were happier.

The CHAIRMAN. That would be perfectly natural.

Dr. SENSENICH. That would be perfectly natural, and you must recognize that the physician is an individualist and if he is not satisfied in Government employment, he is not going to remain. All physicians will not elect to take it.

Senator PEPPER. Well, a physician does not have to come under this plan. Any doctor in my home town, a choice doctor who has a big private practice, does this law make him come in?

Dr. SENSENICH. No; but I think that the head of Social Security the other day admitted that if the citizen wanted his services he had to pay twice. He paid the compulsory insurance and also paid this separately.

Senator PEPPER. That is correct, but the doctor himself, from the viewpoint of the doctor, does not have to come under this plan unless he agrees?

Dr. SENSENICH. But you would like to have him in the plan. I did not mean to interrupt.

Senator PEPPER. I think it would be desirable to have him in the plan.

Dr. SENSENICH. If you do not have them you would lead to the deterioration of service.

The CHAIRMAN. The bill permits him to perform partial service under the plan and also remain in private practice.

Dr. SENSENICH. That has not worked out too happily, sir.

Senator PEPPER. Doctor, is not what you are saying based upon ignoring the fact that everybody recognizes that this is not offered as a panacea for all ills and to make everybody happy and immediately well and keep them well? It is a question of comparison of this proposal and its effect, the good and the bad of it, with the good and the bad of the present system or the good and the bad of a system that is based upon voluntary membership under various plans. Now, I am sure that nobody has attempted to give you the inference that this was a perfect plan, that it met everything that everybody would like to have met. But the essential problem is, is it in the over-all better for the people of the country than the present plan or than a system of voluntary plans all over the country? Our opinions may differ about that. But should not one weigh against this case the masses of the people that do not have any doctor, and can never get this high-priced specialist that charges these big fees, and deserves them, for his skill? In life do you not find you have a balance of interests?

Dr. SENSENICH. Senator Pepper, that is exactly what we are trying to do, and I have with me today these witnesses who will present the very factual points.

Senator PEPPER. Very well.

Dr. SENSENICH. In an effort to establish first of all whether there is the need we think there is and what the effect would be on this or whether it would not be better to give a little time to some voluntary system.

Senator DONNELL. Mr. Chairman, I appreciate the fact that time is passing. This is an important witness, as indeed all of them have been.

Doctor, returning to the question of freedom of choice, we will take this situation I mentioned where the per capita system of payment is agreed upon by a majority of doctors, and at a given place we will say there are 10 doctors and 10,000 people, and we will say 1,000 are assigned to each one of those doctors. There is a difference in the ability of those doctors, just like lawyers, dentists, shoemakers, and anybody else?

Dr. SENSENICH. That is right, sir.

Senator DONNELL. And some doctors are able to make greater success than others even though all of them have passed the examinations prescribed by the State laws and the examinations in the medical schools?

Dr. SENSENICH. That is right.

Senator DONNELL. Under this plan, as I understand it, in a case such as I have cited, if the people in a community recognize Doctor A as of outstanding ability, it would appear to me that his quota would be promptly filled?

Dr. SENSENICH. That is right, sir.

Senator DONNELL. And the other people, who did not get on his quota, would be remitted back to the other gentlemen?

Dr. SENSENICH. That is right.

Senator DONNELL. Some of whom may or may not be as qualified as Doctor A?

Dr. SENSENICH. That is right.

Senator DONNELL. The very fact that doctor A has acquired confidence in the community is some evidence that he is better qualified than some other practitioner?

Dr. SENSENICH. That is right.

Senator DONNELL. Under the present situation, as we now have it, we have the privilege of going to a doctor and he has the privilege of determining whether he can or cannot take us, is that right?

Dr. SENSENICH. That is right.

Senator DONNELL. There is no governmental compulsion?

Dr. SENSENICH. That is right.

Senator DONNELL. Whereas under the system I described there is governmental compulsion from which there can be no variation? That is correct, is it not?

Dr. SENSENICH. Yes.

Senator DONNELL. With respect to the situation here relative to Congress that the chairman referred to, I appreciate the fine services which Dr. Calver has rendered, and in the Saturday Evening Post there is a very interesting article on that. It is true that if a number of members of Congress go to Dr. Calver, all Dr. Calver has any legal authority to do is to make recommendations which members of Congress may or may not follow?

Dr. SENSENICH. That is right.

Senator DONNELL. But if the law goes into effect, and Dr. Calver has 1,000 people, and 1,001 comes up, he cannot administer to the treatment of No. 1,001; that is correct, is it not?

Dr. SENSENICH. That is right.

Senator DONNELL. Now, I want to ask you, also, under this bill, what your opinion or judgment is as to the degree of power placed in the Surgeon General by the authority to designate the practitioners who shall be qualified as specialists or consultants? Do you

regard that as a power that is fraught with some dangers, perhaps, to put it in one man's power to make that determination?

Dr. SENSENICH. There is no method provided by which he is judged. It is a bureaucracy in its administration.

Senator DONNELL. I observe that there is some statement that he shall determine for each specialists in accordance with general standards previously prescribed by him after consultation with the advisory council; but the authority to set forth the standards is vested in the Surgeon General, one man?

Dr. SENSENICH. That is right.

Senator DONNELL. And the very term "advisory council" speaks for itself, that the council is advisory and has no ultimate power?

Dr. SENSENICH. That is right.

Senator DONNELL. Even if it did have the power, it would vest in a group of men and women the power to determine whether or not out in my own home, or Senator Smith's home, or in Oregon or Washington, whether the particular person is or is not qualified to be a specialist?

Dr. SENSENICH. That is correct.

Senator DONNELL. Do you regard that as a desirable feature of this bill?

Dr. SENSENICH. I do not.

Senator DONNELL. You do not. I am not going to prolong this. I do want to ask you one more question, though, in conclusion of the questions I would like to ask along this line.

We had one witness here yesterday, whom I am confident was actuated by the best motives, and yet she made a statement in substance that the opposition to this bill is not honest. That was the statement. This witness testified to respect for any honest opposition, but made the statement that the opposition to S. 1606 is not honest.

I want to ask you this question, Doctor: In your opinion as a practicing physician and as a member of the American Medical Association do you think that the position taken by the American Medical Association is actuated primarily by selfish interests or by interests which have to do with the general welfare of the people of the United States of America, and I am going to ask you concretely in answering that question whether in your opinion the action of the American Medical Association was honest or dishonest in opposition to this bill?

Dr. SENSENICH. It is an honest opposition. It is definitely an honest opposition, and that is further stated in the program of health objectives and is supported by nearly 100 years of performance. Remember that the Government and the lay people have in no instance created the laws by which health measures are controlled. Our laws have come about at the recommendation of and by the stimulation of the medical profession.

Senator DONNELL. I said that was the concluding question. Your answer brings forth this thought. The American Medical Association contains about 125,000 persons, and represents a very large percentage of the entire practicing members of the professions?

Dr. SENSENICH. Yes, sir.

Senator DONNELL. I realize asking you the question as to whether or not the action of the association is honest or dishonest also means I was asking about your own honesty or dishonesty. That is em-

barrassing, and perhaps you are a prejudiced witness, but to my mind I think it is proper to ask an eminent member of the profession, just as you would a member of the bar or a member of the bench with respect to the legal profession, and I want to ask you again this question, and I do close with this:

In your judgment as a practitioner, a man whose reputation is at stake, a man who occupies a position such as you do with the American medical profession, do you think that the position taken by the association is taken as a result of some selfish interest of the profession, or is it a position taken as a result of earnest effort to try to bring forth a plan which in the honest opinion of the association would best serve the health and public welfare?

Dr. SENSENICH. There is no question of the honesty back of it, and for the proper care of health measures. There is no question about the honesty in opposition of legislation which we feel will be harmful, and we will present such evidence as is available to prove that it is harmful.

Senator DONNELL. Thank you, doctor.

The CHAIRMAN. Doctor, we have had equally important witnesses, men of high standing in the country, who feel that the American Medical Association is somewhat behind the times in regard to legislation of this kind, which is necessary for the protection of the health of the American people.

We had a witness on the stand the other day who was a very prominent man, of the Harvard Medical School, Dr. Butler. Do you know Dr. Butler?

Dr. SENSENICH. Yes; I know Dr. Butler.

The CHAIRMAN. Here is what he testified:

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, that 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.

He also said:

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 asked:

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.

And a witness here the other day, William Green, testified that in his judgment this legislation is absolutely necessary for the country and that if it is not passed, the American medical profession will be placing themselves in a very serious position, because the people of this country are going to insist on having proper medical care, modern medical care, for every citizen in the country, within their means. They have got to have it.

And it seems to me that the medical profession will be making a mistake if they do not sit down and study this legislation and propose whatever amendments they think would perfect it, because it is

the only way in which to bring modern medical care to the American people.

Dr. SENSENICH. Senator Murray, may I say that the competence of a witness and the usefulness of a witness depends largely on information and competency and honesty. The statement on the part of the doctor from Harvard University was not factual.

As to Mr. Green, whom I have had occasion to meet a long time ago, I do not know that he is informed.

The CHAIRMAN. He is informed on the condition of the health of his people.

Dr. SENSENICH. But he is not in a position to pass upon the medical side of it, as to the determination of medical care and how to obtain it and the effect upon medical care of this system.

The CHAIRMAN. They have a division or subdivision set up in their organization, which is a very well organized body, staffed by experts, economists, who have made a very careful study of this problem for the benefit of the American Federation of Labor, and its members, and they have come to the conclusion that legislation of this kind is absolutely imperative for the welfare of the country and for the welfare of the great working masses of our people.

Dr. SENSENICH. Senator Murray, I am not reflecting in any way upon Mr. Green, whom you know and whom I respect. However, this kind of problem cannot be answered by economists alone; that is the point I am trying to make.

The CHAIRMAN. Surely.

Dr. SENSENICH. That, also, with reference to Mr. Green.

The CHAIRMAN. And we are not seeking to present a piece of legislation here which is the result of the work of economists. We have had very distinguished doctors from all over the country who have cooperated with us and advised us with reference to this legislation. I have had letters from my own State of Montana in which doctors have given me their views on the bill, and many of them feel that this legislation is all right and that it should be passed. A great many members of the medical profession take that stand. I am sure you know that.

Dr. SENSENICH. There are some; a very, very small number.

The CHAIRMAN. Well, I have attended meetings where they seem to appear in great numbers.

Dr. SENSENICH. The trouble is in those meetings there is a certain automatic selection. Those that are for go and those against do not. That is our experience, at least.

May I say, Senator Murray, after all we want everyone to have the best medical care, and we will cooperate with anyone and anybody in the matter of procuring that care, if it is possible to get it.

And we have met with your committee. Senator Pepper remembers it, and you remember, too, we met with your committee several times. We were in not so long ago with reference to the Hill-Burton bill. We are here not for the purpose of criticizing the people who developed this legislation or promoted it, but rather to point out from a factual basis what its effect will be on medical care.

Senator PEPPER. Doctor—

Dr. SENSENICH. Yes, Senator.

Senator PEPPER. Is it not fair to say that the representatives of the people, such as the Congress, have a perfect right to determine what in

their opinion is in the public interest in helping the people preserve their health?

Dr. SENSENICH. That is right.

Senator PEPPER. And this is not a matter that the people have elected the doctors to decide for them. We have got a perfect right to draw up any data that we think is relevant to the subject and to legislate in this field as in other fields? That is correct, is it not?

Dr. SENSENICH. Correct, if I may answer one thing: I think they would expect that you would get the best advice you could get in the preparation of that legislation. I do not think any legislator with non-medical experience is competent to judge. That is with all due respect.

Senator PEPPER. But you will have to admit that in the trial of a case at law if a witness has a personal interest in the matter, the jury is entitled to know that the witness has a personal interest in the advice he is giving?

Dr. SENSENICH. That is right, sir.

Senator PEPPER. All right.

Dr. SENSENICH. But we must also know that the public has an interest.

Senator PEPPER. The difference of it is that we Senators do not make any more money if we pass a good health bill, but a doctor may make more if we do not.

Dr. SENSENICH. That is not the fact.

Senator DONNELL. Well, Mr. Chairman, I think it is only proper to state at this time that the testimony adduced up to this point by the proponents of the bill has been to the effect that the installation of S. 1606 and the plan thereunder will actually prove more beneficial to the doctors, as Dr. Butler indicated in his testimony.

The CHAIRMAN. To the great majority of the medical profession.

Senator DONNELL. Yes, sir.

The CHAIRMAN. But not to those at the top of the medical profession.

Senator DONNELL. Well, I think, Mr. Chairman, the fact is that the American Medical Association is constituted of over 125,000 practitioners who are physicians all over the United States.

Dr. SENSENICH. That is right.

Senator DONNELL. They are representative, do you not consider, of the views of the medical profession taken by and large over the country?

Dr. SENSENICH. That is right, sir.

Senator DONNELL. And the house of delegates has expressed its opposition to compulsory health insurance?

Dr. SENSENICH. That is right, sir.

The CHAIRMAN. And the house of delegates, according to some critics of the American Medical Association, is far behind the times in this field?

Dr. SENSENICH. I should not say that that was factual. The delegates are elected for a 2-year term, and I have never known any democratic institution in which its governing body or policy-making body did not reflect the attitude and belief of its membership, when they are elected every 2 years.

Senator DONNELL. Is it your judgment that the house of delegates does reflect the present, up-to-date opinion of the medical profession?

Dr. SENSENICH. There is no question about it.

Senator DONNELL. You mean to say you think it does?

Dr. SENSENICH. Beyond question.

The CHAIRMAN. Well, thank you for your testimony, doctor. I think you have given us a lot of inspiration here to study this problem very carefully, and we are glad to have you, and I am sure we will benefit from the discussion.

Dr. SENSENICH. Thank you very much for having heard us. We have other witnesses.

The CHAIRMAN. Well, now I think we will recess until 2 o'clock.

Dr. SENSENICH. That will be fine, sir.

The CHAIRMAN. 2 o'clock.

Dr. SENSENICH. Thank you very much.

(Whereupon, at 12:15 p. m., Wednesday, April 17, 1946, adjourned to meet at 2 p. m., Wednesday, April 17, 1946.)

AFTERNOON SESSION

(The hearing was resumed at 2 p. m.)

The CHAIRMAN. The committee will come to order.

Senator Donnell, this morning there was some question raised with reference to the question as to whether or not the bill, the pending bill, had any provision for preventive medicine. I wish to call attention at this time to the section 213 of the bill on page 63, which provides as follows:

Sec. 213. For the purpose 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, etc.

Again over on page 65, subdivision (b) of section 214 provides as follows:

(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.

I believe there is reference also to preventive medicine in some other parts. All through title I, in the grants to States you will find references to preventive medicine.

Senator DONNELL. Yes, sir.

The CHAIRMAN. The first witness this afternoon is Dr. Lowell S. Goin. Before we call on Dr. Goin, I wish to have inserted into the record at this point a statement that has been filed by the State Medical Association of Texas.

(The statement is as follows:)

STATE MEDICAL ASSOCIATION OF TEXAS,
OFFICE OF THE SECRETARY,
Fort Worth, Tex., April 15, 1946.

HON. JAMES E. MURRAY.

Chairman, Committee on Education and Labor,

United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: The State Medical Association of Texas, with a membership of 6,000 practicing physicians appreciates your courtesy in permitting us to go on record as being opposed to the enactment of Senate bill 1606—the Wagner-Murray-Dingell bill.

Our investigations show us that not only the physicians of Texas but the citizens of Texas by an overwhelming majority are definitely opposed to the Wagner-Murray-Dingell bill, inasmuch as it constitutes compulsory prepaid health insurance under Federal control.

As evidence of this definite State-wide opposition on the part of the people of Texas, we point to the fact that a large section of the Texas press, including both large daily newspapers and small country weeklies, have placed themselves editorially on record in opposition to this proposed legislation. We also would respectfully call your attention to the fact that the representatives of the State of Texas in the Congress have, by a large majority, gone publicly on record as being opposed to this Federal legislation. Texas is a pioneer State, a vigorous, fast growing commonwealth. The average Texan thinks and speaks for himself, and above all things jealously guards his freedom of choice in matters which effect his personal liberty and pursuit of happiness. Texans gained their liberty by fighting for it and it is not thinkable that a citizenry which holds such a pride in their State as do Texans, will willingly agree to the regimentation of themselves and their affairs, during peacetime, by any Federal agency. We venture to say, judging from the expressed attitudes of the press of Texas and its duly elected representatives in Congress, that should the matter of compulsory Federal health insurance be put to a vote of the people of Texas it would be defeated at the polls by an overwhelming vote. The people of Texas do not want Federal medicine. They wish to retain their full liberty to select and patronize the physicians of their choice without being handicapped in even the smallest way by any Federal law or directive.

As to Senate bill 1606 and its many complicated details, we wish you to know that a majority of the State Medical Association of Texas, all its officials and all its committees, have read this bill and studied it in detail. In fact, special group meetings of doctors have been called for the purpose of reading the bill in full and discussing its multitudinous and complicated provisions. In these considerations of the Wagner-Murray-Dingell bill the members of the State Medical Association of Texas have attempted to consider the measure impartially and quite unselfishly. Their attempt has been to reach a very simple conclusion—would the Wagner-Murray-Dingell bill be helpful to the health, welfare, and happiness of the 7 million people who live in the State of Texas? Our considered conclusion is that this bill would not better public health in Texas. On the contrary, it would tend to destroy the present system of Americanized medicine in our State by substituting Federal control, and the wealth, welfare, and happiness of Texas generally would soon be seriously and adversely affected.

In regard to title I of S. 1606, the State Medical Association of Texas certainly stands in full approval of Federal grants-in-aid to the States for establishing and maintaining adequate measures for the prevention, treatment, and control of venereal disease and tuberculosis, the extension of the Public Health Service, and the extending of maternal and child-health care to all mothers and children where personal payment for such service would constitute a hardship. Similarly, the State Medical Association most certainly favors Federal grants-in-aid for the purpose of providing full medical care and hospitalization for the indigent. One section of the bill which would seem objectionable is the provision for training thousands of employees in public health work in some central Federal educational set-up in Washington. We believe that such training should be decentralized, and that training of public-health employees could more efficiently be carried out in the hospitals, universities, and other centers of medical education distributed throughout the United States. In such a manner the trainees could more readily become acquainted first-hand with widely varying health problems than they could if they were forced to secure such training in the highly political atmosphere of Washington, D. C.

As to the provisions for Federal aid in the prevention and control of venereal diseases and tuberculosis, it is our opinion that laws already on the Federal statute books make ample and sufficient provisions for these activities.

As to the construction of hospitals in locations where they are needed, we believe that this important matter is fully covered by the Hill-Burton (S. 191) bill which has already passed the United States Senate and is now under consideration by the House of Representatives. This bill, which depends upon the various States to make surveys as to where hospitals are most needed and where they would be self-supporting by the contiguous population appears to us to be the full and complete answer to the hospital construction problem. The Hill-

Burton bill has been endorsed as to principle by the legislative committee of the State Medical Association, and has the full endorsement of the American Medical Association.

In regard to scientific and medical research, it seems to us that this is adequately taken care of in the amended Magnuson bill, S. 1850, which measure meets with the hearty approval of the American Medical Association and which undoubtedly will be endorsed by the State Medical Association at the earliest opportunity.

The State Medical Association of Texas is opposed in every particular to title II of the Wagner-Murray-Dingell bill, which provides for prepaid personal health service benefits, and we believe that the people of Texas are similarly opposed. No matter what any person, however exalted his position, might say in this regard, we are fully convinced that compulsory prepaid health insurance is definitely socialistic. When the Government goes into business, establishes a system of insurance to which everyone must contribute; when it regulates the provision of medical service through Washington; when it regulates fees that doctors are to receive when they participate in the system; when it regulates consultations and determines when consultants are to be consulted, we respectfully submit that this is very definite socialized medicine. We believe that such a system, which interposes great groups of nonmedical Federal employees between the public and their doctors, would constitute a medical system both undemocratic and un-American.

We believe that no universal plan of compulsory prepayment health insurance could ever be successful, or be operated efficiently unless the medical profession is thoroughly in accord with such plan and wholeheartedly cooperates in its administration. On the face of it, so far as Texas is concerned, hardly a doctor gives compulsory health insurance his approval.

The State Medical Association of Texas, and the many county medical societies representing the 254 counties of this State, are all on record as opposing this compulsory medical insurance plan. Their reasons are many and cogent. They feel that so far as Texas is concerned, with its wide-open spaces and vast areas which are thinly populated, such a complicated insurance system could be operated only under extreme difficulties. It is repugnant to the doctors of Texas that this proposed law, if forced upon them, would compel them to devote many hours of their valuable time, which might be used in caring for the sick, to the making of voluminous reports, in triplicate, to Federal bureaus in Austin and/or Washington.

The State Medical Association further feels that the Wagner-Murray-Dingell bill, which puts into the hands of one man, the Surgeon General of the United States Public Health Service, a tremendous power which could be wielded through one vast central agency in Washington present political implications both clear and dangerous. While it is true that an advisory council of 16 members is provided for, yet it should be noted that such council would be appointed by the Surgeon General himself, with the approval of the Federal Security Administrator. Such a council, widely scattered throughout the United States, would likely consist of members fully in accord with the political policy of the Surgeon General, and like so many other councils of an advisory nature would, in effect, be innocuous and more or less a figure head. The State Medical Association believes that there would be definite danger of absolute dictatorship under any law which would give the Surgeon General practically the sole authority to employ doctors and specialists, establish fee schedules for physicians, fix the qualification of specialists, determine how many patients any doctor might have, designate and regulate hospital and clinics to provide service and negotiate contracts with public agencies, nonprofit groups and individuals for providing full medical benefits.

It is our firm belief that such stringent Federal regulation affecting medicine would definitely destroy the private practice of medicine in the United States. Americanized medicine, under Federal control, would forever lose the time-honored relationship between physician and patient and patient and physician, which is the base of its entire structure. The initiative of every doctor restricted and regulated by Federal law would be seriously handicapped and medical research and scientific progress on the part of individual doctors would soon become a thing of the past. The quality of medical care would deteriorate and the independence and self-respect of every practicing physician would correspondingly suffer.

The original Wagner-Murray-Dingell bill, S. 1050, which was referred to the finance committee of the Senate, did give some indication of the tremendous financial burden which it would impose upon the American public. The new Wagner-Murray-Dingell bill, S. 1606, is being considered without a single definite figure to indicate its cost or its terrific tax burden. The people of Texas, as well as the physicians of this State, realize quite well that the matter of dodging the financial requisites was not without a political bearing. However, since in this world nobody ever gets something for nothing, the American public eventually will have to foot this bill, and we believe that every worker and every employer will be surprised and shocked at what they will have to pay for compulsory health insurance if instituted by the Congress. Such payments, if estimated on the financial figures of the first Wagner-Murray-Dingell bill, would mean the collection by the Federal Government of between 3 and 4 billion dollars annually from the people of America for this single purpose. It would seem only fair to the people of the United States that a more definite figure of the cost of the Wagner-Murray-Dingell bill should be made public. Under the present circumstances the people are being asked to accept an additional tremendous financial burden, whether it is called contributions or taxes, the import of which the average citizen is at present unsuspecting and unaware. With Federal, State, and local taxation practically at an all-time high this additional demand would make the present grievous tax burden almost impossible to bear. We believe that if the American public was thoroughly cognizant of what this proposed legislation would cost them, both workers and employers would demand the Wagner-Murray-Dingell bill die in your committee.

The State Medical Association of Texas strongly advocates widespread prepaid health insurance to cover every family and every individual in the State, but it wishes such insurance to be voluntary and not compulsory upon the individual. Furthermore, the doctors of Texas favor the expansion of such insurance as offered by private enterprise rather than through Federal direction and control. Voluntary prepaid health insurance can be provided, and is provided, at a far less cost than contemplated in this proposed Federal legislation. The State Medical Association of Texas is actively upholding and sponsoring worthy programs for prepaid hospitalization and medical and surgical care. The State association has gone on record as approving both nonprofit and commercial prepaid health insurance plans, provided only that such plans are financially sound, give free choice of doctors and do not destroy the relationship between physician and patient. In particular, the State Medical Association of Texas has approved the Blue Cross group medical and surgical service in Texas, a nonprofit organization. Similarly it will approve other nonprofit plans, and by approval it means that the doctors of Texas are actively supporting such plans.

Estimating from the provisions of the former Wagner-Murray-Dingell bill, S. 1050, that every worker would have to pay 3 percent of his earnings for compulsory health insurance, we wish to compare such payments with the cost of voluntary hospitalization and essential medical and surgical care as provided by Blue Cross plan in Texas. Taking the average worker, earning the annual wage of \$2,600, 3 percent of such wage paid for compulsory health insurance would amount to \$78 annually. This would cover the worker alone. The Blue Cross plan, when both hospitalization and essential medical and surgical care are included, would cost this worker and his whole family, no matter how many children, \$4.10 a month or \$49.20 a year. This would be a saving of \$28.80 in actual cash expended by the individual worker. Full hospital, and essential medical and surgical care is offered to the unmarried person for \$1.65 a month by the Blue Cross in Texas, with a corresponding saving, when compared with the exorbitant rate likely for compulsory Federal coverage. Under the provisions of the first Wagner-Murray-Dingell bill, S. 1050, which is our only possible yardstick for estimating Federal health insurance cost, an unmarried worker earning \$3,600 a year—the top bracket under the proposed law—would have to pay \$108 annually to the Government for this compulsory protection. A combined hospital, medical, and surgical policy with the Blue Cross in Texas could be bought by this unmarried worker for \$19.80 a year, a saving of \$88.20 a year. The essential health insurance coverage under the Blue Cross plan would have the approval of the State Medical Association of Texas, and is as broad and as efficient as any plan which could be offered by the Federal Government.

The State Medical Association of Texas will continue to use every effort in support of voluntary prepaid health insurance provided through private enter-

prise, believing that the voluntary system is the best system, the least expensive system and the most truly American system.

There is no need for Federal medicine or its socialistic set-up, with low cost voluntary health insurance so widely available to the American public.

In conclusion, we urge that your committee report unfavorably upon the Wagner-Murray-Dingell bill, S. 1606, in all particulars.

Respectfully submitted.

H. F. CONNALLY, M. D., *President.*

Attest:

HOLMAN TAYLOR, M. D.,
Secretary.

NOTE.—Attached, as exhibit A, in this submission is schedule of benefits provided by the Blue Cross plan in Texas, as referred to on pages 8 and 9 of this communication.

(Exhibit A will be filed with the committee.)

The CHAIRMAN. The statement of the State Medical Association of Texas refers to a schedule of benefits provided by the Blue Cross plan in Texas, and a copy of this document will be filed with the committee for the information of the committee.

(The pamphlet, Blue Cross Comprehensive Service for the Whole Family, Dallas, Tex., is filed for the information of the committee.)

The CHAIRMAN. There will also be inserted into the record at this point a statement from the New Mexico Medical Society, a statement from the Academy of Medicine of Cleveland, a statement from Dr. Franz Goldmann, associate clinical professor, of the Yale University School of Medicine, a statement from the Committee for the Nation's Health, and one from Alamance General Hospital, Burlington, N. C.

(The statements are as follows:)

STATEMENT OF CARL H. GELLENTHIEN, M. D., PRESIDENT OF THE NEW MEXICO MEDICAL SOCIETY, PRESENTED TO THE UNITED STATES SENATE COMMITTEE ON EDUCATION AND LABOR, APRIL 17, 1946

Geographically, New Mexico is the fourth largest State in the Union. Only Texas, California, and Montana outrank it. It is a sparsely populated State, with roughly 3.5 people per square mile. The population in 1940 was 531,818; and the area 122,303 square miles, or approximately twice the combined area of all the New England States. It is divided into 31 counties, the smallest of which, Bernalillo, is as large as Rhode Island; and the largest, Socorro, has approximately the same area as Massachusetts. The major activities and industries are agricultural; that is, ranching and farming. Sixty-six out of every hundred persons in 1940 lived in rural territory.

Mora County, where I live, in northeastern New Mexico, has a population of 10,387, according to the 1940 census. The size of the average family is 4.5. The Spanish-American population in round numbers is 96 percent (and for New Mexico is about 40 percent). The area is 1,942 square miles. The majority of the population are small landowners, scattered in villages, in the canyons, or on ranches. According to the county extension agent, there are 54,000 acres of cultivated land, both dry and irrigated, and 1,120,000 acres of grazing land.

There are no towns over 1,332 population in Mora County, no manufacturing of any type, no mining, and only a small amount of lumbering, which is mainly mine props or railroad ties. Only two towns, Mora and Wagon Mound, have electricity at present, but the Rural Electrification Administration is now building a power line in the county.

There is opportunity for improvement in many things in New Mexico.

All of us in New Mexico naturally want larger annual incomes.

There is need for improvement in the housing situation. While we do have a shortage of housing, it is due mostly to the migration from rural to urban centers as a result of increased annual incomes. In rural communities, they always have and can now build adobe and lumber buildings, shortage or no shortage of building materials. The adobe and lumber are on the ranch and require only the physical effort to process and use them. Our biggest problem

is to educate and sell the native New Mexican the pleasures of running water in the kitchen and an indoor toilet.

The State public health department with the New Mexico Tuberculosis Association and the New Mexico Cancer Society, have struggled valiantly for several years for an improved educational program and enforcement of laws to better the public health and education of our people. The totally inadequate amount of money for public health and preventive medicine advancement in the 1945-46 Mora County budget was only \$10,020, a per capita yearly expenditure of only 96 cents. The total assessed property valuation in the county for 1945 was \$1,252,114. About half of this assessment was made against the Santa Fe Railroad, which is by far the largest taxpayer in the county. It has been very favorably inclined toward spending tax money for public health and we are very grateful for this support.

Additional Federal appropriations for the advancement of the public health by preventive medical procedures for our people in New Mexico would be highly beneficial and much appreciated. There is great need for improvement in the venereal disease control program and clinics and the immunization program for the prevention of contagious diseases, such as smallpox, diphtheria, whooping cough, and typhoid fever among school children.

The quality, type, and supply of clothing for all of us in the State can also be improved.

There is still room for improvement in the quality and availability of good schooling for our children.

The people of New Mexico, because of their geographic isolation, the wide-open spaces, and the peculiar requirements of ranch work, are resourceful individuals who do not like charity or hand-outs from the Government or anyone else. They like to stand on their own feet and pay their own way.

The income per family from agricultural production has gone up markedly since the war and the income from other sources last year was \$1,500 to \$2,200. The predicted combined income for New Mexico residents this year is expected to amount to more than \$390,000,000 or approximately \$3,300 per family. If financial assistance were given to insure a better water supply for irrigation through the construction of small dams, production and the average annual income would rise tremendously.

The medical profession of the State during the past year has organized a voluntary prepayment medical service program. Arrangements are being made with Veterans' Bureau to include the veterans living in New Mexico in this medical service plan. There are now 31,000 veterans in the State with a probable 50,000 by the end of the year. The medical profession intends to sell the voluntary prepayment medical service to the State department of public welfare. The department of public welfare will thus remove some of the stigma of charity and medical indigence from its clients by arranging with the State medical society to supply the medical service on the same basis as it does for the self-supporting individual. It is also the plan of the medical society to incorporate the medical program of the Farm Security Administration and the Children's Bureau with its own.

We in New Mexico feel that the quality of medical service will be enhanced by the small hospitals and medical facilities made available under the provisions of the Hill-Burton bill. We think this is a desirable piece of legislation and are planning to use its provisions to the best of our abilities.

The cost of medical care to the people of New Mexico is adequately and economically taken care of by the voluntary medical service plan of the New Mexico physicians service now in operation. The middle-income bracket of our population can afford and is now buying this.

The lower-income bracket, the medically indigent and so-called charity cases, will be better cared for than ever before, with the local and State political agencies buying this service for their clients. The New Mexico medical profession and the New Mexico hospitals have always taken care of the charity cases. We have never had a charity or county hospital in New Mexico.

The higher-income bracket, the so-called rich, are not very numerous in the State, and are able to look out for themselves.

Our greatest deficiency and most crying need in New Mexico is an adequate number of good, all-weather, ranch-to-market roads. That is the most important contribution to the welfare of the people of New Mexico that could be made. A glance at a map of New Mexico shows several large counties, sparsely populated, that have no doctor. They have never had a doctor or hospital, and no

doctor could afford to practice in these counties. If, instead of looking at a political map, one looks at a topographical map, one immediately sees that the county is bisected by a mountain range or a canyon, thus making it impossible to get from one part of the county to another. In Rio Arriba County, the towns of Tierra Amerillo and Gobernador are 45 miles apart but one has to drive 345 miles to get from one town to the other. Sickness does not recognize political and artificial boundaries.

There are two doctors of medicine in Mora County; one who is 73 years old and physically incapacitated, and myself. There is also one osteopath, an intelligent young man who realizes that he is inadequately trained to treat sick humans so is now doing pre-medical work and later plans to enter medical school. There are no general hospitals in the county, although we hope to build one at each end of the county under this Hill-Burton bill.

If we had good roads so that a patient could be promptly taken to the nearest hospital, regardless of county or political lines, he would receive efficient medical care, for there are two excellent hospitals in Las Vegas, 11 miles across the county line. It is common practice in the State for people to drive 50 or 60 miles to a movie or a hospital. To get to our county seat, some of us have to drive over 90 miles each way. The distances in the State are so great and the existing roads so straight and with so little traffic that we at Valmora, for instance, think nothing of driving 160 miles to Albuquerque, conducting our business, and driving back that evening.

So, in summarizing, I express the sentiments of my fellow New Mexicans when I say, "We emphatically do not want more Government interference with our daily lives; we want less. We do not want more taxes; we want less. We definitely do not want the provisions of Senate bill 1606 and its political regulation of our lives. We feel that if you must do something, then give us larger appropriations for the betterment of our public health and general welfare; give us good, all-weather, ranch-to-market roads and help us build small dams to insure ample water for irrigation so that we can raise bigger and better crops and get better prices for our ranch products.

We New Mexicans feel that we have made satisfactory progress since 1540, when Coronado and his Spanish cohorts first arrived, and that we can continue to improve our housing, sanitation, clothing, schooling, and food supply according to the requirements of the times. You may rest assured we will continue to provide adequate and satisfactory medical care for our citizens. We want to do it on our own, however. We do not want to be regimented, socialized, communized, or regulated by Federal Government bureaus.

If Congress feels that it must do something for the people of New Mexico, then help us to help ourselves, but don't try to make us wards of the Government.

ACADEMY OF MEDICINE OF CLEVELAND AND
CUYAHOGA COUNTY MEDICAL SOCIETY,
2009 Adelbert Road, March 15, 1946.

HON. JAMES E. MURRAY,

United States Senate, Senate Office Building, Washington, D. C.

DEAR SIR: The Academy of Medicine of Cleveland, comprising 2,000 doctors, wishes to submit this statement in objection to S. 1606—the Wagner-Murray bill—and respectfully ask that it be included and printed in the report of the hearings on this bill, scheduled to take place before the Committee on Labor and Education.

American doctors—free men with free minds—unrestricted by Government directives and controls, have developed and given to the people of this country the most effective and widely distributed medical care that has ever been provided for any comparable number of people anywhere at any time. They have progressively provided a higher and higher quality of medical care for the people of the United States until this care is second to no other in the world.

Through such voluntary agencies as the Blue Cross Hospital Plans, physician-sponsored medical service plans, employer-employee group insurance plans, all of which are growing at a remarkable rate, needed protections have been provided for more than 25,000,000 people. As of January 1, 1946, these voluntary prepayment plans for hospital and medical care were in operation in 25 States of the Union, 4 States had plans ready to operate, and 4 other States had plans in the formative stage. The extension of these voluntary plans will provide other tens of millions of people with the means for the easier payment of the cost of medical

care. These voluntary methods will eventually provide every American with medicine and medical procedures of a higher quality than were ever before known or imagined.

We object to S. 1606 because, if enacted into law, it would establish a health service completely socialistic in concept. It would establish the Surgeon General of the Public Health Service as medical dictator under the direction of the Administrator of the Social Security Board. It would regiment the doctors, dentists, specialists, nurses, and laboratory technicians; restrict the scope of a doctor's practice to limits set by law; fix the qualifications for specialists; determine what hospitals or clinics may provide service for patients and under what conditions; make a public record of the characteristics and most intimate and sacred personal relationship of each and every patient; and finally restrict the free choice of physicians in that only those physicians enrolled under the proposed plan can be chosen.

We object to S. 1606 because this proposed program would entail the expenditure of billions of dollars more annually than the proponents of this bill estimate, and the recipients of any benefits under this program would be paying an inordinate price for such benefits as compared with similar benefits now available from private insurance companies or from voluntary prepayment plans already operating successfully.

We object to S. 1606 because it is un-American. It regiments the medical profession and it regiments the American people under the dictates of a governmental bureau. The Constitution of the United States, the Bill of Rights, and the American way of life are diametrically opposed to regimentation. The basic tenet in a democracy is that the State is the creature of the citizen. Such revolutionary social planning as outlined in S. 1606 proposes that the citizen will become the creature of the State. This does mean the socialization of medicine and together with other similar un-American social plans will eventually lead to the complete socialization of American life.

The Academy of Medicine hereby voices its unalterable opposition to the Wagner-Murray bill (S. 1606) and urges the complete defeat of this un-American proposed legislation.

Very truly yours,

FARRELL T. GALLAGHER, M. D., *President.*

YALE UNIVERSITY SCHOOL OF MEDICINE,
New Haven, Conn., March 29, 1946.

Senator JAMES E. MURRAY,
Senate Office Building, Washington, D. C.

DEAR SENATOR: AS Senate hearings about various health bills are about to start, I am taking the liberty of sending you herewith the transcript of excerpts from lectures of mine on the subject. Publication of the complete and edited text is scheduled for May issues of the *New England Journal of Medicine*.

Very truly yours,

FRANZ GOLDMANN, M. D.,
Associate Clinical Professor.

FG/o
enc.

EXCERPTS FROM HEALTH BILLS PENDING IN CONGRESS, A SERIES OF LECTURES GIVEN AT THE HARVARD MEDICAL SCHOOL IN FEBRUARY 1946 BY FRANZ GOLDMANN, M. D., ASSOCIATE CLINICAL PROFESSOR OF PUBLIC HEALTH, YALE UNIVERSITY SCHOOL OF MEDICINE

THE NATIONAL HEALTH BILL: DISCUSSION OF PROVISIONS

Any plan for the improvement and extension of our health services must be judged strictly on the basis of merit. Unbiased analysis of the national health bill shows strong and weak points.

The provisions of title I can be expected to exert a powerful and beneficial influence on the badly needed further extension and improvement of general public health, maternal, and child-health services. At long last the sound development of uniform medical care programs for the needy would be initiated. But there are weaknesses that should be eliminated. As it stands, the bill evades the—undeniably intricate—problem of unification of the administration

of health services at the State levels, thus continuing the policy of vesting authority in a multitude of State agencies. To give an example, 22 of the crippled children's programs at present are administered by agencies other than health departments. The measure requires the establishment of a single "public assistance agency" to administer or to supervise the State's medical care program for the needy. Thereby it would bring about a considerable improvement but also perpetuate the old evil of dual administration, the public assistance agencies being responsible for the medical care of the needy, and health agencies having authority for the medical care of self-supporting persons as well as preventive health services for all. At the Federal level not less than three agencies are charged with administrative responsibility, and cooperation and correlation, typical "Ersatz" products, are recommended.

The sections dealing with medical care of the needy fail to eliminate the utterly inadequate method of making cash allowances to individuals for the payment of their bills and to require the use of the prepayment method for the support of services to the needy.

Title II invites many comments on both strong and weak points.

The "right to medical care" is established for all those covered by the program, wherever they live and whatever their income. With this we are nearing the realization of an old American dream—the dream of equality of opportunity for everybody to obtain good medical care. Fairly complete service is organized for the majority of the people under one program, in contrast to the old policy of offering more or less limited service under different programs. Broad coverage is essential from an actuarial point of view, as it makes for effective and economical operation of a plan pooling the risks and resources. The scope of the service, fairly comprehensive as it is, compares favorably with that of very many voluntary health-insurance plans in operation. Continuation of the system of private practice of medicine, dentistry, and related professions and freedom of choice, as proposed in the bill, are the very principles for which the professions have been fighting ever since there has been organized care of the sick. Thus, the professions are offered a unique opportunity to make the program work. The system of voluntary hospitals is maintained in conformity with the concepts and wishes of those who want scope and chance for voluntary effort and philanthropy. Preventive medicine is encouraged through the combination of an organized program for the care of the sick with a system of services for the prevention of illness and promotion of good health; the inclusion of diagnostic laboratory services; the inclusion of "preventive" services and of "periodic physical examinations" or "periodic examinations" in the case of dental service; and easy access to early treatment.

The quality of medical care is promoted by the comprehensiveness of the program; the exclusion from service of persons other than legally qualified physicians, dentists, and nurses; the encouragement of group practice; the availability of consultant and specialist services; the many provisions for the maintenance of professional and hospital standards; and the provision of funds for research and professional education. The proposed method of raising funds for the support of the program is sound and has a long and honorable record in this country as well as a score of foreign countries. It is superior to other methods of finance, because it substitutes organized self-help for charity from the few to the many, eliminates application for aid and determination of eligibility on the basis of financial need, and relieves the administration of the cumbersome procedures inherent in any system utilizing the "means test."

On the debit side of the ledger quite a few items have to be entered that deserve careful consideration.

The success or failure of any health program, no matter how it is financed, depends upon the willing and understanding cooperation of the members of the various health professions. "Doctors can make or break it." The Wagner-Murray-Dingell bill gives the members of the professional groups important rights and defines them in detail. But it contains nothing about the duties of the professions, except for the statement that the general practitioners in the local areas who are participating in the program have a collective responsibility to provide the general services. The question then is warranted whether a satisfactory operation of the program can be expected if the individual physicians have freedom of participation and the medical profession has no collective responsibility for the availability of professional services. To quote from Carl L. Becker: "This is indeed the central problem of all political philosophy and practice, the problem of the one and the many—the difficulty being to reconcile the desirable liberties of the individual with the necessary power of government in

such a way as to do justice as well as may be to the desires and the interests of all individuals and classes in society.¹ In this connection attention must be called to the difficulties that are certain to arise from the lack of Nation-wide licensure. The diversity of State laws is anything but conducive to the better distribution of physicians.

The statements on the proposed administrative organization need amplification and reformulation. In rewriting the pertinent sections each of the following points should be treated under separate headings and elaborated upon: (1) Distribution of administrative powers, duties, and functions among the various levels of government, including the creation of effective local units of administration; (2) professional direction of the service at the Federal, State, and local levels; (3) participation of the health professions, hospitals, and various health and welfare agencies in the organization and administration of the service; and (4) relationship of the prepaid personal health services to other medical care programs and health services under public and voluntary auspices. Emphasis should be placed on utilizing the prepayment service for all rather than operating one program for the majority of the self-supporting people, another for recipients of public assistance and still another one for veterans. The unique opportunity to unify the administration of all health services must not be missed. Preventive health services and medical care programs should be under a single agency. For reasons of expediency the bill omits any proposal that would bring order out of administrative chaos and is content with the make-shift arrangement of coordination. But even this idea is not followed through, as little is said about coordination at the State and local levels.

Another weak point is the exclusion of drugs. The difficulties involved in the effective and economical organization of supply with drugs are great, indeed. As it stands, the bill raises knotty problems. Many physicians, and not only those in rural areas, dispense their own drugs in attending patients. Would they receive payment for an office visit made by the patient only for the purpose of having his prescription refilled? Would the drugs furnished as part of the hospital care be included in the "payment of the reasonable cost of hospital service"? Would exclusion of drugs from the contract induce the hospital to make substantial extra charges for this service?

The proposed rates of payment for hospitalization would not cover the actual cost of care in the best hospitals and thus penalize institutions maintaining highest standards.

The fee-for-service system of payment, one of the various methods offered for selection, has implications that seem to be overlooked by many physicians. As ample experience has shown, combination of the free-choice panel system with the fee-for-service method of payment makes it inevitable to employ cumbersome, annoying, and costly devices for the control of expenditures. This lesson has been learned by many medical societies cooperating with public agencies in the administration of programs of public medical care or sponsoring voluntary health insurance plans. To hope for a satisfactory operation of the program without such controls is to display a naive faith.

Important as the shortcomings of title II are, they are outweighed by the advantages. One general remark applying to both titles of the bill seems to be in order. Phraseology and arrangement leave much room for improvement. Even the experts have to spend countless hours on the analysis of the bill—and might still miss a point. How difficult it is for the general reader, not to mention the busy physician, to avoid misinterpretation and erroneous conclusions! A bill dealing with questions reaching to the heart of the anxieties of everybody should be logically and clearly organized and written in a language fully understandable to the common man.

THE NATIONAL HEALTH BILL: RELATION TO BROAD NATIONAL HEALTH PROGRAM

According to its title, the bill is to provide "for a national health program." Actually, it deals with two essential parts of it, namely, public health services and organized care of the sick. Missing from the bill are proposals for the construction of hospitals and related facilities, the protection of the sick against economic losses caused by disabling illness, and the care of patients with protracted illness.

¹ Carl L. Becker, *Freedom and Responsibility in the American Way of Life*, p. 3. Quoted with permission of the publisher, Alfred A. Knopf, New York.

The first problem is taken up in the Hill-Burton bill, to be cited as the Hospital Survey and Construction Act. Disability insurance is to be included in the revision of the Social Security Act. The problem of 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" is to be studied by the Surgeon General, and to be reported on "with recommendations as to legislation" not later than 3 years after the effective date of title II, S. 1606.

All the bills mentioned are interdependent. Adoption of title I of the Wagner-Murray-Dingell bill and rejection of title II; adoption of the whole Wagner-Murray-Dingell bill without passage of complementary bills, such as the hospital construction bill; or enactment of the Hill-Burton bill without provision for organized payment for services would seriously hamper the development of an effective and economical national health program. No country alert to its social obligations in the field of health service can afford the luxury of piecemeal procedure and half-measures.

THE HOSPITAL SURVEY AND CONSTRUCTION BILL: DISCUSSION

For the first time in American history the development of a broad and balanced program of hospital and related facilities is under active consideration. If passed, the Hill-Burton bill will put an end to the haphazard growth of facilities, with the resultant uneven distribution of all types of hospitals and the deplorable lack of certain special facilities. Due emphasis is placed on quantitative standards. The introduction of the approval system will serve not only to distribute the hospitals better but to improve their quality where indicated. The poorer States are to obtain relatively more financial aid than the wealthier States. The administrative control is vested in the States, as it should be, and unification of the administration is proposed. The State advisory councils are composed of representatives of all groups concerned and thus truly democratic. Enactment of the bill will influence the distribution of physicians and related groups, as it provides for the "workshops" so essential to the practice of modern medicine. The quality of medical care can be expected to improve in areas hitherto undersupplied with adequate hospitals.

The value of the bill in its present form is considerably impaired by several shortcomings.

The measure does not contain provisions for the maintenance of hospitals and the payment for professional services. It is satisfied with "reasonable assurance" on the part of States applying for grants that "financial support will be available for maintenance and operation." To quote a hospital administrator who testified at the Senate committee hearings: "If people are too poor to build a hospital, they'll probably be too poor to run one." Adoption of the Hill-Burton bill without simultaneous passage of bills for the organization of payment for hospital and professional services will create serious problems in many areas. The danger of ghost hospitals must be avoided.

In vain does one look for a statement on the staffing of the hospitals. The nature of standards for the operation of hospitals is left to the States to determine. Are the hospitals to be open to all qualified physicians or to be restricted to some? Are they to be for luxury services? Would the physicians be permitted to charge unlimited fees? These are questions which require clear answers in the bill.

The proposals concerning the powers and functions of the Federal Hospital Council are contrary to the time-tested principles of sound public administration. Although composed of persons who devote nearly all their time to their private interests, the council has considerable authority, including veto power, and important administrative functions. The Surgeon General of the United States Public Health Service and the Federal Security Administrator are made figureheads. Yet, they are the very persons officially responsible to Congress and the public for the proper use of large sums of tax money. Such an administrative structure is utterly unsuitable. Councils composed of part-time members should exercise advisory functions only.

The bill fails to make reference to regional organization of hospitals. For years the experts in all civilized countries have been contending that the pattern of hospital organization which was satisfactory in the nineteenth century has become obsolete in the age of rapid transportation. The future hospitals should be developed to serve regions, rather than political units, a main hospital functioning as the center of an integrated system of district hospitals, rural hospitals, and health centers.

Finally, the amount of money to be appropriated appears small, considering the immediate needs for replacement of obsolete buildings and additions.

THE MATERNAL AND CHILD WELFARE BILL DISCUSSION

A bill dealing with maternal and child-health service is certain to find a sympathetic response. As Sir George Newman once said: "The safeguarding and nurture of motherhood and childlife must be a first requirement in the building of any nation." What then are the relative merits of the health provisions of the maternal and child welfare bill?

The measure would make service available to everybody without discrimination, provide for completeness of service, and develop the program gradually over a 10-year period so as to stimulate the improvement of standards as well as of essential facilities and services. These are highly commendable features. But the bill also has many weak points.

The health provisions of the bill are a half-way measure, as one age group and one condition—maternity—are singled out. The family is divided, and this is contrary to the basic principles of serving the family as a unit. The demarcation by age is artificially and poses intricate administrative problems. The people to be served will wonder why "mom" gets medical care when she is expectant but not when she is sick, why John is "out" when he is 21. And many people will be reminded for the famous question: Are husbands necessary. It would be wiser to concentrate on the passage of a health bill designed for both children and adults and covering all health conditions.

There is little in the bill about the organization of professional services. No definition of professional personnel is given, in contrast to the national health bill which clearly states that licensed physicians, dentists, and nurses shall be qualified to render service. Does this omission imply that nonmedical practitioners can expect to be admitted? The term "group practice of medicine" does not appear at all in the bill. This is all the more regrettable as effective child-health service requires organized teamwork of specialists and general practitioners.

The funds for the support of the program are to be obtained by general taxation. This raises the old question of the relative merits of general taxation and insurance.² In deciding on the future policy utmost care should be taken to avoid the establishment of two systems of raising funds for the support of services for self-supporting people.

The sum to be appropriated is very modest, to say the least. The amount of \$50,000,000 for distribution to the States in the first year exceeds the allocations for the program for the wives and infants of enlisted men (EMIC) by about \$7,000,000 only. It is hard to see how a program for all the mothers and all the children in the country can be operated with the funds suggested, even if the birth rate should decline in the years to come.

YALE UNIVERSITY SCHOOL OF MEDICINE,
New Haven, Conn., April 15, 1946.

HON. JAMES E. MURRAY,
Senate Office Building, Washington, D. C.

DEAR SENATOR: In view of the controversy over the merits of voluntary health insurance I am sending you herewith a statement that may be incorporated in the records of the hearings on S. 1606 if you so desire.

Very truly yours,

FRANZ GOLDMANN, M. D.,
Associate Clinical Professor.

TRANSCRIPT OF EXCERPTS FROM A LECTURE GIVEN AT THE HARVARD MEDICAL SCHOOL ON MARCH 1, 1946, BY FRANZ GOLDMANN, M. D., ASSOCIATION CLINICAL PROFESSOR OF PUBLIC HEALTH, YALE UNIVERSITY SCHOOL OF MEDICINE

VOLUNTARY HEALTH INSURANCE

Voluntary health insurance as an alternative to a compulsory program has been repeatedly recommended by the American Medical Association. In 1938, this organization came out in favor of voluntary "cash indemnity insurance plans to cover, in whole or in part, the costs of emergency or prolonged illness." At the same time the American Medical Association recommended the expansion of workmen's compensation laws "to provide for meeting the costs of illness sustained as a result of employment in industry" and thus endorsed the prin-

² Franz Goldmann, *Public Medical Care*, New York, 1945, pp. 179-190.

ciple of required insurance for occupational diseases. In June 1945, a "constructive program for medical care" was adopted, and 1 of its 14 recommendations called for "the development in or extension to all localities of voluntary sickness-insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association." In December 1945, the house of delegates of the American Medical Association adopted a resolution calling for the "Nation-wide organization of locally administered prepayment medical plans sponsored by medical societies" which would achieve all the objectives of the Wagner-Murray-Dingell bill "with far less expense to the people" and would provide "the highest type of medical care without regimentation." In February 1946, the board of trustees of the American Medical Association issued a 10-point restatement of the association's previously announced 14-point program. Standards for the acceptance of prepayment plans were established. A detailed plan for the development of the voluntary health insurance program was announced to be in process of being worked out by a subsidiary organization known as associated medical care plans, and a new division of prepayment medical care plans was created to administer the voluntary plans under American Medical Association auspices.

The question then is justified whether past experience warrants the belief that the American Medical Association can accomplish its objectives.

In 1945, about 2,600,000 persons were enrolled in "medical society plans," and they accounted for about one-half of the total membership of voluntary prepayment plans covering physicians' services. At a time when purchasing power was at an all-time high, only an insignificant fraction of the population had decided to take advantage of the services offered by medical societies. Although in operation for several years, some of the plans had failed to attract substantial numbers of subscribers. A case in point is the Western New York Medical Plan in Buffalo. This plan, established in 1940 and serving 6 counties with large populations, reported about 40,000 subscribers as of the middle of 1945. With the exception of the programs in Oregon and Washington, the great majority of the medical society plans offer very limited service. In 1945, about two-thirds of the persons enrolled were eligible only for surgical service in the hospital, and in many instances this service was restricted by ceilings on eligibility, the period of care, or the total amount of cost. Only 1 person in 17 was eligible for physicians' care at the home, office, and hospital. In short, the majority of the medical society plans are distinguished by the fact that exclusions exceed inclusions.

The eligibility requirements often contain a clause barring from the prepaid service individuals and families with incomes above the "comfort level." In some instances this level is set as low as \$1,500 for a single person and \$2,500 for the whole family. By establishing income limits, the majority of the medical society plans have insured the poorer risks and disregarded the favorable risks, thus acting contrary to the basic principle of insurance; made the proposition unattractive to large families, management, and labor; and placed the participating physicians in the unenviable position of investigators who have to check the family income in order to detect those patients who earn more than the limit.

The total cost of medical society plans vary too much to allow generalizations. The most successful plan, the Michigan Medical Service, in the middle of 1945 charged monthly rates of \$0.70, \$1.60, and \$2.25 for single subscribers, a family of two, and a family with all unmarried children up to 19 years of age, respectively. These prepayments covered surgical service in the hospital and some ancillary services. The physicians were free to make additional charges from those whose average annual income exceeded \$2,000 in the case of single persons and \$2,500 in the case of families. The Michigan Hospital Service, an outstanding Blue Cross plan, charged monthly rates of \$0.80, \$1.80, and \$2, respectively, for ward care and \$1, \$2.20, and \$2.40 for semiprivate care. To qualify for fairly complete hospital care and surgical service in the hospital, a single person had to make monthly prepayments ranging from \$1.50 to \$1.70, and a family of three or more had to pay in advance from \$4.25 to \$4.65 a month. These amounts equalled 1.2 percent and 1.4, respectively, of the income of a single person earning \$1,500 a year and 2.5 and 2.8 percent, respectively, of the annual income of a family earning \$2,000. It must be borne in mind that in 1945 an annual income of \$2,000 was barely sufficient to cover the ordinary living expenses of the average city family with three members. Substantially higher rates and larger proportions of the income would be needed to extend the scope of the services. High

prepayment rates, however, defeat their own purpose, as they can be afforded by a small fraction of the population only.

Most of the medical society plans actually in operation discourage preventive medicine by excluding health examinations, using "deterrents," such as the "deductible clause," and confining medical care to "catastrophic illness" instead of trying to reduce, if not prevent, the occurrence of serious conditions by providing for early diagnosis and early treatment of any disease. Limited in scope as they are, they cannot foster psychosomatic medicine. In very many instances a premium is placed on surgery with little effort being made to establish and enforce standards as to the competence of those rendering the service for which payment is claimed.

To sum up, many medical society plans are organized merely for the purpose of making financial arrangements for the payment of doctor bills. Little attention can be paid to the improvement of the quality of service. Judging from the numerous articles appearing in medical journals, many of the physicians participating in the medical society plans are dissatisfied and looking for "something else." Not a few show keen interest in cash indemnity plans, although the shortcomings of this method have been proved time and again. In California, the Alameda County Medical Society, in opposition to the State medical society, recommends such a plan, and other county societies are said to have voiced their approval. In Wisconsin, the State medical society has just made an agreement with commercial insurance companies which are to underwrite a limited indemnity policy, and many physicians are beginning to wonder why the medical society should "sell out" to companies organized for profit.

The policies adopted by medical societies in the past were dictated by necessity. The physicians drawing up the prepayment programs entertained no illusions about the impossibility of establishing at reasonable cost a voluntary health insurance program providing for complete service, offering unlimited free choice of physicians, and paying the participating physicians on the fee-for-service basis. Societies which tried it, failed. In California and Michigan, the medical societies had to drop their original "full coverage" contracts because of heavy financial losses. Between the Scylla of very high prepayment rates covering complete service and full payment for professional services and the Charybdis of moderate prepayment rates for complete service with very low fees for the physicians, the medical societies chose the only safe way: The offer of inexpensive and limited service to the subscribers and the promise of full payment to the physicians.

These facts, stated and commented upon in countless publications in medical journals, indicate that the American Medical Association has taken on a Sisypus task. It wants to develop a satisfactory national health-insurance program by voluntary action, although the natural limitations of the voluntary method are well known. It wants to achieve the goal of country-wide organization, although the rank and file of the physicians are divided about the basic principles to be applied. Stormy debates are going on over the advantages and disadvantages of cash-indemnity plans and service plans; of combination and separation of professional services and hospitalization; of complete coverage and partial coverage of service; of rigid and liberal eligibility requirements; of individual practice and group practice. The American Medical Association believes it can make the enactment of a health-insurance law superfluous by promising something better in the future, although the need for a broad and balanced health program is now.

COMMITTEE FOR THE NATION'S HEALTH,
New York 19, April 15, 1946.

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

DEAR SENATOR: Attached is a statement signed by physicians from many parts of the country, endorsing the principles of the national health program. In behalf of the Committee for the Nation's Health, I submit it herewith in the belief that it will be of interest to the Committee on Education and Labor.

Respectfully yours,

CHANNING FROTHINGHAM, *Chairman.*

Enclosure.

We believe from available experience that voluntary health insurance plans will be too costly to give satisfactory medical services for the urgent needs of the American people.

Therefore, we favor a national health program financed by compulsory insurance and delivered by decentralized administration with utilization also of voluntary medical care plans meeting approved standards.

Free choice of physician by patient and complete professional freedom for the doctors must be insisted on.

Channing Frothingham, M. D., Boston, Mass.
Harold Aaron, M. D., New York.
Thomas Addis, M. D., San Francisco, Calif.
B. T. Beasley, M. D., Atlanta, Ga.
Walter Bauer, M. D., Boston, Mass.
Herrman L. Blumgart, M. D., Boston, Mass.
George I. Blumstein, M. D., Philadelphia, Pa.
Ernest P. Boas, M. D., New York.
Byron D. Bowen, M. D., Buffalo, N. Y.
Walter P. Bowers, M. D., Clinton, Mass.
Allan M. Butler, M. D., Boston, Mass.
George Cannon, M. D., New York.
Robert A. Clark, M. D., Pittsburgh, Pa.
Joseph Dalven, M. D., Brooklyn, N. Y.
Francis P. Denny, M. D., Brookline, Mass.
Robert L. DeNormandie, M. D., Boston, Mass.
Edward F. Ducey, M. D., Muskegon, Mich.
Lewis A. Eldridge, Jr., M. D., Great Neck, N. Y.
Jacob Fine, M. D., Boston, Mass.
Charles A. Flood, M. D., New York.
James L. Gamble, M. D., Boston, Mass.
Edwin F. Gildea, M. D., St. Louis, Mo.
Franz Goldmann, M. D., Hamden, Conn.
Emmett Holt, Jr., M. D., New York.
Thomas S. Harvey, M. D., Edgewood, Md.
Henry C. Knowlton, M. D., Bangor, Maine.
Edward B. Krumbhaar, M. D., Philadelphia, Pa.
William S. Ladd, M. D., New York.
John V. Lawrence, M. D., St. Louis, Mo.
P. J. Lipsett, M. D., Oakland, Calif.
John S. Lockwood, M. D., New Haven, Conn.
F. D. W. Lukens, M. D., Philadelphia, Pa.
Harry Mackler, M. D., Elizabeth, N. J.
Leo Mayer, M. D., New York.
George W. McCoy, M. D., New Orleans, La.
Hugh McCulloch, M. D., St. Louis, Mo.
Irvine McQuarrie, M. D., Minneapolis, Minn.
James H. Means, M. D., Boston, Mass.
T. Grier Miller, M. D., Philadelphia, Pa.
George R. Minot, M. D., Boston, Mass.
Robert B. Osgood, M. D., Boston, Mass.
Edward A. Park, M. D., Baltimore, Md.
John P. Peters, M. D., New Haven, Conn.
Richard M. Peters, M. D., St. Louis, Mo.
Max Pinner, M. D., Berkeley, Calif.
Edwin F. Price, Jr., M. D., St. Louis, Mo.
Lt. Comdr. Robert W. Quinn, M. D., Dublin, Ga.
H. B. Richardson, M. D., New York.
Elmer Richman, M. D., St. Louis, Mo.
G. Canby Robinson, M. D., Baltimore, Md.
George Saslow, M. D., St. Louis, Mo.
J. Walter Schirmer, M. D., Needham, Mass.
Kathryn L. Schultz, M. D., Baltimore, Md.
Benjamin Segal, M. D., New York.
David Seegal, M. D., New York.
Elmer L. Sevringhaus, M. D., Nutley, N. J.
Dudley C. Smith, M. D., Charlottesville, Va.
Rebecca Solomon, M. D., Meriden, Conn.
Oliver H. Stansfield, M. D., Worcester, Mass.

Joseph Stokes, Jr., M. D., Philadelphia, Pa.
 Richard F. Thompson, M. D., Denver, Colo.
 Borden S. Veeder, M. D., St. Louis, Mo.
 L. C. Newton Wayland, M. D., Santa Barbara, Calif.
 Myron Wegman, M. D., New York.
 William C. Williams, M. D., Rutherford, N. J.
 Edward L. Young, M. D., Boston, Mass.

ALAMANCE GENERAL HOSPITAL, INC.,
 Burlington, N. C., April 11, 1946.

The Honorable JAMES E. MURRAY and
 MEMBERS OF THE SENATE COMMITTEE ON EDUCATION AND LABOR,
 Washington, D. C.

Re: Senate bill S. 1606.

GENTLEMEN: Thank you for your kind telegram asking our opinion of S. 1606.

Title I of the bill, if kept on a State level, should be of use in helping the fight against venereal disease and tuberculosis. Its usefulness in maternity and child welfare work and in help of the needy is also possible—again if kept on a State level.

Title II—that portion of the bill providing for compulsory insurance—we disapprove in its entirety, because in our opinion this legislation would not improve medical care in the United States but would result in an early, rapid, and continued deterioration of such care. We believe, however, that medical care can be soundly and continuously improved by methods already initiated and being developed in the traditional pattern of our life. There are good bases for those opinions and belief.

1. The evidence of experience both here and abroad is against this legislation. The Veterans' Administration in this country is an example of the deterioration and relative loss of pace of medical care under a governmental set-up.

England and Germany are illustrious examples abroad. After a few decades of modified state medicine, medical leadership passed definitely and overwhelmingly from them to the United States.

2. Legislation that decreases incentive will usually be found harmful. This legislation would leave practically no incentive to patients to provide for their own needs and would leave little but bureaucratic incentive among doctors. By this we mean that doctors would no longer feel the need to excel professionally but only to excel in the maneuvering for preferment in a governmental department.

3. Legislation that decreases freedom unnecessarily is contrary to the basic principle that has made us great as a people. This country fought for and founded itself upon the new political concept of the right of freedom for the individual—so long as that right did not interfere with the similar rights of others.

This proposed legislation starts with the unnecessary curtailment of some freedom but is so written that in the course of a few decades it would remove practically all freedom of choice among patients and doctors—eventually from practically the whole population.

4. For the long term, the proposed legislation is psychologically bad, or we might better say psychiatrically bad. It is "paternalistic." The objection to so-called paternalism is this: People, whether they be children, employees, professionals, or nations, develop because of opportunity, incentive, and responsibility; they do not develop by reason of having these motivating forces removed. This legislation would remove all these desirable motivating forces from patients and doctors alike.

5. The philosophy of the proposed legislation is unsound. It has the same fallacy that the National Prohibition Act had and the same fallacy that State religion had. Contrary to the major premise of such legislation it has been demonstrated time and time again that people cannot be legislated into goodness. This applies to economics and medical care as well as morals. The successful legislation in each field appears to be limited to that area where individual freedom encroaches upon another individual's rights. In economics—thou shalt not steal; in medicine—thou shalt not give smallpox, tuberculosis, or diphtheria to thy neighbor; in religion—thou shalt not kill, commit adultery, bear false witness. But short of this point the rights of an individual must be recognized. It is the great difference between the Confucian and Christian concept.

Confucius thought that people could be legislated into goodness. Christ understood that the individual is the basis and that a nation or social order will be good only when the individuals that make it up become good. It has not been an accident that the Christian nations have been the great ones—the nations that have recognized the essentialness of the individual and given him the incentive and opportunity to progress. Their economic progress has been a reflection of their spiritual freedom. State medicine can do no better than state prohibition or religion. They all have the same fallacy.

6. The economic need for spreading the cost of medical care is rapidly being taken care of. The strides of Blue Cross and insurance plans recently are phenomenal.

In North Carolina the Hospital Savings Association, sponsored jointly by the Hospital Association, the Medical Society, and the public, now has 270,000 members. Of these 125,000 also have obstetrical and surgical coverage. The Hospital Care Association has 125,000 members of whom 50,000 have surgical benefits. The Medical Service Association has 40,000 members.

In the United States as a whole some 21,000,000 are reported covered by Blue Cross plans. Another 10,000,000 are covered by other insurance plans.

Coverage under these plans is growing rapidly in scope and numbers.

7. Increasing hospital facilities in the smaller towns and rural areas will greatly increase good medical care and do it soundly with relatively little cost. The providing of hospitals and the employment of voluntary insurance will be safer, better, and cheaper than any system of State medicine. S. 191 is a step in the right direction.

8. The indigent admittedly remain and probably will always remain a problem. Those who are indigent as a result of being born either physically or mentally deformed remain largely a eugenic problem. Those who are indigent because of failure to develop initiative, foresight, industry, and character remain a psychiatric problem. To encourage the latter class to remain indigent would be a disservice to the Nation.

Sincerely,

GEORGE L. CARRINGTON, M. D.

Chairman, Medical Society of North Carolina Committee.

ALAMANCE GENERAL HOSPITAL, INC.,
Burlington, N. C., April 16, 1946.

The Honorable JAMES E. MURRAY

*And Members of the Senate Committee on Education and Labor,
Washington, D. C.*

Addendum—Re: S. 1606.

GENTLEMEN: Since writing the preceding discussion about this bill I have read the statement that Representative John D. Dingell made before your committee. After reading his statement I felt that if one of the sponsors of the bill could have such an erroneous idea about its contents it would be wise to call attention to some of the specific language of the bill.

Section 203 (a)—“The Surgeon General of the Public Health shall perform the duties imposed upon him by this act under the supervision and direction of the Federal Security Administrator, and after consultation with the Advisory Council.”

This certainly means that it would be politically run.

Section 204—Re: “The Advisory Council.” The Advisory Council is advisory only. No other power is granted it.

Mr. Dingell states that the bill specifically provides for free choice of the doctor by the patient and free choice of patient by the doctor. It is true that such general language is used in the bill but it appears to be used to hide the truth as the following specific sections of the bill definitely prevent such free choice:

Section 205 (c)—“Specialists or consultants shall be those so designated by the Surgeon General.”

Section 205 (d)—The service of a specialist or consultant shall ordinarily be available only upon the advice of the general practitioner or when approved by a medical administrative officer.

Section 205 (e)—The Surgeon General shall publish in each local area the names of practitioners who have agreed to furnish services under this title.

Section 205 (g) 1, 2, 3, 4—Payments for services shall be made on a fee basis, per capita basis, salary basis, or "on a combination or modification of these bases as the Surgeon General may approve" or "by another method."

Section 205 (j)—The Surgeon General may prescribe maximum limits to the number * * * for whom a practitioner * * * may undertake to furnish medical care.

Section 205 (1)—In each area the provision of general medical care shall be the collective responsibility of all practitioners who have undertaken to furnish such benefit.

Section 206—Hospitals—The Surgeon General shall publish a list of participating hospitals. He can also withdraw the name of the hospital.

As a matter of cold fact the bill is not even an insurance bill. No insurance company would probably be allowed to get away with a policy providing such loopholes as this bill.

Section 210 (a)—Limitation of benefits. The Surgeon General may determine that every individual required to pay a fee for general medicine, dental, nursing benefits, for the first service or with respect to each service in a period of sickness or course of treatment. He can also set the fee.

Section 210 (c)—Maximum number of days hospitalization in any benefit year shall be 60.

Section 210 (e)—The cost of laboratory work may be limited.

Sincerely,

GEORGE L. CARRINGTON, M. D.,
Chairman, Medical Society of North Carolina Committee.

The CHAIRMAN. I would also like to insert into the record at this point statements from Dr. R. C. Kash, of Lebanon; Tenn., and Edwin L. Page, of Concord, N. H., of the Medical Society of North Carolina, and from the Committee for the Nation's Health.

(The statements are as follows:)

R. C. KASH, M. D.,
MARTHA GASTON HOSPITAL,
Lebanon, Tenn., March 16, 1946.

Senator J. E. MURRAY,

Senate Office Building, Washington, D. C.

DEAR SENATOR MURRAY: I understand that hearings of the proposed Wagner-Murray-Dingell bill are to begin soon and since I cannot be in Washington at that time for testifying before the committee am submitting this document with the request that it be read to the committee and incorporated into the record of proceedings.

To begin with, I am no high-powered city specialist. Certainly they deserve nothing but credit for the years of study and application and the unusual technical ability they possess. But I know the dust and jolt of country roads, and the simple and humble life of country people. Also, I do not think I am adverse to a recognition of public needs. Before practicing medicine I was health officer here for 7 years and no one could work that long in a public office without developing an interest in the public welfare. As a result of the information gained during that period, and the work we did toward improving the public lot, coupled with an intimate knowledge of the needs and wants of people in a small town and rural section, I submit the following for your consideration:

1. Medical practice is not a commodity nor a trade. Long years of intense preparation (in my own case 4 years at the University of Kentucky, 4 years in Vanderbilt Medical School, 2 years internship and 1 year postgraduate study at Johns Hopkins) is needed before a man can take the fate of human lives in his hands.

2. The personal relationship between a doctor and his patient is so close that no law nor directive will ever be able to sever that tie.

3. A doctor who is fit to see or be seen in a case of illness must of necessity have a mind of his own, be able to use it as he sees fit, and not be encumbered with regulations, red tape, and other obstacles to freedom of thought and action.

4. Like prohibition, that did not work, a law that proposes to amount to the stifling of initial initiative among the medical profession, will not work. A doctor's initiative can be killed but his interest in doing something he does not want to do can never be made to work.

So much for the negative side. What do I suggest?

1. Limit the activities of the Federal Government to subsidizing local charitable organizations in helping those who are economically unable to take care of medical needs.

2. Pass the Hill-Burton hospital bill as amended.

3. Establish social service departments in all counties and employ workers to investigate and report on individual needs for medical care. After all, the cost of medical care per annum is a very small part of the annual budget, of any individual or family.

4. Make possible the establishment of full-time public-health services to serve all the people.

I think we have figures to bear out our contention that while our system of medical care is not perfect (what system in anything is perfect?) we still have the best in the world. Our American doctors have done more to alleviate human want and suffering than all other doctors in the world combined.

Yours very truly,

R. C. KASH, M. D.

STATEMENT OF ELWIN L. PAGE, SENATE BILL 1606

I reside in Concord, N. H. I retired a few weeks ago from the Supreme Court of New Hampshire because of the constitutional limitation of age. I belong to no pressure group and have sedulously avoided membership. I represent no group or individual interested for or against this bill other than my independent self. I am, as far as this bill is concerned, in the pay of no person or organization.

As a plain citizen I desire to oppose title II of the bill on two grounds:

I. In my opinion, this title is based on the philosophy that social good may be compelled by law. A lifetime in the practice and administration of law leads me to the contrary view. If people in general are to depend for their well-being on compulsion by Government, rather than on themselves, I think we shall inevitably pay the penalty in lessening self-dependence and individual character, which are the roots of a successful democratic system. The loss of those roots will in the end sap the strength of democratic government, and leave us nowhere to turn except to a strong, undemocratic government, which, I am sure, is not the goal of Congress.

II. While the philosophical reason has a practical enough bearing, I go on to observe a point that is purely practical—the economic impact of title II. As I understand it, the cost is to be paid by a tax of 3 percent on earnings up to \$3,600 a year. There has been some suggestion, I believe, of making the tax 4 percent. Thus the maximum deduction from wages or earnings would run as high as \$108 or \$144 a year. At the minimum now proposed, 60 cents an hour, 40 hours a week, 50 weeks a year, the minimum tax on the wage earner would run from \$36 to \$48 a year.

That is a high cost. Millions of people in the moderate income brackets carry health policies of good coverage at less than the maximum cost. Even more millions, of whom I am one, have coverage in voluntary, cooperative organizations like the Blue Cross and Blue Shield. I buy that coverage for \$27 a year—hospital, medical, surgical. I was recently in hospital for a slight operation. My hospital bill, over and above my coverage, was a mere trifle, approximately the difference between ward care and the private room I chose. My coverage, voluntarily taken, costs me considerably less than the minimum direct cost proposed under title II.

But that is only a part of it. The employer, presumably, will pay an equal sum into the fund, immediately doubling the costs suggested, and making them range from \$72 to \$288 a year. And that is not the end. Some appropriations will be necessary to administer the act, if it is passed. So we should have this situation: The wage earner will pay directly a cost of coverage higher than the cooperative cost, and that cost will fall wholly upon his pocket. The equal contributions by the employer, and the public taxes for administration, will come out of production and eventually will be passed on to the consumer, and the laborer covered by this scheme will inevitably pay his share, even if he never realizes it, in the cost of living. The consumer always foots the bill in such matters. So the insured under the cooperative system pays for his protection a moderate sum, and that is the end of it. Under the proposed scheme he would pay outright a sum which, at the minimum, would be one-third or three-fourths

greater; at the maximum would be 2½ to 10 times as great. What he would get for his money would be home nursing and dental care in limited and unknown volume, and he would pay a killing cost for it, even if he did not have also to pay indirectly his share of consumption costs more than equal to what he pays directly.

I argue for the common man. Draw from his sustenance in this way, and you will destroy forever his chance to get voluntary coverage at a far lower cost. And, incidentally, you will detract from his independent character, as observed under the first head. For if you pass this title II, you will at once destroy the cooperatives that already protect about one-seventh of our population and are in position to cover the rest at low cost. If the common man in the United States understood the implications of title II, there would be small demand for it. To state it bluntly, enactment would result, though that clearly is not the intention of the proponents of the bill, in a case of man's inhumanity to man.

EDWIN L. PAGE.

The CHAIRMAN. We will now proceed with the statement of Dr. Goin.

Senator DONNELL. Pardon me, I noticed Dr. Sensenich arose as if he wanted to be heard.

Dr. SENSENICH. I was going to introduce the next speaker. He is Dr. Lowell S. Goin, of Los Angeles, Calif., who will represent the American Medical Association in his presentation, and I will let him qualify himself as to his medical connections. He is in the practice of medicine.

The CHAIRMAN. Very well. Dr. Goin, you may proceed.

STATEMENT OF DR. LOWELL S. GOIN, OF LOS ANGELES, CALIF.

Dr. GOIN. I am Lowell S. Goin, of Los Angeles, Calif. I am a practicing physician, and I happen to be president of the California Physicians Service, which is a voluntary health-care plan of California, and I am also president of the College of Radiology and the Radiological Society of North America. I thank the committee for this opportunity to appear before them. I have a statement which I should like to present to the committee.

VOLUNTARY PLANS CAN EXPAND TO MEET THE NEED

I feel a great sympathy for the objectives which are hoped to be attained by the enactment of this bill, and I admire the humanitarianism of those who work so hard for their attainment. There is not the slightest doubt that the sudden and unpredictable imposition of heavy costs for medical care is frequently catastrophic. The physicians of America are well aware of this and, individually and collectively, have devoted much time and energy to an attempt to solve the problem. They believe that a solution is becoming apparent, and that, given reasonable time, will be reached. They believe that the solution will be a better one than that currently proposed, and that more medical care, and much better medical care, will be available to the American people if voluntary plans are allowed to evolve than if compulsory health insurance becomes law. If it be argued that no voluntary plan completely meets the need, I reply that that is true, but that evolution is not a rapid process and that in a field in which there is little or no experience, haste must be made slowly. That this is likewise true in Government-controlled compulsory health-insurance

plans is shown by German and British experience, Title II of S. 1606, for example, contains 17 sections, but the German insurance law had, before the war, grown to more than 3,300 sections—a certain indication of the complexity of the problem and of the impossibility of composing a neat and effective solution.

The American Medical Association, speaking, I am confident, for the overwhelming majority of American physicians, opposes this legislation on five grounds.

1. The existence of a need for it has been established more by emotional statements than by logic and documented facts.

2. Even if the need were soundly established there is no experience to indicate that compulsory health insurance would benefit the public health, although there is some reason to believe that it would lower the health standards.

3. The costs are totally unpredictable, and no one has even a fair idea of what such a program would cost.

4. Medical care is not the sole factor involved in good health, and there are many things that could properly be done to benefit the public health before we embark on a program such as is proposed.

5. Voluntary health plans are more in keeping with the American tradition and will result in far better care being given to our people.

I should like now to discuss each of these five points in turn:

SELECTIVE SERVICE FIGURES NOT CONVINCING

1. The social planner maintains that the state of health of the American public is deplorable and that medical neglect is a commonplace occurrence. The reason, they say, is the interposition of a financial barrier between the sick man and the doctor, and argue that to remove this barrier will solve our health problem. Last fall the President of the United States in a message to Congress pointed with horror to the shocking figures of selective-service rejections as an indication of the dire need for the enactment of compulsory health insurance. Is it of no significance that our mortality and morbidity rates are among the lowest in the world? Is it an accident that the United States now leads the world in medical education? Is our constantly increasing expectancy of life a reflection of our deplorable state of health? Do you know that the American death rate for diphtheria is about one-half that of Great Britain or prewar Germany? Diphtheria, incidentally, is an excellent indicator, since it is one of the few diseases for which we have specific preventive and curative measures, and since, there being no secrets involved, the German and British physicians know as well how to treat it as do Americans.

So much has been made of the selective-service rejection figures—the 5,000,000 IV-F's—that they deserve a moment of special attention. Senator Pepper's interim report analyzes the 4,217,000 rejectees and breaks them down into groups. Four hundred and forty-four thousand eight hundred were rejected as "manifestly disqualified." These include the armless and the legless, the totally blind, the totally deaf, the deaf mutes, etc. What medical care could have made this group whole? How shall the amputated leg be restored, and who knows how to cure optic disease. The modern concept is that mental disease is largely a constitutional inborn inability to cope with reality. What

has medical care to do with it? Five hundred eighty-two thousand one hundred were rejected for mental deficiency. That is to say, they simply lacked the intelligence to become soldiers or sailors, or, indeed, useful citizens of any sort. They are the idiots, the imbeciles, and the low-grade morons. Even a very slight knowledge of eugenics will persuade anyone that this group does not constitute a medical-care problem. Together, these three groups reach a total of 1,727,600, or more than one-third of the rejectees. If they are now excluded, there remain 2,426,500, a little less than one-half the famous 5,000,000. Three hundred twenty thousand of these were rejected for musculo-skeletal defects.

Senator DONNELL. Of the total number, you mean?

Dr. GOIN. That is the congenitally short leg, the club foot, the withered arm, the congenitally dislocated hip, the absence of a half vertebra and the consequent crooked back. How, I ask, would medical care have restored these unfortunates to usefulness? Two hundred and eighty thousand were rejected for syphilis. Treatment for syphilis is offered freely everywhere. As a matter of fact our statute books are simply loaded about syphilis prevention. I doubt that there is a community in which a syphilitic may not receive treatment from a department of public health. One wonders how compulsory health insurance would have eliminated this group. Two hundred and twenty thousand were rejected for hernia, probably for hernias so severe that the Army was unwilling to attempt repair. I mean by that that likely these were bad hernias because I did think the Army repaired some. Hernia is the result of a congenital defect in the inguinal or femoral canal, presumably due to a defect in the germ plasm. If such a defect exists, its bearer is likely to have a hernia, and medical care has nothing whatever to do with the occurrence of hernia. One hundred and sixty thousand were rejected for eyes, by which I suppose is meant defective vision. Now, it is true, that some forms of blindness, ophthalmia neonatorum, for example, may be prevented by adequate medical care, and I think every State has a law requiring the installation of silver into the eyes of the newborn, and it is my belief that ophthalmia neonatorum is practically an extinct disease. But I think it fair to assume that this group of 160,000 did not include the blind, but those with visual errors too great to permit good or even fair vision. If one is born with an eyeball too long, or too short, or one that is not symmetrical, then one will have a refractive error and one will either wear glasses or not see very well, and medical care again has nothing at all to do with it. These groups total about 1,000,000, and the rejections which might be due to a lack of medical care are thus reduced to about 1,500,000, or about one-third of the shocking figure of 5,000,000. Although it is quite problematical whether any program of medical care would have altered substantially this figure, we may rest on it, confident that the figures fall a good bit short of establishing an urgent need for the enactment of compulsory health insurance.

COMPULSORY HEALTH INSURANCE WILL NOT IMPROVE HEALTH

2. Even if we had thoroughly established the need for some better plan for medical care, it would be proper to inquire whether a proposed plan offered some reasonable probability of improving

public health. Since compulsory health insurance has existed in various parts of the world for fairly long periods of time, it should be possible to examine the experience in those areas and, by analogy, establish the probable effect of our plans upon our own health. I think it quite interesting to note that compulsory health insurance has been in effect in San Francisco for some years as regards the municipal employees. The insured are served by the same physicians and in the same hospitals as are noninsured persons. In spite of the fact that no financial barrier exists between an insured person and a physician, the incidence of ruptured appendix is higher among the insured than among the uninsured. In this instance, at least, the removal of the financial barrier, so abhorred of the social planner, did not seem to benefit the insured public. The morbidity and mortality rates are higher in nearly all insurance countries than in our own. May I quote to you from Dr. Nathan Sinai's book, *The War of Health Insurance*? Remember that he is a most able and ardent advocate of compulsory health insurance. He says, "Contrary to all predictions, the most startling thing about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually, and the continuously increasing duration of such sickness. Various studies in the United States [he says] seem to show that the average recorded sickness per individual is from 7 to 9 days per year. It is nearly twice that amount among the insured population of Great Britain and Germany and has practically doubled in both countries since the installation of insurance."

Senator DONNELL. Might I ask a question, what is the approximate date of Dr. Sinai's book, if you know?

Dr. GOIN. I would say roughly 1943 or 1944, maybe it is 1942. This seems to me a rather sound argument against compulsory health insurance, although Dr. Sinai probably did not intend it thus. To clinch the matter he adds: "It seems to be a safe conclusion that insurance has certainly not reduced the amount of sickness." This puzzles me a little, since I have naively assumed that the intent was to reduce the amount of sickness and to improve health. I believe that the evidence in hand warrants the flat statement that compulsory health insurance will not benefit the public health.

THE COSTS ARE UNPREDICTABLE

3. When compulsory health insurance was proposed in California, a year ago last January, no one appeared with any sound idea as to its cost. The guesses varied between \$20 per person per year and \$80 per person per year. Most thought that \$40 was a fair figure. I think it significant that costs are nowhere discussed in the present bill, the Surgeon General of the Public Health Service being given a blank check. At \$40 per person per year, the program would cost \$4,000,000,000, and no one really knows whether this amount would suffice. Experience elsewhere indicates that there is needed at least one employee (not including those actually delivering medical service) for each 100 insured persons (Crownhard, J. G., *Sickness Insurance in Europe*, 1938, p. 25). On this basis we would need to increase the Government pay roll by about 1,500,000 employees. And yet, to pay this vast army, to pay the doctors, to pay for hospitalization, and for

the other benefits offered, no sums are named, no appropriations are made and no limits are set. This is a rich country, but no wealth is unlimited.

OTHER STEPS SHOULD BE TAKEN FIRST

4. A sort of current custom is to use the term "medical care" and "health" as if they were interchangeable—as though one were a synonym of the other. As a matter of fact, medical care is only a small part of the health problem—not even the most important part. Health consists largely in not being sick; medical care consists largely in an attempt to cure or alleviate disease. Nearly all—perhaps all—of the health legislation which has been proposed from time to time has been written by social planners, seldom, if ever, in consultation with physicians. Consequently nearly all of it contains much wishful thinking and not too much reality. Too much confidence is placed in preventive medicine; too much earnest belief that periodic health examinations will prevent disease, and all the legislation evidences a complete failure to understand that preventive medicine simply has not yet attained the goals wished for. To cite a very few of the problems: How shall heart disease (except that due to rheumatic fever) be prevented? What sort of health examination will be efficient in its control? How shall we prevent, or even recognize, early brain tumors? Shall every one with a headache have encephalographic or ventriculographic studies? Shall we do gastrointestinal X-ray studies on every one with indigestion and, if so, where shall we obtain the skilled personnel? How are bone tumors prevented, and what periodic examination makes one aware of the pneumonia of next week? Medical care is, and will for a long time continue to be the care of the sick, and this, I repeat, is only a fraction of the health problem. Some other fractions to which Government might well turn its attention are sanitation, hygiene, health education, adequate diet, good housing, adequate clothing, working conditions, patent-medicine control, and many others. If Government is sincerely interested in the health of the citizen, why should it not suppress patent-medicine advertising? Why should it not regulate the cults, and require that all who wish to practice the healing arts pass the same tests? Why should it not control radio publicity of nostrums, vitamins, and the like? This current legislation is attacking only a small segment of the health problem, and even if it were to accomplish all that its proponents claim, it still would not solve our health problems.

VOLUNTARY PLANS ARE PREFERABLE

5. Voluntary health plans will, if given the opportunity, do the job, and do it better than Government-controlled plans can do. These plans, which already include a very large number of persons, are in accord with our traditional emphasis on personal responsibility, prudence, foresight, and thrift. They have an American dignity which is lacking in the regimentation of compulsory health insurance. They can be and are more economically administered, they can and do give better medical care, and they will be and are supported by thousands of physicians who are bitterly and unalterably opposed to Government-controlled medicine. In California we have made a good start. Our California Physicians Service offers medical care

at modest costs—a quarter of a million of our people have availed themselves of it, and appear to be quite satisfied with it. The Farm Security Administration had a medical-care program for the rural indigent. California Physicians Service took it over and gave better medical care for less money, and to the satisfaction of those giving and receiving the care. California Physicians Service has just signed a contract with the State Grange, providing medical care for nearly 100,000 farm people. These activities, which are duplicated in most of our States, are indications of how voluntary plans can meet the challenge—how they are meeting it, and how they will continue to do so with a steady and healthy growth if they are not crushed by the monster of bureaucratic control.

The CHAIRMAN. Doctor, is it not true that most of the objections that are made to the compulsory system with reference to the relationship between physician and patient apply equally to the voluntary systems?

Dr. GOIN. Senator, I am really familiar only with the California voluntary system and in that instance I will answer "No; it is not true."

THE CALIFORNIA PHYSICIANS SERVICE

The CHAIRMAN. Will you explain the California system again briefly?

Dr. GOIN. That is a voluntary health-care plan in which people are enrolled as beneficiary members and are served by doctors who are professional members. The doctors are paid on what is called a unit basis, that is to say that the funds received in a given month are pooled and after the necessary administrative expense and a reserve for unforeseen contingencies, such as an unexpected epidemic next month, are set aside, the remaining money is divided equally among the doctors on the basis of what service they have rendered. The minimum amount of medical service is presumed to be a visit to the doctor in his office, one office call. That is known as one unit. The fee schedule is then in multiples of that unit. There is no one that intervenes at all between the doctor and his patient. There are practically no regulations, none that I know of that concern the practice of medicine.

The CHAIRMAN. Does your system give full coverage to the people that belong to it?

Dr. GOIN. Not quite, Senator.

The CHAIRMAN. What do they cover?

Dr. GOIN. We have three types of contract that we offer. We offer the so-called catastrophic coverage in which the insured is covered for hospitalization and surgery, including fractures and dislocations.

The CHAIRMAN. That is only in cases of catastrophe?

Dr. GOIN. It is a case requiring any sort of surgery plus fractures and dislocations which are considered to be surgery, they are specifically included.

Then we have the same contract with the so-called medical rider, in which the patient receives medical care if he is hospitalized. And then we offer a third contract known as the "two-visit deductible" in which the patient, the subscriber, is fully covered except that he must pay for the first two visits to the doctor. However, if the first two visits lead to hospitalization and surgery, he is not obliged to pay for

them. The purpose of the two-visit deductible is to prevent the insured from imposing upon the professional member.

The CHAIRMAN. All three of the systems would not cover all of the service that is proposed under the pending bill.

Dr. GOIN. All except the first two visits to the doctor, Senator.

The CHAIRMAN. You do not provide for maternity care, do you?

Dr. GOIN. Yes, sir; after 10 months. The subscriber must be a subscriber for 10 months before she is eligible but thereafter she is completely eligible.

The CHAIRMAN. Do you provide dental care?

Dr. GOIN. No, sir.

The CHAIRMAN. And no nursing care?

Dr. GOIN. The ordinary floor nursing in the hospital, no home nursing.

The CHAIRMAN. And no eye care?

Dr. GOIN. We do not prescribe glasses, but any eye disease is just as amenable to treatment as any other disease.

The CHAIRMAN. You take the position that the compulsory system would result in a deterioration of the medical service, of the medical profession in the country?

Dr. GOIN. I am persuaded of it.

The CHAIRMAN. Is not it true that at one time the American medical profession considered favorably compulsory—

Dr. GOIN. That is true. I think we are all entitled to one mistake.

The CHAIRMAN. That was a serious mistake made by very excellent men.

Dr. GOIN. That is right, but since that time we have developed a good deal of experience.

The CHAIRMAN. But for a long time you were also opposed to a voluntary system.

Dr. GOIN. I could not say that is true. I think the American Medical Association did not regard voluntary care plans with much favor for some time, largely because there had been no experience developed, and none knew how to do these things, or whether they could be done.

I think the doctors are rather complete realists. We face conditions as they are. If we have an incurable patient, for example, we do not hope to cure the patient; we hope to make them as comfortable as possible until death intervenes. They thus learn to be realistic. To want to do something and to do it are not synonymous terms, and I think for a long time we doubted whether there was enough experience in the world to justify any type of health insurance.

I think slowly it is developing that there is an increasing amount of experience which does justify it, and therefore we have reversed our attitude and we now support these matters.

The CHAIRMAN. Without some system of insurance, or some means of making modern medical care available to a large section of the people of this country, they would go without adequate care.

Dr. GOIN. No; I could not agree to that, sir.

The CHAIRMAN. You do not accept that at all?

Dr. GOIN. No; I do not.

The CHAIRMAN. You think that the American people can get all of the medical care they need?

Dr. GOIN. I heard Senator Pepper this morning describe the lack of medical care in his home State. Of course, I have no way to know

what occurs in Senator Pepper's home State. But I can say this, that I have been in the practice of medicine for 34 years, and that during that time I have never refused any person any medical care that I thought I was competent to give, nor do I know any of my fellows that have done so. Now, perhaps, there are people who have done otherwise.

The CHAIRMAN. You think that the present system, then, of having the medical profession wherever they find patients coming to them that are unable to pay, that they should accept those patients and care for them?

Dr. GOIN. I certainly do. I think it is not only their duty, I think it is their privilege to do so.

The CHAIRMAN. And you think that that would be the result in this country, if we did not have any compulsory system?

Dr. GOIN. No, sir. I do not wish to be misunderstood. I do not argue for the maintenance of the status quo. I think we must find some better way to distribute medical care. I am not yet sure what that better way is. My preference for the moment is for voluntary health-care plans, but I think it is also true that one need not be sure of the right answer to know when the wrong answer is wrong.

The CHAIRMAN. Of course, there are a great many members of the profession, and even members of the American Medical Association who disagree with you in these views.

Dr. GOIN. Well, a great many in that, a few thousand are a great many. But I think 95 percent of the physicians of American would agree with my views.

The CHAIRMAN. I have here a release just issued by the Committee for the Nation's Health, which I will ask to have inserted in the record.

I will read it.

DISTINGUISHED PHYSICIANS SUPPORT HEALTH BILL

A distinguished group of physicians, all members of the American Medical Association, in a telegram to Dr. Channing Frothingham, chairman of the Committee for the Nation's Health, took sharp exception to the AMA stand on the Wagner-Murray-Dingell national health bill now under consideration by the Senate Committee on Education and Labor.

"We believe from available experience," the telegram reads, "that voluntary health insurance plans will be too costly to give-satisfactory medical services for the urgent needs of the American people.

"Therefore, we favor a national health program financed by compulsory insurance and delivered by decentralized administration with utilization also of voluntary medical-care plans meeting approved standards.

"Free choice of physicians by patient and complete professional freedom for the doctors must be insisted on."

The list of physicians signing the telegram includes doctors in private practice throughout the United States, medical-school teachers, research scientists, clinicians. Among the group is a winner of the Nobel prize, Dr. George R. Minot of Boston, Dr. Thomas Addis of San Francisco, well-known medical professor at Stanford University Medical School, Dr. George W. McCoy of New Orleans, nationally known for his work on the control of infectious diseases, Dr. Edwards A. Park, of Baltimore, professor of pediatrics, Johns Hopkins University. The list of signers follows:

Channing Frothingham, M. D., Boston, Mass.
 Harold Aaron, M. D., New York.
 Thomas Addis, M. D., San Francisco, Calif.
 B. T. Beasley, M. D., Atlanta, Ga.
 Walter Bauer, M. D., Boston, Mass.

Herrman L. Blumgart, M. D., Boston, Mass.
 George I. Blumstein, M. D., Philadelphia, Pa.
 Ernst P. Boas, M. D., New York.
 Byron D. Bowen, M. D., Buffalo, N. Y.
 Walter P. Bowers, M. D., Clinton, Mass.
 Allan M. Butler, M. D., Boston, Mass.
 George Cannon, M. D., New York.
 Robert A. Clark, M. D., Pittsburgh, Pa.
 Joseph Delven, M. D., Brooklyn, N. Y.
 Francis P. Denny, M. D., Brookline, Mass.
 Robert L. DeNormandie, M. D., Boston, Mass.
 Edward F. Ducey, M. D., Muskegon, Mich.
 Lewis A. Eldridge, Jr., M. D., Great Neck, N. Y.
 Jacob Fine, M. D., Boston, Mass.
 Charles A. Flood, M. D., New York.
 James L. Gamble, M. D., Boston, Mass.
 Edwin F. Gildea, M. D., St. Louis, Mo.
 Franz Goldman, M. D., Hamden, Conn.
 Emmett Holt, Jr., M. D., New York.
 Thomas S. Harvey, M. D., Edgewood, Md.
 Henry C. Knowlton, M. D., Bangor, Maine.
 Edward B. Krumbhaar, M. D., Philadelphia, Pa.
 William S. Ladd, M. D., New York.
 John V. Lawrence, M. D., St. Louis, Mo.
 P. J. Lipsett, M. D., Oakland, Calif.
 John S. Lockwood, M. D., New Haven, Conn.
 F. D. W. Lukens, M. D., Philadelphia, Pa.
 Harry Mackler, M. D., Elizabeth, N. J.
 Leo Mayer, M. D., New York.
 George W. McCoy, M. D., New Orleans, La.
 Hugh McCulloch, M. D., St. Louis, Mo.
 Irvine McQuarrie, M. D., Minneapolis, Minn.
 James H. Means, M. D., Boston, Mass.
 T. Grier Miller, M. D., Philadelphia, Pa.
 George R. Minot, M. D., Boston, Mass.
 Robert B. Osgood, M. D., Boston, Mass.
 Edwards A. Park, M. D., Baltimore, Md.
 John P. Peters, M. D., New Haven, Conn.
 Richard M. Peters, M. D., St. Louis, Mo.
 Max Pinner, M. D., Berkeley, Calif.
 Edwin F. Price, Jr., M. D., St. Louis, Mo.
 Lt. Comdr. Robert W. Quinn, M. D., Dublin, Ga.
 H. B. Richardson, M. D., New York.
 Elmer Richman, M. D., St. Louis, Mo.
 G. Canby Robinson, M. D., Baltimore, Md.
 George Saslow, M. D., St. Louis, Mo.
 J. Walter Schirmer, M. D., Needham, Mass.
 Kathryn L. Schultz, M. D., Baltimore, Md.
 Benjamin Segal, M. D., New York.
 David Seegal, M. D., New York.
 Elmer L. Sevringhaus, M. D., Nutley, N. J.
 Dudley C. Smith, M. D., Charlottesville, Va.
 Rebecca Solomon, M. D., Meriden, Conn.
 Oliver H. Stansfield, M. D., Worcester, Mass.
 Joseph Stokes, Jr., M. D., Philadelphia, Pa.
 Richard F. Thompson, M. D., Denver, Colo.
 Borden S. Veeder, M. D., St. Louis, Mo.
 L. C. Newton Wayland, M. D., Santa Barbara, Calif.
 Myron Wegman, M. D., New York.
 William C. Williams, M. D., Rutherford, N. J.
 Edward L. Young, M. D., Boston, Mass.

So there are a great many doctors around the country that are giving study to this problem, and are of the opinion that a compulsory health system would be advisable in this country.

Dr. GOIN. Senator, might I remark that it is not at all established that these men have given study to this problem? Perhaps they are

well wishers who would like to see good done to humanity. It, I think, would be very interesting to know how many of the telegrams Dr. Frothingham sent out did not get affirmative answers.

I spent Sunday with a man in New York who is a professor of pediatrics at Columbia who refused to send such a telegram. His name is not there. I do not think it is a very large number compared to the number of doctors, and if it please the committee, I could within 10 days get a similar telegram signed by 1,000 names for each name on there.

The CHAIRMAN. I am not disputing that. I am merely pointing out that these men who are on that list are men of prominent standing and distinction in the country.

Dr. GOIN. That is true.

The CHAIRMAN. And that they are giving study to the problem and are of the opinion that a compulsory health system is advisable.

Dr. GOIN. That is right. Some of them have devoted their lives to getting a compulsory health system activity. Peters, Addis, and Butler, for instance, devoted almost their entire lives to getting such a system. I presume they are sincere.

The CHAIRMAN. When did these doctors commence to promote such a program?

Dr. GOIN. I know Addis, to my personal knowledge, has been advocating it for 16 years.

The CHAIRMAN. And the American Medical Association generally opposes it?

Dr. GOIN. That is right.

The CHAIRMAN. I notice that in this report of Medical Care for the American People that was issued in 1932, a committee on the costs of medical care, that the American Medical group at that time was opposed to the voluntary system. That is true, is it not?

Dr. GOIN. I could not say, but I would not be at all surprised because as I said before at that time we had no body of facts on which to proceed on a voluntary health care plan, and they had to be worked out piecemeal, slowly, painfully, and frequently expensively.

The CHAIRMAN. I had reference here to the minority report at that time signed by—

Dr. GOIN. The signers of the minority report do not represent the American Medical Association. It represents eight doctors, members of this committee.

The CHAIRMAN. The members who were on that committee at that time.

Dr. GOIN. Well, they were just doctors who were on the committee. I do not know if they are even members of the American Medical Association. They were certainly not there in that capacity.

The CHAIRMAN. They consist of A. C. Christie, George E. Follansbee, M. L. Harris, Kirby S. Howlett, Arthur C. Morgan, N. B. Van Etten, Robert Wilson, Alphonse M. Schwitalla, and Olin West.

Dr. GOIN. Schwitalla, for instance, is a Jesuit priest; not a doctor at all.

The CHAIRMAN. He is a professor at St. Louis University.

Dr. GOIN. He is dean of the St. Louis Medical University and is a priest; not a physician.

The CHAIRMAN. I understand that. He is a student of these problems.

Dr. GOIN. But not a member of the American Medical Association.

Senator DONNELL. If I may interrupt, I call attention to page 151 of the volume from which the chairman is reading at which Dr. Schwitalla is described as "A. M. Schwitalla, PHD." I think the other gentlemen are mentioned as "MD", but he is referred to as "PHD."

The CHAIRMAN. After this meeting of the committee that was set up at that time, these medical men, who signed this report, opposed the voluntary system and advocated the compulsory system. Is that right?

Dr. GOIN. I could not answer. I do not know. I am not familiar with it.

The CHAIRMAN. I will read it.

Dr. GOIN. I think it would be of little significance since it is nearly 16 years since the report was written. A great many things have happened.

Senator DONNELL. From what page are you reading?

The CHAIRMAN. I am reading from page 163.

Senator DONNELL. From the minority report?

The CHAIRMAN. Yes.

The Committee on the Costs of Medical Care has been in existence for 5 years and during that time has collected at considerable expense a great body of data. Among these data are extensive comments on insurance medicine as it has developed and is now working out in various countries in Europe, and also in this country. In 1931 Simons and Sinai conducted a study of health insurance for the American Dental Association which the majority report of the committee summarizes on page 99. One of the statements in their summary is as follows: "Every attempt to apply the principles of voluntary insurance on a large scale has proved to be only a longer or shorter bridge to a compulsory system. Every so-called 'voluntary' system is successful in just about the proportion that it contains compulsory features." Nothing has been made clearer than the fact that voluntary health insurance schemes have everywhere failed. In Europe they have been replaced by compulsory systems which are now under trial. Even in Denmark, where the system is nominally voluntary, there are indirect but very effective means of compulsion.

I understand that this report was submitted to the house of delegates of the American Medical Association, and that the house of delegates approved this in 1933.

Is that true?

Dr. GOIN. I could not say. I was not a member of the house of delegates at that time. But I repeat that I think it has but little significance since times have changed a great deal in the ensuing years. That report was probably written about 1930.

Senator DONNELL. 1931.

Dr. GOIN. 1931, perhaps. I think we are in a considerably different situation.

I would like to answer an objection that they raise, however, that the voluntary health insurance, all these plans, have always heretofore failed. I think that is true, too, but they must have been speaking of voluntary health insurance plans in Europe since we had none in this country at that time.

I might call your attention to the fact that attempts at democracy also did fail in Europe, and had we been guided by their failures we would not have had a republic in this country; that no country, until we did so, wrote a truly democratic constitution such as we live under; that voluntary health insurance plans might have well been

nourished by the rugged fertile democratic soil of America, whereas they would be like the wheat that was sown among the rocks in the parable, in Europe, where they have a working class they would almost consider indigent, where they have a social economic culture derived from the feudal period, where conditions are so much different that I do not think there is any valid comparison.

I would think if we could cover 71,000,000 people in America with life insurance on a voluntary basis, without any compulsion whatever, persuading these people to buy the insurance because they believe they need it, I see no reason to believe we could not cover 71,000,000 people with a voluntary insurance.

The CHAIRMAN. We have been trying for a long while to spread health insurance in this country, but we have not succeeded.

Dr. GOIN. Not very long, Senator.

The CHAIRMAN. Do you think it would be possible in any length of time to get a complete coverage in the country under a voluntary system?

Dr. GOIN. I think the voluntary systems, if they were not handicapped by the fact that they are largely under the management of doctors and State medical societies having at their disposal extremely limited funds and having not much business experience, and being totally unable to afford the publicity that they should have, and the sales campaign that they should have, if we were freed from those restrictions, I think we could sell an enormous amount of voluntary health insurance in a very short period of time.

The CHAIRMAN. But these voluntary health systems do not give the people joining them full medical coverage.

Dr. GOIN. No, nor does the compulsory health insurance, although the bill says that it will.

But the fact is that it takes time to develop these things, Senator Murray, and one cannot just dash in and turn everything at first crack.

The CHAIRMAN. What medical care or service do you mean to say that is not covered by the pending bill?

Dr. GOIN. It is all covered by the bill. But most of us have seen how it is actually applied and we are not too impressed.

The CHAIRMAN. You mean to infer that it would never be carried out?

Dr. GOIN. Well, it would be carried out in compliance with the letter of the law, but it would not be any good.

Twenty-five people walking through my office and saying they have a cough, and having prescription 271 handed to them by me is not medical care in my mind.

The CHAIRMAN. How would it be better under a voluntary system?

Dr. GOIN. You do not have any interference; any regulations. The doctor treats his patient as he sees fit. If the patient does not like him, he goes somewhere else.

Under our voluntary health plan in California, any patient may select me if he likes, but if he does not like me, there is nothing to compel him to come to me. He can go to my neighbor. Hence, he is likely to find the medical care he wants. Nobody tells me what I must do to these patients.

The CHAIRMAN. Under this bill nobody tells the doctor what he must do.

Dr. GOIN. Oh, Senator, I could not quite agree with that.

The CHAIRMAN. That is what I consider your personal construction of the language. But it is not susceptible of that construction in my judgment. The bill properly construed does not interfere or attempt to supervise the doctor in any respect. In fact, it specifically undertakes to point out that it does not interfere with the doctor, or with the relations of the patient and doctor.

Dr. GOIN. Senator, if I could tell you a small personal experience that has not to do with compulsory health insurance, but is closely analogous to it, I will tell you that a very close friend of mine, a lieutenant colonel in the Army, had an ulcer of the duodenum: had an occurrence of it after 2 years in the Army; had it recognized and treated.

A year and a half later he had a second recurrence at which time the Army failed to find the ulcer. This is a matter of opinion.

At this point he came to me as a private physician and friend and I again demonstrated that he had a penetrated ulcer of the duodenum. Being a lieutenant colonel, he was prepared to go to the colonel in command of the regional hospital and argue with him. If he had been an enlisted man, he would not have done very well. But he went to the colonel and said, "This is the fact." The colonel looked at it, and said, "There is no such thing as a vitaminic ulcer. It is not in the Army book." Maybe they do not have it in the Army, but civilians do, but that is the way regulations go.

The CHAIRMAN. I do not know about that.

Dr. GOIN. I am assured by my friend in the Navy that you cannot make a diagnosis that is not in the Navy book.

The CHAIRMAN. I do not know anything about the practice of medicine in the Army, or the Navy, but my understanding is that they made a great record in the war, and that the men, both in the Navy and in the Army, were very excellently taken care of, and there was absolutely no criticism whatever of the medical profession in the Army or the service that they rendered. It was extremely satisfactory and effective.

Dr. GOIN. Remember it was given by civilian doctors who only put on uniforms out of patriotism and are not making a lifetime job out of it. There is a big difference.

The CHAIRMAN. But you think they rendered a good service.

Dr. GOIN. I think they did a magnificent job in the call of patriotism.

The CHAIRMAN. Do you not think the doctors in this country and the various clinics and laboratories, operated under a group-practice system, also give excellent service to the American people?

Dr. GOIN. I think it varies a good deal between various clinics, but in general, I would think "yes."

The CHAIRMAN. The system of group practice in this country has, to a large extent, supplanted the former practice of individual doctors.

Dr. GOIN. I would not say so. I think the individual doctors are by far in the majority.

The CHAIRMAN. But the group-practice system is growing in this country, and it is tending to—

Dr. GOIN. Yes, sir.

The CHAIRMAN. It is the modern method of medical care now recognized as the most efficient. Is not that true?

Dr. GOIN. I would say it is an excellent way to practice.

The CHAIRMAN. Is it not much better than the old system of a single practitioner attempting to take care of a patient?

Dr. GOIN. I do not think a single practitioner does attempt to take care of a patient except in the most trifling incident. I do not think he has any hesitance to summon consultation. He does not secure the approval of the administrative officer of the district, either, but he does in this bill.

The CHAIRMAN. How does that affect the service that he would render, even if he did contact the administrative officer?

Dr. GOIN. Senator, I think the minute you interpose an administrative officer between the sick man and the consultant, you begin to complicate the system.

The CHAIRMAN. We have this system right here in the Senate of the United States. I go to an administrative officer, Dr. Calver, and he sends me out to the Naval Hospital. I go out there and I am checked up by doctors that I never saw before, and never heard of before. They tell me what is the matter, and recommend treatment.

Dr. GOIN. Would it be unfair for me to point out that you are a distinguished Senator from the United States, and not a fellow who works down at the docks.

The CHAIRMAN. If it is good enough for a distinguished Senator, it might be good enough for a person who works down on the docks.

Dr. GOIN. That is true, but the reverse is not necessarily true.

The CHAIRMAN. It seems to me that the system is good because it is effective, and because it is the modern way of handling the sick.

Dr. GOIN. Senator, I cannot believe that you would compare the service that a Senator gets in a Government hospital with the service that an ordinary plain day laborer might expect to get at the hands of panel doctors, subject to the administrative officer's directives. I cannot believe that.

The CHAIRMAN. You mean to infer then that an ordinary person walking into one of these voluntary systems would not get complete and excellent care?

Dr. GOIN. Voluntary system?

The CHAIRMAN. Yes.

Dr. GOIN. If he did not, he would go elsewhere.

The CHAIRMAN. You think it is only a United States Senator going through the Naval Hospital that can get the finest kind of care? Is that the idea?

Dr. GOIN. No, sir. What I say is that you probably get attention far surpassing that which might be expected to be received by an ordinary panel patient who is a laborer, who goes to the panel doctor, who is subject to the directive of the medical administrative officer of the district.

I think there is no comparison whatever between the two situations, and I think you will admit it.

The CHAIRMAN. I do not understand the medical officer in the district having anything to do with the situation after the relationship of patient and doctor is established under this bill.

Dr. GOIN. Section 205, paragraph (a), Senator, establishes it. It says that the patient may have a specialist if his attending doctor requests it; if it is approved by the administrative medical officer of the district.

The CHAIRMAN. What is wrong with that?

Dr. GOIN. I think a good deal is wrong with it. I do not wish a medical administrative officer intervening between me and my desire to have a consultant if I am not satisfied with your medical attention.

The CHAIRMAN. Line 15, page 46 is as follows:

(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.

Is not that a reasonable regulation?

Dr. GOIN. I would not think so, sir.

The CHAIRMAN. You would not?

Dr. GOIN. No. Under voluntary health care plans he could have the service of a specialist on his own demand. If he were sick and not satisfied with my doctor and wanted a specialist, I would feel I were entitled to get it on demand.

The CHAIRMAN. It says:

The services of a specialist, or consultant shall ordinarily be available only upon the general or family practitioner or of a specialist or consultant attending the individual.

Dr. GOIN. But if the family practitioner does not think you need a specialist, the patient cannot have one.

In line 21, "until the medical officer approved of it." That, I think, is unwarranted interference between the doctor and patient.

The CHAIRMAN. The various voluntary plans that have been called to my attention are all plans that do not give full medical care and hospital service. They all have some qualifications which prevent a person from getting the advantage of full modern medical care, and 9 times out of 10 they would be compelled to pay for the services that they would find themselves in need of.

Dr. GOIN. Senator, I can speak with authority only for the California physicians, which, as I told you, I am president of the board of trustees. But speaking authoritatively for that service I would say that is not the case.

The CHAIRMAN. That is not the case of California.

Dr. GOIN. No.

The CHAIRMAN. You have described your California system here in the course of your testimony.

Dr. GOIN. That is right.

The CHAIRMAN. We are glad to have it.

Dr. GOIN. Yes; I did describe it.

The CHAIRMAN. Have you any pamphlet, or any statement which comprises the system that we may have?

Dr. GOIN. No; I have not. I could easily send you one, and I have here a brief outline of the rural activities of March 28 of this year that you may have if you like.

The CHAIRMAN. We would be glad to have it.

Dr. GOIN. I would be glad to send the complete plan.

The CHAIRMAN. Thank you. We will put it in the record.

(The matter referred to is as follows:)

OUTLINE OF CALIFORNIA PHYSICIAN'S SERVICE RURAL ACTIVITIES—MARCH 28, 1946

I. THE GRANGE

In the fall of 1945, California Physician's Service was asked by the California State Grange if a plan of prepaid medical and hospital care could be worked out for the Grange members in California on a State-wide basis. There are over 300 Pomona granges, or divisions within the Grange, comprising some 25,000 farmers, who with their dependents represent approximately 75,000 to 80,000 individuals.

The program developed by California Physicians' Service is on a 3-year basis. The first year, the program will offer surgical care, care of fractures and dislocations and hospitalization. At the end of the first year, experience under the contract will be reviewed, and if warranted by experience, medical care while the member is hospitalized for illness will be added. After review at the end of the second year, some form of ambulatory medical care will be provided if previous experience justifies it.

The rates established for the coverage, payable on a quarterly, semi-annual or annual basis, are as follows:

	<i>Per month</i>
Male only-----	\$1.55
Female only-----	2.00
Two persons-----	3.80
Three or more persons-----	5.40

The program has been accepted by the board of directors of the Grange. At annual meeting of the Grange early this year, details of the program were presented to some 2,000 members, and were enthusiastically received.

It was felt that enrollment under the program could best be handled by setting up committees within the individual chapters. Wives of Grange members will handle the actual solicitation and instructions. California Physicians' Service will supply descriptive literature, and will furnish speakers for Grange meetings throughout the State. Enrollment will start in about two weeks, beginning in Fresno and Sonoma Counties first.

The California Physicians Service board of trustees has authorized certain exceptions to the regular enrollment requirements because of the unusual nature of the group. Instead of a 75 percent participation requirement, 50 percent of the individual chapter membership will be required. The farmer's annual net income is to be based on the average income during the 5 years from 1935 to 1940. On this basis the \$3,000 income limitation will apply. Also, the 65-year age limitation is to be waived for all Grange members.

II. FEDERAL SECURITY ADMINISTRATION

From 1940 to date, California Physicians Service has had a contract with the Farm Security Administration under which those farmers who were borrowers from the Federal Security Administration and whose annual incomes were less than \$2,000 receive medical care for themselves and their families.

III. COMMUNITY PROGRAMS

California Physicians Service has recently developed a program of community enrollments, under which applications for membership are accepted from self-employed individuals and from groups of two to five not ordinarily accepted. This would of course include farmers. During the month selected, which starts with a community health week, applications for California Physicians Service are accepted from self-employed individuals and small groups.

Community programs are under way now in Santa Cruz, Solano, and Orange Counties, and within the next year such programs will be inaugurated in all counties. Hence, if a farmer is not a member of the Grange, he may secure medical protection and the services of some 6,300 physicians through either the Federal Security Association program or the community program in his own locality.

The CHAIRMAN. I merely wish to point out that the plans we have been examining—voluntary plans. All have qualifications and

exceptions which vary in the various sections of the country. Your plan you say is a complete plan, affording complete medical care and hospitalization.

Dr. GOIN. It is not quite a complete plan. As I told you, we have three different types of contracts. The best, the most complete one excludes the first two visits to the doctor. We have thus far found it necessary to do so for this reason, that John Jones drinks a lot of gin on Saturday night, and wakes up feeling pretty bad on Sunday morning. If he has to pay to see the doctor, he takes an aspirin, and wishes he had not taken the gin. Otherwise, he sees the doctor and that breaks the plan.

Therefore, we have been obliged to impose these two visits. I do not think anybody would avoid a doctor if he had to pay two calls to the doctor, possibly not to exceed \$10 anywhere, and not to exceed \$5 or \$6 in most places.

The CHAIRMAN. On the other hand there are a great many people in this country, working people, employed in the various industries, and in mining and so forth, who have families, and who are compelled to live upon a modest income, and in such cases as that, even without having overindulged themselves, and without any cause on their own part, they become sick, and often times they neglect going to a doctor because they hesitate to incur the cost of such a visit.

We find that in the testimony we have received here continually for several years.

Dr. GOIN. I would be inclined to agree with that, but I would also like to add that these same people have commonly spent much more than the cost of one or two visits to the doctor on patent medicines, strange and irrational cults, advice from incompetent persons which has led to the expenditure of money. Education is a part of this problem.

The CHAIRMAN. That is right. And that is exactly what this bill is seeking to avoid. The people who sell these patent medicines are contributing to the funds for the purpose of opposing this very program.

Dr. GOIN. Possibly so. I do not know about it.

The CHAIRMAN. I know about it, and in the drug stores throughout the country where you go in and buy this patent medicine they slip a little bit of propaganda into the package warning you against this bill that is pending here in the Senate of the United States.

Dr. GOIN. I am very glad to hear that. I am much encouraged.

The CHAIRMAN. You would like to encourage that?

Dr. GOIN. Yes.

The CHAIRMAN. You would like to continue the system in this country, then, of the sale of patent medicine and quack remedies?

Dr. GOIN. No, sir. I would like to continue the encouragement of the opposition of this piece of legislation.

The CHAIRMAN. And you do not care where that opposition comes from.

Dr. GOIN. I do not know—

The CHAIRMAN. You are perfectly willing to contribute to any methods that would defeat this bill.

Dr. GOIN. Perhaps, not any. I do not believe it has been shown that the patent-medicine interests are tied in to opposition of this bill. Perhaps it is. I am not aware of it.

But I certainly endorse the distribution of the propaganda by the druggists.

The CHAIRMAN. Are you familiar with the National Physicians Committee of Chicago?

Dr. GOIN. Not particularly.

The CHAIRMAN. You have heard of it?

Dr. GOIN. Yes; I have even contributed to it.

The CHAIRMAN. You have? And they have sent out a lot of false and malicious propaganda in the country against this bill, calling it political medicine and socialized medicine. Is that true?

Dr. GOIN. I think we would have to define our terms, Senator. Your "false and malicious" might be different than mine.

The CHAIRMAN. When they totally misrepresent the provisions of the bill, do you not think that is malicious?

Dr. GOIN. I have not seen it done.

The CHAIRMAN. I have seen it. They circulated their propaganda and it has been distributed all over the United States.

Dr. GOIN. As Dr. Sensenich said this morning, if it is propaganda, you do not agree with the purpose of it. It is only missionary work if you do.

The CHAIRMAN. You think this propaganda should not be objected to?

Dr. GOIN. I do not object to it.

The CHAIRMAN. You do not object to it?

Dr. GOIN. No, sir.

The CHAIRMAN. You are perfectly satisfied with the propaganda issued by the Physicians Committee of Chicago?

Dr. GOIN. All that I have seen has satisfied me.

The CHAIRMAN. Of course, there are a lot of people that feel that way about it.

Dr. GOIN. I dare say.

The CHAIRMAN. I must admit that you are within your rights in wanting to support that kind of a procedure to prevent legislation of this kind.

Dr. GOIN. I think so.

The CHAIRMAN. I have here a note to the effect that the British Medical Association has made a statement approving the medical plan, the medical health insurance system they have in Great Britain, and are making proposals now for the extension of its service.

They say in their statement, "Despite its defects, this service has been an undoubted success." That is the statement issued by the General Medical Service of the Nation, April 1938, by the British Medical Association.

Senator DONNELL. What is the date of that, Senator?

The CHAIRMAN. April 1938.

Dr. GOIN. My understanding is that they are very bitterly opposing the extension to the National Medical Service plan now proposed.

The CHAIRMAN. The information that I am receiving is that they are in favor of it.

Dr. GOIN. I saw an article in Time of just 1 or 2 weeks ago perhaps, in which all the evils and dangers were pointed out at great length, and the British quoted, perhaps, unfairly. I think it is important to notice what is back of that in Great Britain, which is very obviously

for the benefit of public health, as it repeals compulsory vaccination. I think that is a most remarkable point of sincerity. The enactment of the British service to hospitalize also contains a provision that abolished vaccination.

The CHAIRMAN. Is that by the British Medical Association?

Dr. GOIN. No; it is by the bill proposed in the British Parliament.

The CHAIRMAN. Well, of course, I do not know what that bill contains, but I am talking here about the British Medical Association.

Dr. GOIN. It is perfectly obvious to me that a proposal to further benefit the public health, and a proposal to abolish vaccination are mutually incompatible.

The CHAIRMAN. I would think so myself.

Dr. GOIN. I think that is a remarkable evidence of the sincerity back of the Prime Minister's attempt to nationalize medicine.

The CHAIRMAN. I am not familiar with that. I am sure that it would be very carefully investigated by the British medical practitioners over there.

Dr. GOIN. I think so, too.

The CHAIRMAN. Any questions, Senator?

Senator DONNELL. Yes.

Dr. Goin, Senator Murray offered into the record a release issued today at the head of which is the expression, or statement, "Committee for the Nation's Health, 402 Sixth Street NW., Washington, D. C."

That statement sets forth a copy of, or excerpts from, I am not certain which, a telegram from certain gentlemen addressed to Dr. Frothingham.

Had you ever seen that telegram before?

Dr. GOIN. Yes. Dr. Frothingham sent out a telegram last Wednesday or Thursday, I think it was, to a selected group of people asking them to sign this telegram. The way I happened to see it was that a friend of mine received it and asked me my advice.

Senator DONNELL. And the language of the telegram was set forth in the request, was it not?

Dr. GOIN. No; it was not. Just a telegram endorsing this legislation.

Senator DONNELL. Endorsing this legislation.

Dr. GOIN. Yes.

Senator DONNELL. Did the telegram which you say mention specifically S. 1606?

Dr. GOIN. Yes, sir.

Senator DONNELL. I note with interest the fact that the quotation from this telegram which was offered into evidence this afternoon does not mention S. 1606 at all. It reads as follows:

We believe from available experience,
the telegram reads:

that voluntary health insurance plans will be too costly to give satisfactory medical services for the urgent needs of the American people.

Therefore, we favor a national health program financed by compulsory insurance and delivered by decentralized administration with utilization also of voluntary medical care plans meeting approved standards.

Free choice of physician by patient and complete professional freedom for the doctors must be insisted on.

I call your attention, Doctor, to several facts about that telegram which I think are of considerable interest. In the first place, as indicated, there is no mention whatsoever of this particular bill, S. 1606. You observed that as I read it.

Dr. GOIN. Yes.

Senator DONNELL. In addition to that, I want to ask you about this: I am unable to determine whether this telegram is intended as an endorsement impliedly, without mentioning it, of this bill, or whether it is a very careful attempt to express an opinion favorably for the general idea of compulsory insurance, but with certain safeguards which the signers of the telegram specifically wanted to have incorporated before they would approve it.

I call your attention to this, and I want to ask you your opinion on it. It says, as I have indicated—

Therefore, we favor a national health program financed by compulsory insurance and delivered by decentralized administration with utilization also of voluntary medical care plans meeting approved standards.

I will ask you to state, Doctor, from your study of S. 1606, whether you consider the plan set forth in S. 1606 as a “decentralized administration” of compulsory insurance?

Dr. GOIN. No, sir; highly centralized.

Senator DONNELL. Highly centralized into the Surgeon General, and the Social Security Board, here in Washington.

Dr. GOIN. That is correct.

Senator DONNELL. An advisory council composed of people from various parts of the United States, but as the name implies only advisory council. Is that right?

Dr. GOIN. I do not think an advisory council needs to be considered, much.

Senator DONNELL. In other words, the council may render valuable advice, but, after all, the ultimate decision, as indicated in S. 1606, rests in some instances in the Surgeon General, in other instances in the Federal Social Security Administrator, the head of the entire system. That is right, is it not?

Dr. GOIN. Yes.

Senator DONNELL. So you would not regard this bill, S. 1606, as conforming to this requirement of this telegram, that the program be delivered by decentralized administration.

Dr. GOIN. No; I would not.

Senator DONNELL. It also, I think, gives quite an implied compliment to the voluntary medical-care plans which have been instituted. It states, after the language “we favor a national health program financed by compulsory insurance and delivered by decentralized administration,” it states the following: “with utilization also of voluntary medical-care plans meeting approved standards.”

Would you understand that to mean, Doctor, the plans adopted by voluntary associations, such as the California and other associations over the country?

Dr. GOIN. I would not understand it at all. I do not see what is meant by that.

Senator DONNELL. It is susceptible of the construction, however, that they are referring back—the signers of this telegram—to some voluntary medical-care plans that somebody has previously instituted.

Dr. GOIN. It could be. So-called friendly societies were incorporated in the British plan.

Senator DONNELL. The point I am making is that there is in this telegram, first, no specific approval of S. 1606; second, a qualification, as I read it, that the program should be delivered by decentralized administration, which you do not think is created by S. 1606.

Dr. GOIN. No; I do not.

Senator DONNELL. And, in the third place, that the telegram distinctly refers to a favoring utilization of voluntary medical-care plans.

Now, in the next plan I observe this, which I want to ask you about: The telegram said: "Free choice of physician by patient and complete professional freedom for the doctors must be insisted on."

Do you think, Doctor, that under S. 1606 free choice of physician by patient exists?

Dr. GOIN. No, sir.

Senator DONNELL. Do you think that complete professional freedom for the doctors is assured?

Dr. GOIN. No, sir.

Senator DONNELL. For instance, the right of the Surgeon General to designate who shall be considered as specialists under the terms of section 205, and the right of the Surgeon General to designate who shall be considered consultants, that is a restriction, is it not, upon the absolute freedom of physicians?

Dr. GOIN. Certainly.

Senator DONNELL. So the telegram, as I have indicated, therefore, has these various features which I think should be added in the record as supplementing the language of the telegram.

Now, further, about this telegram, who is Dr. Frothingham?

Dr. GOIN. Superintendent of the Massachusetts General Hospital in Boston.

Senator DONNELL. Of the Massachusetts General Hospital in Boston.

Dr. GOIN. Yes.

Senator DONNELL. Has Dr. Frothingham been active, do you know, along the lines of compulsory insurance for some time?

Dr. GOIN. It is my impression that he has, but I speak under correction. I am not too positive.

Senator DONNELL. Do you know of the meeting that was held at the Carleton Hotel in Washington, D. C., April 1, 1946, either for the organization of or by the Committee for the Nation's Health?

Dr. GOIN. No; I did not.

Senator DONNELL. Did you ever hear of the Committee for the Nation's Health before the present time?

Dr. GOIN. Never.

Senator DONNELL. Do you know whether it is a long-established committee or a recently established committee?

Dr. GOIN. I do not know, but I would assume, if it were of long existence, I would know about it, and I do not.

Senator DONNELL. Do you know a man by the name of Michael M. Davis?

Dr. GOIN. By reputation.

Senator DONNELL. You have heard of him?

Dr. GOIN. Yes, sir.

Senator DONNELL. Do you know whether or not he had anything to do with the preparation of this telegram?

Dr. GOIN. No, I do not.

Senator DONNELL. Do you know Dr. Ernst Boas?

Dr. GOIN. Not personally, but by name.

Senator DONNELL. I note he is one of the signers of the telegram, and I note from tomorrow's schedule that the doctor is to appear here under the designation of "chairman, Physician's Forum, Inc." That is an organization, as I understand from previous testimony, consisting of about 2,000 doctors. Is that correct?

Dr. GOIN. No, I do not know. I know it is a group of physicians in favor of compulsory health insurance, and many leftist trends.

Senator DONNELL. You know it to be a small organization?

Dr. GOIN. Yes, sir.

Senator DONNELL. It is not at all the size of the American Medical Association, is it?

Dr. GOIN. No. Goodness, no.

Senator DONNELL. Doctor, I would like to ask you also whether you know of an organization with offices at the same address at which appears the Committee for the Nation's Health, entitled, "Committee on Research and Medical Economics."

Dr. GOIN. Never heard of it.

Senator DONNELL. Did you ever hear of Fred Stein?

Dr. GOIN. No.

Senator DONNELL. Or Paul Kellogg?

Dr. GOIN. No.

Senator DONNELL. Do you know whether Dr. Frothingham is a member of such a committee as that?

Dr. GOIN. No.

Senator DONNELL. Then I will not pursue that inquiry further, save only to say, Mr. Chairman, that I propose a little later on to present certain evidence with respect to the meeting at the Carleton Hotel on April 1, 1946.

Now, Dr. Goin, in your testimony, near the outset of it, you referred to the occasion of the complexity of the problem, and you illustrated that by the fact that while title II of S. 1606—that is to say, the compulsory-insurance portion of the bill—contains 17 sections, that the German insurance law had, before the war, grown to more than 3,300 sections.

Dr. GOIN. That is right.

Senator DONNELL. Now, just as indicative, doctor, of the fact, first, that it is not solely because of the prolificacy of the German language that it has grown to that extent—

Dr. GOIN. I think the same thing is true in Great Britain.

Senator DONNELL. Now, I hand you this book and ask you if you can estimate the weight of this book by taking it in your hand.

Dr. GOIN. A couple of pounds, I guess.

Senator DONNELL. Will you look in there and tell us the number of pages and the title of that book?

Dr. GOIN. It has 1,281 printed pages, and 2 or 3 numbered ones for notes.

Senator DONNELL. What is the title of it?

Dr. GOIN. "The National Health Insurance Act of 1936 to 1938, with explanatory notes, cases, decisions of the Minister of Health, and statutory rules and orders."

Senator DONNELL. By whom issued?

Dr. GOIN. By Henry Lesser, bachelor of laws, London, Gray's Inn, barrister at law, with a foreword by Elliot, M. C., M. P., Minister of Health, and published by the Africa House, Kingsway, London, 1939.

Senator DONNELL. Mr. Chairman, I would say it is reassuring to say that lawyers had to assist in getting out this book.

At any rate, this book is entitled "The Law of National Health Insurance" and the frontispiece has indicated what it is as to its contents.

Dr. GOIN. Yes.

Senator DONNELL. I hand you another book which consists of some 360 pages, exclusive of the index, and ask you to state what that book is.

Dr. GOIN. I know about this book.

Senator DONNELL. What is this book.

Dr. GOIN. This is the British Panel Doctor's bible. He has to look at this before he can tell what is the matter with the patient, or what to do with him.

Senator DONNELL. By whom is that issued?

Dr. GOIN. "Medical Insurance Practice," by "R. W. Harris and Leonard Shoeten Sack," and it seems to have been written by R. W. Harris, and Leonard Shoetern Sack, both lawyers. No; the first one is an assistant administrator of health, and the second one, a barrister,

This is the fourth edition of 1937. It is issued by the British Medical Association. It is addressed to "The General Practitioner."

Senator DONNELL. That is the one you referred to in your testimony.

Now, let me read a little bit of the language here as indicative of the type of instruction that is given here. You say this is the "bible."

Dr. GOIN. That is what we call it.

Senator DONNELL. For instance, I call attention to page 173. This is headed:

(3) Where the insured person asks for treatment as the private patient.

The acceptance of a fee from an insured person, not on your list, who specifically asks for treatment as a private patient does not ask for breach of your terms of service, but it is usually to be deprecated. It may cause you considerable inconvenience if he afterwards denies that he made such request and applies for repayment as explained above. No doubt the nature of the dispute would be narrowed if you took a statement from him in writing before giving him treatment, but even so, you are not free from the possibility of the patient making troublesome with unfounded allegations later.

Doctor, is there anything about taking such statements by patients before you even danger yourself of the possible risk of false allegations under our practice today?

Dr. GOIN. Not thus far. I would take it that that is the illustration of what is meant by the often repeated "freedom of the physician" under the compulsory health insurance.

Senator DONNELL. Doctor, under the volume which the chairman read, entitled "Medical Care for the American People" and issued in 1932, being the final report of the Committee on the Cost of Medical Care, together with a minority report, you will recall that the chair-

man read from the minority report certain reference to the summary made by Messrs. Simons and Sinai in 1931.

Now, I call your attention to what the chairman read, but what might be inadvertently overlooked, that the report which Messrs. Simons and Sinai made was at the instance of the American Dental Association. Did you observe that?

Dr. GOIN. Yes.

Senator DONNELL. You know that to be a fact?

Dr. GOIN. Yes.

Senator DONNELL. Now, Doctor, let me ask you, it is entirely possible, I am not sure about this, I have no doubt that the chairman is of the opinion that it is true, and it may be, that this report of Messrs. Simons and Sinai was adopted by the American Medical Association. Do you know if it was?

Dr. GOIN. No; I do not know.

Senator DONNELL. Now, the findings in the report, are set forth on pages 99 and following. I will read a few words: "A. M. Simons and Nathan Simons conducted in 1931 a study of the professional and economic problems of health insurance for the American Dental Association. Their principal findings were," and then, No. 5: "Every attempt to apply the principles of voluntary insurance on a large scale has proved to be only a longer or shorter bridge to a compulsory system. Every so-called 'voluntary' system is successful in just about the proportion that it contains compulsory features."

That is the language to which the chairman referred this afternoon.

I understood you to say, Doctor, earlier in your testimony that you are not arguing for the maintenance of the status quo.

Dr. GOIN. That is right.

Senator DONNELL. And you agree there may have been mistakes make in the past.

Dr. GOIN. That is right.

Senator DONNELL. And mistakes in the future.

Dr. GOIN. Almost certainly.

Senator DONNELL. But that the American Medical Association, am I correct in this understanding of your testimony, in your judgment, whether you have given it or not, am I correct in your view, that the American Medical Association is making an honest and conscientious and diligent effort to solve the health problems of the Nation at this time?

Dr. GOIN. There is no doubt that that is true.

Senator DONNELL. Would you concur with the view of anyone who testified, as did one witness yesterday, that the opposition to S. 1606, at least, insofar as it refers to the American Medical Association, which was not mentioned by the witness, would you concur in the view, however, as applied to the American Medical Association that its opposition to S. 1606 is inspired by dishonest motives?

Dr. GOIN. I cannot understand what dishonest motives there would be to inspire it.

Senator DONNELL. Do you think it is inspired by any dishonest motives?

Dr. GOIN. I certainly do not.

Senator DONNELL. Doctor, you have practiced medicine a good many years.

Dr. GOIN. Yes, I have.

Senator DONNELL. Leaving aside the considerations of professional modesty, what has been your general observation of the type and character of the members of the medical profession as a nentirety, as to whether they are honorable, upright, generous, and charitable men?

Dr. GOIN. I would say that the medical profession, like the legal profession and the clergy, and any other profession, has always some rascals within it, but by and large, I would think that the character of the men engaged in the practice of medicine is rather of a superior type.

Senator DONNELL. You think that the American Medical Association is representative of the highest ideals and of the highest membership of the medical profession in this country?

Dr. GOIN. I do not think there is the slightest doubt of it.

Senator DONNELL. It composes about what percentage of the actual practicing membership of the profession in this country?

Dr. GOIN. That is a difficult thing to answer, but I would guess five-sixths; about 170,000 doctors, and about 120,000 members of the association. It is generally estimated from 20,000 to 25,000 doctors do not practice either because of prolonged bad health, other occupations, or because they have retired, or other reasons.

Senator DONNELL. At one point in your testimony when your attention was called by the chairman to the fact that certain gentlemen, it may have been the signers of this telegram, possibly others, I do not recall, did not agree with you, I think you said that as to that portion of your testimony you thought 95 percent of the doctors would agree with you.

Is that a correct statement?

Dr. GOIN. I do think so.

Senator DONNELL. And generally speaking, Doctor, without going down into the minutia of your testimony, generally speaking as to the principles of your testimony here today, is it your judgement that the great majority of the medical profession of this country would concur with the views you have expressed?

Dr. GOIN. I am absolutely certain of it.

Last February, that is, February 1945, I debated with a doctor who was in favor of compulsory health insurance then pending in California. I made the statement in debate that I thought that 90 percent of the doctors of California would oppose this measure.

Without the slightest hesitation, he said, "I will make it 95 percent," and he was the opponent.

ADMINISTRATIVE COST OF THE PLAN

Senator DONNELL. Doctor, you were referring to the costs of this compulsory insurance, and I understood your statement to be that it was impossible to determine what it is.

I want to call to your attention in that connection, however, to one fact that appeared to me was somewhat significant, and that is that you point out that experience elsewhere indicates that there is needed, at least, one employee, not including those actually delivering medical service, for each 100 insured persons. Is that correct?

Dr. GOIN. That is taken from a citation.

Senator DONNELL. From Crownhart, on Sickness in Europe. That is a publication of 1938.

Dr. GOIN. Yes.

Senator DONNELL. You pointed out that on this basis, which would need to increase the Government pay roll by about one and a half million employees.

Dr. GOIN. Yes.

Senator DONNELL. My recollection, Mr. Chairman, is that our esteemed colleague, Mr. Byrd, has pointed out that there are 3,160,000 governmental employees at this time.

So that your judgment is, I take it, from what you state here, that assuming the facts set forth by Mr. Crownhart, that the number of Government employees would have to be increased by something over a third of what are now employed by the Government.

Dr. GOIN. That would seem to be the case.

Senator DONNELL. Those, I understand from your statement, do not include the doctors.

Dr. GOIN. That is right.

Senator DONNELL. What would these one million and a half people be?

Dr. GOIN. They are the clerks and the administrative officers. It is just thousands of employees it takes to administer such a complex thing all over the United States.

Senator DONNELL. You would have to have an employee in practically every city of any size in the United States, would you not?

Dr. GOIN. If I remember correctly, and I probably do not, in prewar Germany the sickness insurance, not including accident insurance, which was administered by a separate institute, had a national institute, 13 regional institutes, something like 33,000 local offices, each of which obviously has to have at least 1 employee.

In Berlin the main institute is an enormous building comparable to our buildings here in Washington. It must be staffed with thousands of employees.

Senator DONNELL. Roughly speaking, are you able to give us an estimate of what grade of salary this one million and a half people, other than doctors, would receive? Is \$2,000 a year too high for the average?

Dr. GOIN. I doubt if it is high enough.

Senator DONNELL. Say we take \$2,000 a year. That would be \$3,000,000,000 a year just for the employees, other than doctors.

Dr. GOIN. That is right.

Senator DONNELL. Do you have any ideas as to how many doctors would be engaged in this plan? Are you able to estimate at all?

Dr. GOIN. I hope a very small number, but I could not say.

Senator DONNELL. But if the plan became effective, and reasonable opportunity were given for its success, undoubtedly there would be many thousands of doctors in it, would there not?

Dr. GOIN. I think it would take 150,000 doctors or more, a good deal more, to administer it.

Senator DONNELL. Do you think that it would take nearly all the time of nearly all of those men to administer their duties under this act?

Dr. GOIN. Goodness; I should think so.

Senator DONNELL. What would you be able to estimate the average amount that those men would have to receive per person in order to adequately compensate them for their services?

Dr. GOIN. That is a deep secret. It was in California, too, when we had a long series of conferences with CIO, who insisted they loved the medical profession and wanted to do well with them, and thought they did not do well, and ought to make more money, have more leisure for vacations, graduate study, research, if they guaranteed this bill. But when we came down to brass tacks, Mr. Minsky, their research expert, thought \$5,000 would be ample for any doctor.

Of course, in England they only get about \$2 per person per year, for insured persons.

Senator DONNELL. Would your judgment be that \$5,000 is certainly not too high? It would be, if anything, considerably too low to compensate for the average professionally equipped man who has put in his time studying for a profession of that type and importance.

Dr. GOIN. I would think so, although, of course, they get lower salaries than that in the Army and Navy, and Public Health Service.

Senator DONNELL. Would you think \$5,000 a year, on the average, would be a fair estimate as to what they would have to have in order to live in reasonable respectability, and commensurate with their position in life?

Dr. GOIN. I should guess so because out of this \$5,000 they have to maintain their office, assistance, telephone, automobile, and supplies.

Senator DONNELL. That would look low to me, but I take that figure as a very low figure. That figure would be \$750,000,000 a year for the doctors.

Now, I should not be a bit surprised if it would be a good bit more than that, would you?

Dr. GOIN. No.

Senator DONNELL. If we take \$750,000,000 a year and then take for the clerical employees and others that you have mentioned, the one million and a half, \$3,000,000,000, you get up to \$3,750,000,000 as the cost of operation of this system.

Now, with that in mind, Doctor—

Dr. GOIN. May I say that nearly all the experts think that much too low?

Senator DONNELL. What do most of the experts think it would be?

Dr. GOIN. They think from four to four and a quarter billion dollars for the first year, and the actuarial opinion is that the cost will not begin to level for at least 50 years, and it is very likely to reach 10 or 12 billion dollars.

Senator DONNELL. Are you familiar with S. 1050, that is, the Wagner-Murray-Dingell bill?

Dr. GOIN. No.

Senator DONNELL. It includes most of the substance of S. 1006, and other features, old-age insurance, et cetera.

Dr. GOIN. I have read an extract of it.

Senator DONNELL. There was presented in evidence yesterday, as I recall it, certain figures as to the estimates of various persons as to the total expenditures under the whole plan, old age, and so forth.

First, based on Senator Wagner's figures and remarks, \$11,625,000,000.

Second, based on Tax Foundation's study, \$11,787,000,000.

Third, based on the author's estimate, that is, Mr. Earl E. Muntz, of New York University, \$13,405,000,000.

Fourth, based on Hirschfield, \$14,625,000,000.

Now, Doctor, taking those figures for a tentative basis of it, do you think that any revision ought to be made up or down on this figure of say, in the neighborhood of four to four and a quarter billion dollars for a start on this medical phase of it?

Dr. GOIN. I would not know. The total figure includes a good many other benefits, does it not?

Senator DONNELL. Yes, it does: Health, old age, and unemployment insurance.

Dr. GOIN. As I recall it, 1.8 percent of the total goes in there for unemployment benefits, and about 2 percent for old age. Is that right?

Senator DONNELL. I do not recall the exact percentage.

Dr. GOIN. On that basis I think that figure is a little too low if I am correct in my recollection of the distribution.

Senator DONNELL. You think the distribution for the medical part is too low?

Dr. GOIN. Yes.

Senator DONNELL. So that at any rate, as I understand it, your view would be that a conservative estimate would be \$4,000,000,000 a year for the compulsory health insurance.

Dr. GOIN. I would think so. Of course, I am by no means a fiscal expert.

Senator DONNELL. I understand. You are giving us your general observation and based on the knowledge of the salary the people get, and what you think is a reasonable compensation for doctors, in fact under the reasonable compensation, as I understand you mean, and your judgment as to how many people would be required.

There would have to be somebody in every town or city practically in the United States, would there not, as an assistant in this work?

Dr. GOIN. There must be.

Senator DONNELL. And in most cases, take, for instance, a city like your own, in California, there would have to be, I have no doubt, hundreds of persons there, would there not?

Dr. GOIN. It would be enormous.

Senator DONNELL. And even a small city of 10,000 or 15,000, or 5,000, or 1,000 would have to have somebody there to handle the immediate problems that would arise. Is that right?

Dr. GOIN. I should think so.

Senator DONNELL. For instance, if a situation arose in which it was necessary to decide quickly whether John Smith was qualified, Dr. John Smith, qualified to act as a consultant or specialist, there would have to be somebody there representing the Surgeon General to look him over and decide.

Dr. GOIN. That is right.

Senator DONNELL. What kind of a man are you going to have to have there, Doctor, to look him over? Would you not have to have a doctor to look over a doctor to tell whether he is qualified?

Dr. GOIN. Our profession found, after a long, thoughtful contemplation of the matter, the only way to have it was to have him examined

by a jury of his peers and see if he was qualified. We can qualify our specialists by a 3- or 4-day examination if the man wishes to submit to the qualifying examination.

Senator DONNELL. Take the ordinary layman who is not a doctor. He would be confronted with very great difficulties, located out in Las Vegas, N. Mex., for instance, to determine whether or not Dr. William Smith is qualified to be certified as a specialist. Do you not think there would be some difficulty?

Dr. GOIN. I do not see how they could possibly decide it.

Senator DONNELL. Is not that one of the difficulties of this bill, that you are going to have to give to an army of employees all over this country the right to determine whether or not doctors are qualified to act as specialists or consultants? Is not that one of the defects of this bill?

Dr. GOIN. Either that or—that is a defect, and the only alternative is that the list may be determined at periodic intervals by the Surgeon General, himself.

The CHAIRMAN. Is not that a situation that exists independent of this legislation? It is a very difficult thing for a layman out in Las Vegas, N. Mex., to tell who is an expert, who is a specialist, under the modern phase of medical practice.

Dr. GOIN. That is true.

The CHAIRMAN. So that point raised there is not solely applicable to the proposed legislation. It exists independent of it.

Dr. GOIN. Except that there is this difference: If Dr. Jones, in Las Vegas holds himself forth to be, let us say, an ear, nose, and throat specialist, he has expressed himself. If he is falsely holding himself forth he is exposing himself to a good deal of trouble because he then becomes bound by the standards of conduct of the other specialists of that neighborhood. Whereas, if he remains as a practitioner he is not so bound and is less liable to malpractice.

But if he is a specialist, Mr. Smith may go to him, but not under this bill.

The CHAIRMAN. Then is not this bill a safeguard? Under this bill the advisory committee of the local community assists in preparing the list of those who would be qualified as specialists, and then you have the official recognition of this specialist, and the patient does not have to guess about it at all.

Dr. GOIN. I do not want my penetrating ulcer to wait until somebody decides whether the fellow in the community is a surgeon or not. I would rather have my abdomen opened and fixed before I die.

The CHAIRMAN. Of course you can find fault with any bill. It seems to me that we are taking up a little bit too much time quibbling over these points involved in this legislation. I do not think it serves any purpose that is of any benefit to us at all. I do not think it accomplishes anything.

It seems to me that you have already stated, clearly enough, your opposition to the legislation. You have stated your reasons why you are against it, and I do not think that it is necessary to prolong the examination along this point.

Of course I am not going to stop you. I am merely suggesting this to you.

Senator DONNELL. I appreciate the suggestion of the chairman. I shall be as brief as I can. I differ with the chairman as to the importance of this. I regard this as extremely important.

The CHAIRMAN. You are submitting leading questions to a witness who is biased in your favor, and everybody knows, of course, before he took the stand, that he is utterly and unalterably opposed to this legislation. We know that.

It seems to me that you have covered the whole situation with the testimony that you have already in the record.

Senator DONNELL. May I proceed, Mr. Chairman?

The CHAIRMAN. Yes.

Senator DONNELL. I will make it as brief as I can within what I think are reasonable limits.

Dr. Goin, in the situation to which I referred, to which you referred in your testimony, about the man who needs a consultant or a specialist, under the present prevailing system in this country, the individual patient or his family has the right, at any rate, to determine whether or not he shall get the services if obtainable of a given doctor.

Dr. GOIN. Certainly.

Senator DONNELL. Whereas under the plan set forth in S. 1606 it would be determined by the Surgeon General through his local representative, down in the particular community, as to whether or not the given doctor is qualified to act as a consultant or specialist.

Dr. GOIN. Well, the sick person can have a consultant on recommendation of his general practitioner, too.

Senator DONNELL. But no one can be paid as a specialist or consultant under the terms of subdivision (c) of section 205 unless he has been designated by the Surgeon General. That is correct, is it not?

Dr. GOIN. Yes.

Senator DONNELL. I want to make one or two other points, quite briefly. One of them is the point that I think is the point that easily arises in one's mind, and that is the possibility of political situations arising. That is to say, suppose that there be an administration here in Washington that has a great army of employees, 33,000 like they have in Great Britain, or 66,000, or 75,000, or whatever it may be, or 1,500,000, as this estimate is, in your testimony. Those 1,500,000 people are scattered all over the United States, carrying on these very important functions. There certainly would be the opportunity, would there not, Doctor, for favoritism and political administration to enter into the determination by the local representative of the Surgeon General in Las Vegas, N. Mex., for illustration, as to whether John Smith is or is not a specialist or consultant. That opportunity would exist, is that right?

Dr. GOIN. Humanity is pretty weak, Senator.

Senator DONNELL. Yes; and the political danger is one that should be borne in mind.

Dr. GOIN. Yes, I think it is a very great danger.

Senator DONNELL. I want to express this, and I think it is highly important. Someone handed this to me.

Not only do the costs include these 150,000 physicians, and so forth, but this plan involves hospitalization, nursing, dentistry, possibly other benefits. I do not recall if there are others or not. So that the figures of 4¼ billion would certainly seem to be very conservative and perhaps billions of dollars under the actual cost.

Am I correct in your judgment on that?

Dr. GOIN. I honestly believe that they are very conservative.

Senator DONNELL. Now, Doctor, there is one other question. In regard to the point that you mentioned about the voluntary societies having the right to require that the first two visits of the doctor should be paid for at the expense of the patient.

Dr. GOIN. That is provided in this bill, too.

Senator DONNELL. I was going to call attention to the fact that section 210 (a) not only gives the Surgeon General the right after consultation with the advisory council and with the approval of the administrator, to determine whether or not a fee should be paid with respect to the first or second visit, but it reads this way:

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.

As I understand it, Doctor, that gives the authority to the Surgeon General, after the consultation indicated and with the approval of the Administrator of the Social Security System, to say to a given individual that you will have to pay for all the services rendered to you.

Dr. GOIN. There is no question about it at all in the language of the act.

Senator DONNELL. So that what we have understood was a compulsory insurance system under which all of us would get this equality of opportunity if the Surgeon General decides against it would be resolved into a situation where we would have to pay even though we paid our taxes. Is that correct?

Dr. GOIN. That is right.

The CHAIRMAN. I might call attention there that in the bill, in section 210 (a), you will find, commencing on line 12, the following language:

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.

Of course it is very proper that such provision should be in there, just for the very same reason that the doctor explained a few moments ago, why they have the provision requiring payment for the first visit, which may be waived if it is found that the person is really entitled to some real hospital care.

Dr. GOIN. It is waived, as a matter of fact. No option about it.

The CHAIRMAN. So that this provision, if we do have compulsory health service, is a wise precaution, is it not?

Dr. GOIN. Yes; but it somewhat lessens the comparative spread of benefits between compulsory and voluntary health insurance plans because the proponents of compulsory health insurance complain steadily about this two-visit deductible thing, saying it was not complete coverage. You, yourself, said so.

The CHAIRMAN. This has nothing to do with avoiding complete coverage. This has to do with the regulation which prevents people

who may imagine that they want medical care and service, when they do not need it at all.

Dr. GOIN. That I pointed out to you, Senator, is exactly the reason we have in the voluntary plan, not to limit people but to protect the entire plan. I think it is definitely necessary in both plans.

Senator DONNELLE. I think, Senator, it should have been mentioned. I am sorry I omitted mentioning it.

Dr. GOIN, may I ask you just one final question, and that is reason No. 2 that you mentioned for which the American Medical Association opposed this legislation, indicates that even if the need were soundly established, there is no experience to indicate that compulsory health insurance would benefit the public health, although there is some reason to believe that it would lower the health standards.

Just what do you mean by "health standards"?

Dr. GOIN. I think it is fairly well shown under compulsory health insurance people are sick oftener and longer.

Senator DONNELLE. What is the reason for that incidence between the existence of health insurance and these various results?

Dr. GOIN. I think that the increasing incidence of sickness is largely due to malingering. I think it is interesting to note that in Rhode Island, where they have cash benefits for sickness, that the incidence of sickness rises in the summer coincident with the opening of the race track, and not in the winter when one would expect to have the colds and pneumonia and so forth.

It is also interesting to note that in 1923, in Germany, the value of the German money fell to practically nothing. I was there and saw it happen. And that because it was not worth while to get sick and get the few marks involved, the days of sickness as measured by inability to work, fell off to 100,000,000 that year.

Senator DONNELLE. Thank you, Doctor.

That is all I have to ask him, Mr. Chairman.

The CHAIRMAN. Well, Doctor, you recognize that there is a difference of opinion among the profession with reference to whether a compulsory system of insurance or a voluntary system of insurance would be the proper system to accept in this country?

Dr. GOIN. I do recognize it, with a qualification.

The CHAIRMAN. Yes.

Senator DONNELLE. Pardon me. Were you going to state the qualification?

Dr. GOIN. I would like to.

The CHAIRMAN. Yes. Go ahead.

Dr. GOIN. That those who favor compulsory health insurance are very largely people who do not and never have practiced medicine. Very largely they are teachers, research workers, and so forth.

The CHAIRMAN. We had Dr. Allan Butler on the witness stand the other day. He practices medicine.

Dr. GOIN. I do not think, Senator, if you will excuse me; I think he is a full-time professor.

The CHAIRMAN. He testified he practiced medicine not only in the daytime but in the nighttime.

Dr. GOIN. Maybe we have got a different definition.

The CHAIRMAN. He says he goes to the hospitals and has patients to take care of, and apparently is an active practitioner.

Dr. GOIN. There is no doubt about it; but he does not gain his livelihood that way.

The CHAIRMAN. Maybe the most of it.

Dr. GOIN. I think most of it is from the salary at Harvard.

The CHAIRMAN. Anyway, he is an outstanding physician and highly qualified?

Dr. GOIN. He is an outstanding doctor, there is no question about that.

The CHAIRMAN. Senator Donnell asked him some questions about the opposition to this legislation, and Doctor Butler says:

I think 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 A. M. A. 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.

So apparently there are some men in the profession who do think that there is some basis for feeling that the opposition of the American Medical Association in this matter is somewhat biased.

Dr. GOIN. Could I make a reply?

The CHAIRMAN. Yes.

Dr. GOIN. Having all respect for Dr. Butler's very high professional standing, and although I would have the greatest and most admiration for his professional opinion, I think that his statement is sheer nonsense.

The CHAIRMAN. Will you tell me, Doctor, how the house of delegates are elected?

Dr. GOIN. Yes; because I know it and I do not think Dr. Butler did.

The CHAIRMAN. Very well.

Dr. GOIN. The house of delegates are elected, as near as may be, one-half each year by the component State societies. My State society in California has a house of delegates. Those members are elected by the county medical association, and representation is based on population, just as the House of Representatives is here.

That body elects delegates to the American Medical Association again on the basis of medical population. Our State has 8. No State has less than 1, regardless of its size.

Half of these are elected each year, and they are elected for a 2-year term. I am a delegate for the State of California. If the California Medical Association does not like the way I conduct myself it is very easy for them to discharge me. As a matter of fact, they discharged all of the delegates a year ago, put them out of office.

I think it is one of the most democratic bodies I have ever seen. It is constituted almost exactly like Congress is. You cannot elect people to serve for a day or two; it would be silly.

As far as the bureaucracy that has control, I have not yet come in contact with it. No one has ever told me what I should say or think. I have violently and zealously opposed the American Medical Association on the floor of its house of delegates. Nothing happened to me.

I think it is sheer nonsense to say a bureaucracy controls the opinion. Opinions are made by the house of delegates with perfectly free and open discussion.

Someone read testimony this morning that these committees are appointed for years. There is no such thing. They are appointed each session by the speaker.

The CHAIRMAN. As a general rule, the men who appear in the house of delegates are elected each time they come up for election?

Dr. GOIN. I think they change constantly.

The CHAIRMAN. Well, if a reputable physician from my State is elected to the house of delegates he is not displaced?

Dr. GOIN. He is apt to be elected two or three times.

The CHAIRMAN. I have often met them on trains, traveling to a meeting.

Dr. GOIN. That is true of Congress, is it not?

The CHAIRMAN. Men who came to the house of delegates annually for years.

Dr. GOIN. I think that is to the advantage of the Nation and the American Medical Association.

The CHAIRMAN. I am not criticising it at all, but as Dr. Butler points out, naturally they are conservative. Naturally they are inclined to not be in favor of radical changes in the plan of medical care in this country.

Dr. GOIN. Well, I think most of us, like most mature Americans, are not in favor of radical changes, period. Not just medical care. Change should evolve slowly.

The CHAIRMAN. That is true, but of course our country has radically changed in the last 40 years. Forty years ago we were largely an agricultural country, but in the last 30 or 40 years we have developed huge industries in certain sections of the country where masses of people are congregated, and sometimes earnings are low and health conditions bad, and they find it difficult to get adequate medical care under the existing modern system of medical practice.

And that is the reason why agitation has developed in the country for some change, and it seems to me that every change which has ever been made or advocated in the history of this country for the benefit and welfare of the common people has been met with charges that it is communistic or socialistic, revolutionary or dangerous, and yet when it is enacted the people come to accept it and would not permit anybody even to threaten to change it.

That has happened on almost every beneficial measure enacted in our history. When it is proposed originally it creates consternation on the part of those who have certain vested interests or feel that they have certain vested rights and they are fearful of the change, and yet they themselves finally come to recognize it later on as entirely worthy and satisfactory.

Dr. GOIN. I think that is true; but I think it is also true that during the last 30 years there were a great many radical changes not enacted to our benefit. Not all proposed changes have been enacted into law.

The CHAIRMAN. I do not know what radical changes were proposed and which were not enacted. I cannot think of any that were proposed that failed to be enacted eventually.

For instance, they had to fight here for 10 years to get the TVA because vested interests opposed it.

We had to fight many, many years for an income-tax system in the United States. That was regarded at one time with great fear and consternation by people in this country; and finally we got it. Now no one would dare to suggest that it be done away with.

And the same way with workmen's compensation. I remember when I first went West to the mining camps at Butte, Mont., where we have deep mines and accidents occur almost daily. Sometimes 100 people are injured or killed or maimed. They had no system to take care of those men except by lawsuits; and the lawyers usually exacted 50 percent of the recovery. We have enacted now compensation laws in the country which were bitterly opposed by the medical societies.

Mr. William Green was here yesterday and told the story of the enactment of the workmen's compensation laws in the State of Ohio, which were bitterly opposed by the medical profession in that State. He was a senator in the State of Ohio at the time that legislation was passed. They claimed that it was socialistic and very vicious legislation. Now it is accepted and is entirely satisfactory to everyone.

Senator DONNELL. Mr. Chairman, may I say one further thing before the doctor leaves the stand?

Doctor, do you consider, from your observation and experience, that it is practicable for the American Medical Association to develop a satisfactory voluntary nonprofit prepayment insurance plan?

Dr. GOIN. Not the American Medical Association, but its component State associations I think can and will do so.

Senator DONNELL. You are familiar with the movement that is in process?

Dr. GOIN. Yes.

Senator DONNELL. The organization of the corporation recently?

Dr. GOIN. Yes.

Senator DONNELL. The matters discussed here by the witness this morning?

Dr. GOIN. Yes; I am.

Senator DONNELL. And you regard it as possible for the State associations to work it out?

Dr. GOIN. I do.

Senator DONNELL. Do you think it will be?

Dr. GOIN. I do.

Senator DONNELL. Yes, sir.

The CHAIRMAN. Thank you, Doctor, very much for your very excellent presentation here this afternoon. We have enjoyed hearing you.

(At the request of Senator Pepper the following statement was inserted in the record:)

On September 20, 1944, Dr. T. Henshaw Kelly, M. D., secretary of the California Physicians Service, said in his testimony before the subcommittee of which I am chairman:

"You will never get care for all the people unless you make them take it, which means some form of compulsion."

This statement of Dr. Kelly followed a policy officially adopted by the California Medical Association with respect to making membership in the California Physicians Service a condition of occupancy in Federal public housing projects.

On the basis of a poll of members of the council of the California Medical Association, Dr. Philip K. Gilman, then chairman of the council, said in a letter to Mr. Langdon Post, regional director of the Federal Public Housing Administration:

"A majority of the council has voted to approve the making of participation in CPS a condition of occupancy in the housing areas."

The question on which members of the California Medical Association Council were polled read as follows:

"I am in favor of making participation in CPS a condition of occupancy in the Federal housing areas of California as a means of insuring the high percentage of participation which CPS apparently requires in order to make such projects carry their own financial burden."

(Subsequently the chairman requested that the following letters, which appeared in the Congressional Record for June 19, be inserted in the record.)

(The matter referred to is as follows:)

FEDERAL SECURITY AGENCY,
Washington, May 17, 1946.

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

DEAR SENATOR MURRAY: This is in reply to your letter of April 26 requesting a report on the "statistics of selective service rejections, together with a thorough analysis of Dr. Goin's assumptions and conclusions."

An analysis of some of the implications of selective service rejection statistics has been published by Mr. G. St. J. Perrott, of the United States Public Health Service, in the American Journal of Public Health for April 1946. Enclosed is a copy of the journal since reprints of the article are not yet available. From Perrott's analysis the following points are to be noted:

1. It is difficult to evaluate the level of national health on the basis of rejection rates. "At any particular period the rejection rates tell only the relative number of individuals who did not qualify according to standards of that period. As has been seen, some of these standards had no relation to physical status."

2. Statistics on prevalence of defects among examined men offer a better index of the national health picture provided that all defects are properly identified and recorded. These statistics cover all the men examined, those rejected and those accepted, and disclose a great many more defects than shown by the rejection statistics.

3. Statistics on men examined between November 1940 and September 1941 reveal that 1,583 defects were found for each 1,000 men examined. Although some of the defects were minor and did not affect the individual's ability to serve in the armed forces, whatever their nature or their degree, the defects were of importance to the individuals concerned.

4. It must be noted that these examinations covered the Nation's young men, presumably our healthiest group. It follows that in the rest of the adult popu-

lation the prevalence of defects must be far greater. The enormous volume of defects, in a sense, reveals that a less favorable picture exists than that furnished by the rejection figures.

5. Where comparisons were possible between statistics collected on the prevalence of defects in drafted men of World War I and World War II, little evidence was found of improvement between the two periods.

With reference to Dr. Goin's statements regarding the relationship of medical care to defects found in the drafted men, a most thorough discussion of the whole question appears in the hearings before a subcommittee of the Committee on Education and Labor, United States Senate, pursuant to Senate Resolution 74. Of pertinent interest is the testimony given on July 10, 11, and 12, 1944, by such eminent medical authorities as Col. L. R. Rountree, Maj. Gen. G. F. Lull, and Gen. W. C. Menninger, among others. Their statements do not bear out many of Dr. Goin's assertions, and provide definite answers to some of his allegations.

First of all, it is apparent that Dr. Goin gives the term "medical care" the restricted meaning of therapy, and does not include in it the broad preventive as well as rehabilitative measures which are today considered to be part of medical care. Thus, when he implies that medical care has nothing to do with the 701,700 men rejected for mental disease, he is contradicting the considered opinion of psychiatrists, including Colonel Menninger, who point out that there is need for psychiatrists and for mental hygiene programs to give the necessary preventive and early treatment to maladjusted individuals.

In the statement on the number rejected because of hernia, Dr. Goin asserts that the hernias were probably "so severe that the Army was unwilling to attempt repair." Major General Lull stated at the above-mentioned hearings that "we (the Army) have not at the present time the personnel nor the beds available to correct these defects."

I should like to point out also that the increasing expectancy of life and reduction in diphtheria rates, both of which Dr. Goin mentions, emphasizes the value of mass attack on disease. These improvements have largely been brought about by work in the field of public health; the first by extension of prenatal care and of environment sanitation, the other by immunization. The increase of life expectancy must, of course, be understood to have affected only the young and not the old; life expectancy after 40 years of age has increased hardly at all since 1900.

In sum, while it may be true that we are among the leading nations in health status, it should be clear by now that there is still a great deal of room for improvement. As the selective service findings clearly demonstrated, and I quote Colonel Rowntree, "We are not the vigorous people that we thought we were. The people must be educated to accept the fact that we have a high percentage of defects, deficiencies, disabilities, disorders, and diseases. We must be educated to demand medical care in proportion to the demonstrated need of that care."

Sincerely,

WATSON B. MILLER, *Administrator.*

SELECTIVE SERVICE REJECTION STATISTICS AND SOME OF THEIR IMPLICATIONS

(By G. St. J. Perrott, F. A. P. P. H. A., Division of Public Health Methods, U. S. Public Health Service, Washington, D. C.)

President Truman in his health message to Congress on November 19, 1945, reported that the Selective Service System has brought the widespread physical and mental incapacity among the young people of the Nation "forcibly to our attention in terms which all of us can understand."

"As of April 1, 1945," the President stated, "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 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."

These facts are not new, as the President pointed out. Health authorities have been concerned about the serious state of ill health among American youth since late in 1941 when the Selective Service System published its first analysis of the health status of inductees. In this paper it is proposed to discuss the validity of the data as a measure of the prevalence of physical and mental defects and diseases, with particular reference to changes in prevalence which have occurred since 1918. The data will be examined with a view to estimating the significance of these findings to public health.

Rejection rates must be a first consideration in any evaluation of selective-service findings. These rates varied greatly during the war. In the first year of selective service, registrants were given complete physical examinations by local board physicians. Those who were found to be fit were sent to Army induction stations for final physical examination and, on the basis of this latter examination, were accepted or rejected for military service. Rejection rates for this period (November 1940 through September 1941) averaged 52.8 percent of all men examined. Following Pearl Harbor, a marked reduction was noted. This was probably due to pressure on local boards and induction stations for additional military manpower.

By January 1943 the rates reached an all-time low of 28 percent. They rose gradually during the year, however, reaching a high of 42 percent during the last 4 months of 1943. The increase is attributed mainly to: (1) a higher age average among men examined, and (2) a higher proportion of previously rejected men among examinees as local boards reclassified registrants in an effort to meet their quotas.

The decrease in the rejection rate from 42 to 31 percent by the end of the first five months of 1944 resulted largely from two conditions. The average age of men examined was lower than in the previous period, and examination facilities at induction stations were taxed by unusually heavy inpourings of selectees.

Rejection rates began again to increase by the middle of 1944, progressing steadily from 36 percent in June to 45 percent in November. The reasons were: Induction for limited service was halted in June; and in the same month psychological tests for mental capacity were modified so that some illiterates who previously would have been inducted were rejected. Moreover, during this period greater emphasis was placed on the need for inducting men suitable for combat replacements.

These changing procedures affecting the trend of rejection rates illustrate some of the difficulties involved in evaluating the level of national health in terms of acceptance or rejection for military duty. [At any particular period the rejection rates tell only the relative number of individuals who did not qualify according to standards of that period. As has been seen, some of these standards had no relation to physical status.]

In discussing rejection rates, Col. Leonard G. Rowntree, Chief, Medical Division, National Headquarters, Selective Service System, said: "Rejection rates based upon the number of registrants rejected for military service per 1,000 men examined have limitations in their use as criteria of good civilian health. Rejection rates are dependent upon too many factors, as for instance (1) changes in standards of induction, (2) changing deferment policies, (3) varying numbers of registrants by age, race, urban-rural areas, all of which introduce variables correctable only through the calculation of specific rejection rates, (4) whether a registrant is coming up for the first, second, third, or fourth examination, and (5) how far military standards exceed those required of normal civilian living. Selective Service, therefore, regards the rejection rate per 1,000 men examined as useful in measuring the Nation's health only in terms of the limitations placed upon such rates. The incidence of all recorded defects in accepted and rejected men is a better index of the health picture. The latter is only limited insofar as all defects may not be recorded."

In addition to this limitation, however, there are other elements that must be considered in any attempt to arrive at a true evaluation. These include differences in examining techniques at various examination centers, idiosyncrasies of the examining personnel, and the attitudes of the examinees.

A comparison of the reports for November 1940 through September 1941 and for April 1942 through December 1943 illustrates the effects of these factors on selective-service findings of the prevalence of disease and disability.

In the first report 1,583.3 defects per 1,000 men examined were recorded; in the second, 1,000.2 defects for each 1,000 examinees. Between the two periods, the coding procedures were changed so that the complete list of defects was not always available in the 1942-43 data. Since the defects were summarized in

order of significance, the limitations of coding would result in the omission of less significant defects and account, at least partly, for the drop in rate.

The effect of such omission and of the other stated factors can be gaged by a comparison of rates for specific kinds of defects. For example, in 1940-41 when the coding was more complete and when flat feet were a cause for rejection, foot defects, with an average of 172.4 per 1,000 men, led the list of disabilities. By 1942-43, however, minor foot ailments were considered unimportant, and reporting on this category fell to 54.6 per 1,000 examinees. Similarly, dental defects—averaging 167.8 per 1,000 men—were second highest among defects listed for 1940-41. By 1942-43, the incidence had fallen to 113.0 per 1,000 examinees. This, likely, was due to the failure of examining personnel to record all cases of carious or missing teeth, or to give dental defects sufficient precedence for inclusion in the coding, since these defects no longer were cause for deferment.

Marked decreases also are found in the prevalence of throat diseases, skin diseases, and defects of the abdominal viscera as the need for more military personnel grew urgent and examining physicians tended to concentrate on the more serious defects. The relatively minor conditions were included as secondary defects only and thus omitted in the coding.

On the other hand, reports of important defects remained fairly constant in 1942-43. Eye defects, for example, varied only slightly in the two periods. There also was little change in the reported prevalence of neurological diseases, or of diseases of the lung, kidney, and ear. A large proportion of conditions in these groups of defects were outright causes for rejection; and reporting, necessarily, was fairly complete.

The great increase in the incidence of tuberculosis (9.7 to 19.1) is accounted for largely by a change in examination procedure. Chest X-rays did not become an examination routine until 1942; therefore, it is reasonable to suppose that many cases of tuberculosis among pre-Pearl Harbor inductees passed through examining stations undetected.

The wide variations in reports of educational and mental deficiency recorded for the two periods are easily traceable to different definitions of "educational deficiency" in effect during the two periods. Between November 1940, and May 15, 1941, regulations stated that registrants were acceptable who "appear to have normal understanding, whose speech can be understood, who have no definite signs of organic disease of the brain, spinal cord, or peripheral nerves, and who are otherwise mentally and physically fit." During this period, illiteracy was mentioned in the records of 3.6 registrants per 1,000 examined. On May 15, 1941, however, the standards were raised to require that a registrant should be able to "read and write the English language as well as a student who has completed 4 years in an American grammar school." These standards remained in force until April 1, 1942. As could be expected, rates for educational and mental deficiency rose in the period.

Mental disease, which was high among the more serious defects in both periods, was found in 67.5 men out of every 1,000 examined in 1942-43. At the top of the list among these diseases were psychoneurotic disorders, psychopathic personality, and grave mental or personality disorders. Since serious attention was given by examining physicians to evidence of mental disease in both periods, and since the reports for the periods are consistent, it could be concluded that reporting and coding of the incidence of mental disease was fairly accurate.

These comparisons bring out the fact that the order of defects may have been closely associated with prevailing regulations for the rejection or acceptance of examinees for military service. The judgment of the individual examiner in evaluating the relative importance of a series of defects also must be considered as a factor in determining the listing. It is likely, then, that reporting on many defects varied as selective-service regulations changed; that recording of secondary defects tended to be overlooked as coding procedures were simplified, and that the opinion of examining physicians in classifying defects according to relative importance was associated to some degree with military standards.

Review of the figures leaves little doubt that the figures for 1940-41 more clearly approach the actual prevalence of defects, although how close that approach is can only be guessed. There seems reasons to believe that the figures present a fair picture of the prevalence of major defects—with allowances made for variations in examining techniques, in the judgment of examining physicians and in the recording and coding of defects. It also seems obvious that the many factors which influenced the recognition and recording of secondary defects detract from the accuracy of the reports.

None of the factors which have influenced the reporting and coding, however, obscures the enormous volume of defects. Since all defects—whatever their nature or degree of concern to military authorities—are of importance to the individuals affected, the findings of Selective Service pose a public health problem which must be solved before good health can be achieved for the population.

Too much emphasis is still placed on the decline in mortality as a measure of achievement in health work. Death is by no means the sole measure of the level of national health. To raise the health level, it is essential that increased attention be given to preventing and curing those conditions which cause illness or which reduce the capacity of the individual.

Since the last war the national mortality rate has declined by 3.1 per 1,000 population. Among young men 20 to 34 years, the death rate has gone down nearly 30 percent. One could feel more complacent if this reduction in mortality were associated with an equal reduction in disability. But such is not the case as comparison of the findings in World War I with those of World War II illustrates,

Reports on the prevalence of defects in the first war show that 661.9 defects were recorded per 1,000 men examined—in contrast to 1,000.2 defects per 1,000 in 1942-43 and 1,533.3 in 1940-41. Just as the differences between the 1940-41 and the 1942-43 data are due largely to the coding of the diseases, so it must be suspected that failure to record many minor defects in World War I accounts for a major part of the discrepancy in the records of the two wars. In addition, differences in the medical terminology of the two periods make it difficult to determine the exact classification of defects in many instances. Diagnosis of a number of diseases also underwent refinement in the interval between wars.

As a result, although wide variations in some general groupings will be noted, differences in specific categories, where similarity in terminology permits comparison in the two periods are not always as great as might be expected. Among diseases of the eye, for instance, 61 defects per 1,000 men examined were found in 1917-18, against 123.5 in 1940-41. Yet for bilateral and unilateral blindness—an easily defined defect which can be assumed to have been reported in the same category for both wars—the difference is small. Similarly, there is only small variation in recordings of the incidence of trachoma and the slight decrease noted in 1940-41 may point to some public-health accomplishment in the conquest of this disease.

Increased medical knowledge is a factor that cannot be overlooked in comparing the incidence of a number of defects. This is particularly true of asthma, cardiovascular disease, and venereal disease. Since diagnosis of these conditions is much more frequent throughout the population today than 20 years ago, it follows that the incidence among a selected group in 1940 should be greater than in 1917.

Variations in the incidence of tuberculosis are of especial interest since examination procedures in effect in 1940-41 more closely approximated those of 1917 than in any other period of World War II. Moreover, the decline in incidence rates for the two periods bear fairly close resemblance to the drop in the national tuberculosis mortality rate between 1920 (113.1) and 1940 (45.9). Since the incidence of tuberculosis increased markedly with the inauguration of chest X-rays as an examination routine—moving to 19.1 per 1,000 men in 1942-43—it seems evident that (1) considerable tuberculosis when undiscovered in 1917-18, and (2) that the incidence of the disease actually was lower in 1940 than 20 years previously.

Loss of members is an obvious defect that cannot be influenced by any of the elements affecting reporting or diagnostic procedures; therefore, these figures can be accepted at face value. The great similarity in rates for this type of defect, as well as for others which are easily observed, leads to the conclusion that the prevalence of a number of defects in 1917 was probably about the same as in 1940-41.

Certainly, evidence of great improvement is not reflected in the comparison. While slight decreases may be indicated in the incidence of a few defects and diseases over the 20-year period, they are too small to be proof of progress. Examination of the findings of World War I and World War II, then, seems to attest to the conclusion that the health level of the American people has not improved in the same degree as mortality for at least two decades.

The central fact remains that the findings of both wars show an enormous amount of ill health in the population.

During and after World War I, draft data were reviewed, analyzed, and interpreted. Over the ensuing years, medical statisticians decried the low level

of health among the Nation's young men and viewed the situation with alarm. It is regrettable that the papers produced by these statisticians represent the sole use to which the findings of World War I were put.

Now, once more protests are being raised against the health level—this time based on the amount of defects found among the sons of World War I examinees. It is to be hoped that the implications of these latest wartime health reports will be regarded as an index of the degree of actual need and will be utilized in planning health services which must be supplied to bring to oncoming generations the benefits of knowledge already at hand.

Reports of defects found among young men examined for military duty in World War II can serve as signposts to health authorities in plotting future activity. Much of the past achievement in public health has been due to the application by health departments of epidemiological case finding techniques to the control of disease spread. Selective-service data make available a new source of information for evaluating the relative extent of particular physical and mental defects.

The President in his recommendations to the Congress for the establishment of a national health program has used the reports on medical examinations of selectees to gage the total health needs of the country. Nation-wide programs for the prevention and cure of tuberculosis, venereal diseases, and other communicable diseases are now authorized by the Congress. State and local health authorities can use selective-service findings to ascertain where existing programs should be strengthened and what additional services are required. In the past, health authorities have turned to mortality rates as a major index for determining problems of public-health significance. The limitations of these rates in evaluating health needs have been recognized. Knowledge provided by mortality statistics is confined to deaths resulting from specific diseases. A well organized attack on the whole health front requires comprehensive and current information on the prevalence of disease and defects—in short, complete morbidity reporting in every State. In lieu of this, selective-service data, while not so accurate, offer an immediate and potent source of information on the prevalence of those defects which it is within the province of public health to prevent or remedy.

TABLE 1.—Prevalence of certain recorded defects among drafted men, World War I¹ and World War II²

Diseases or defects	Rate per 1,000 men examined		Diseases or defects	Rate per 1,000 men examined	
	World War I	World War II		World War I	World War II
All diseases or defects.....	3 661.9	3 1,583.3	Hernia and inguinal rings.....	55.4	3 79.7
Eyes.....	3 61.0	3 123.5	Hernia.....	27.6	34.8
Blindness, bilateral and uni- lateral.....	7.5	6.5	Enlarged rings.....	27.8	34.4
Trachoma.....	1.2	0.5	General diseases.....	46.7	38.1
Defective vision.....	46.3	83.3	Gonorrhoea.....	36.0	7.1
Ears.....	3 15.4	3 50.1	Syphilis.....	9.5	30.8
Defective hearing.....	7.1	9.4	Chancroid.....	1.2	0.2
Otitis media.....	7.3	8.3	Varicose veins and varicocele.....	8.8	32.1
Asthma.....	2.3	5.4	Mental deficiency.....	12.2	15.3
Hypertrophic tonsillitis.....	33.8	44.1	Epilepsy.....	3.9	3.7
Tuberculosis (all forms).....	24.7	9.7	Mental alienation.....	3.8	16.3
Cardiovascular.....	3 50.2	3 83.1	Crippled or paralyzed members.....	48.7	76.8
Valvular diseases of the heart.....	29.6	12.7	Lost members:		
Cardiac hypertrophy.....	4.2	2.8	Upper extremities:		
Tachycardia.....	5.0	6.7	Fingers.....	7.6	7.1
			Other.....	1.6	1.5
			Lower extremities.....	4.6	3.6
			Flat feet.....	104.4	162.0
			Curvature of the spine.....	7.7	15.0

¹ From table 4 in Britten, R. H., and Perrott, G. St. J., Summary of Physical Findings on Men Drafted in the World War. Public Health Reports 56:41-62, 1941.

² From table 7 in Selective Service System, Causes of Rejection and Incidence of Defects. Med. Stat. Bull. No. 2 (Aug. 1), 1943.

³ The sum of the rates for specific categories of defects does not always add to the rate for the general category because of the omission of specific categories not comparable to the two periods: World War I and World War II.

FEDERAL SECURITY AGENCY,
Washington, May 29, 1946.

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

DEAR SENATOR MURRAY: This is in reply to your letter of April 10, 1946, requesting information on the extent of up-to-date statistics on the health of the Nation and the need for medical care.

Current or very recent data are available for numerous aspects of the medical care problem. Among these are data on mortality, the incidence of communicable disease, the findings of selective service examinations, the number of physicians, dentists, and hospitals, the use of hospital beds, membership in health and hospital insurance plans, and family expenditures for medical care.

When these data are examined, particularly in their geographical detail, a great deal of variation among States and communities is to be observed which is correlated with economic status. In the poorer States, for example, the infant and maternal mortality rates are higher, there are fewer hospital facilities, and physicians and dentists, and less hospitalization. This is clearly shown in the enclosed table. It is obvious that the populations of the poorer areas do not get as much care as those of the richer since the poorer areas do not attract sufficient medical personnel and facilities. The effects are reflected in such items as increased infant and maternal mortality rates.

That the wealthier groups in the population obtain more medical services confirms the more detailed findings of the Committee on the Costs of Medical Care in 1929 and of the National Health Survey in 1935-36. Both studies, one made in a period of prosperity, the other during a depression, brought out the economic inequalities in the prevalence of sickness and the utilization of medical care facilities. This inequality is apparently always present, and is further illustrated in the pattern of family spending for medical care. Studies in 1929, 1935, 1941, and 1944, all show that the wealthier the family the greater the amount in dollars spent for medical care, yet the poorer families have to spend a greater proportionate amount of their total income for such care.

We trust that this letter answers your request, and we shall be glad to supply any data you may desire.

Sincerely,

WATSON B. MILLER,
Administrator.

Certain health indexes in States grouped according to income

	Year of data	1942 per capita buying income (in dollars)			
		Under 600	600-799	800-999	1,000 and over
Number of States.....		14	12	11	11
Infant mortality rate (deaths under 1 year per 1,000 births).....	1943	48.1	47.8	39.4	36.5
Maternal mortality rate (puerperal deaths per 1,000 births).....	1943	3.3	2.4	2.0	1.9
General and allied special hospital beds per 1,000 population.....	1942	2.5	3.4	4.2	4.3
Persons per physician.....	1940	1,201	967	898	743
Persons per dentist.....	1940	3,587	2,120	1,775	1,573
Percent of births hospitalized.....	1943	47.2	74.5	83.4	89.4

FEDERAL SECURITY AGENCY,
Washington, May 29, 1946.

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

DEAR SENATOR MURRAY: This is in reply to your letter of April 10, 1946, asking for information relative to the testimony of Mr. William Logan Martin on private health insurance plans in Alabama.

Mr. Martin testified that in Alabama arrangements have been made "for hospital organizations to include and provide for doctors' care," and that "for a maximum

payment of \$49 a year, any size family from 2 to 20 can get the medical service it needs."

Mr. Martin's statements are correct in part and incorrect in part. In Alabama the Blue Cross plan—Hospital Service Corp. of Alabama—in 1945 expanded its scope of service to include physicians' services in the hospital. (It is one of eight Blue Cross plans which have done this; elsewhere the same objectives have been attained through the development of separate medical plans which are affiliated with the Blue Cross plan.) This plan offers two hospital contracts; one at a cost of \$2.20 a month for a family offers care in a private room, the other at a cost of \$1.50 a month for a family offers ward care. Both contracts provide 21 days of care for each member of the family in the first year of membership, 22 days in the second year, 23 days in the third, 24 in the fourth, 25 in the fifth, and 26 days per year thereafter. Both contracts define a family as husband, wife, and all children over 60 days and under 16 years of age. The hospital care furnished in addition to room and board and the general floor nursing includes use of operating or delivery room, anesthesia supplies, regular laboratory services, regular drugs and medications, and dressings and casts. There is a waiting period of 12 months for maternity care.

The plan offers a medical contract at a cost of \$2 a month for a family. This covers surgery (in the hospital, office, or home), obstetrical service (delivery), physicians' visits in the hospital for medical cases, and, for hospital bed patients only, anesthesia service up to \$15 per admission, X-ray service up to \$15 per admission, radioactive treatment up to \$10, physiotherapy up to \$15, allergy tests up to \$10, special laboratory services up to \$10, and basal metabolism or electrocardiographic tests up to \$5 for each test. There is a waiting period of 12 months for obstetrical service and of 3 months for tonsils or adenoid operations. The benefits are not in the form of services but consist of indemnity allowances against the physician's charge. Thus, the allowance for a tonsillectomy is \$25, for a normal delivery \$50, appendectomy \$100, and single hernia \$75. For physicians' visits in the hospital, \$2 for each visit is allowed. The physician can charge the patient extra beyond these allowances if he wishes. In sum, for a payment of \$50.40 a year a family would receive fairly complete coverage for hospital care and physicians' services in the hospital. With ward service the same coverage could be obtained for \$42 a year. However, in neither case would physicians' services in the home and office be covered.

As of January 1, 1946, 141,066 persons in Alabama—5.2 percent of the State's population—had the hospital coverage, and 7,018 persons had the medical coverage.

Nationally, the Blue Cross Hospital Service plans had an enrollment on April 1, 1946, of 20,000,000 persons. These have proved the most successful application of the insurance principle to hospitalization in the United States. However, Dr. J. W. Mountin, Chief of the Division of States Relations, United States Public Health Service, in his testimony on S. 1606, made the following statement about the voluntary plans, which coincides with my own views:

"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 industrialized 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, home nursing, or other special items—encompasses less than 3 percent of our national population.

"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."

I shall be glad to furnish your committee with any other data on this subject which will be helpful in consideration of the provisions of the national health bill (S. 1606).

Sincerely,

WATSON B. MILLER,
Administrator.

The next witness is Dr. Victor Johnson, of Chicago, Ill.

Dr. SENSENICH. Mr. Chairman, may I ask before Dr. Johnson begins his testimony that the record shows a statement of Dr. Joseph H. Howard, who was to have appeared, and who I am very sorry to say is ill and unable to appear.

May I ask that his statement be accepted for the record?

The CHAIRMAN. Yes.

(The statement referred to is as follows:)

STATEMENT BY DR. JOSEPH H. HOWARD, PRESIDENT, CONNECTICUT STATE MEDICAL SOCIETY, TO THE COMMITTEE ON EDUCATION AND LABOR, UNITED STATES SENATE, APRIL 17, 1946

Senator Murray, in a recent letter, requested leading professional organizations in the field of health and medical care to join in a cooperative attempt to stake out specific health goals for the coming 5 years. He suggests that it would be a mistake to focus attention entirely on methods.

In 1939 Dr. Haven Emerson said: "We are now in fact the possessors of better general health, are less afflicted with preventable diseases, are more secure in the survival of our offspring to maturity and have an average expectancy of life greater than that of any population group in the history of man, comparable in size, variety of races, and distribution in age, occupation, and economic and climatic conditions. We are today at the very zenith of a nation of progress toward national health" (Source: Reprint from Chicago Medical Society Bulletin, September 8, 1945).

Conditions today are much improved over 1939 when Dr. Emerson made this statement.

The United States is fortunate in having more physicians than most European countries:

	<i>Persons per medical doctor</i>
United States-----	767
Great Britain-----	1,069
France-----	1,596
Sweden-----	2,600

Unfortunately physicians are not well distributed in the United States, but the oft-repeated statement that rural areas are not well supplied with doctors as compared with Europe is not true, and according to the International Labor Office, rural physicians in Germany cover 3,500 to 5,000 people per physician.

The same reason, undoubtedly, exists in all countries for lack of interest in medical practice in rural areas; not only because of small income, for in Europe that is taken care of by Government payments, but there are also the lack of facilities for raising a family and lack of proper diagnostic facilities, which restrict the desire of physicians to settle in rural areas. The development of good roads encourages people to drive to larger communities to obtain what they consider better medical care.

No group in this country is more concerned with the relocating of physicians so as to provide a better distribution of medical service in the rural areas than is the medical profession of the United States. One may travel through the great Southern and Western States and wonder how it is possible to give good medical service to thousands of small communities widely spread over that area, yet improvement is being shown and doubtless will continue to be shown in the relocating of physicians who are returning from military service. There is no better distribution of such services, apparently, in those countries where the Government has control of the situation.

The claim is made that the maternal mortality rate is unduly high in this country as compared with other countries and that this is an argument to support the point that the present practice of obstetrics in the United States is inferior.

This is a point which hits close to home with me because I am an obstetrician and am vitally interested in this problem.

Between 1933 and 1943 the maternal mortality rate declined 60 percent and yet at the same time there was an increase in the birth rate of 30 percent. Until

less than a decade ago the maternal mortality rate remained nearly constant for a long period of time in most countries. Minor fluctuations occurred from year to year. An abrupt reduction occurred during the latter part of the nineteenth century as a result of the introduction of elementary antiseptics.

The maternal mortality rate remained at the same level until 1930. Then came a slight decrease and in 1936 a sharp drop occurred, and in 7 to 8 years this rate was reduced by one-half. I am speaking of the maternal mortality rate on a world-wide basis and it is interesting to note that these reductions occurred chiefly in the United States, Switzerland, South Africa, Mexico, Scotland, New Zealand, Eire, Australia, Canada, England, and Wales. There is no satisfactory explanation for this except the wider use of transfusion and the introduction of the sulfonamide drugs. These affected the rate from puerperal infection, but the decrease in mortality also occurred in deaths due to hemorrhage and toxemia.

Although the sharp decline in the maternal mortality rate occurred at the beginning of the grants-in-aid to States from Social Security funds, the same decline occurred in the other countries I have mentioned at the same time so that it is evident that Social Security aid does not supply the answer. (Source: "Infant and Maternal Mortality in the Modern World.")

During the period 1938-40 the maternal mortality rate for the United States was 4.11 and this country stood fourteenth in the list of 21 countries. However, for 1942, which is the last year for which official records are complete, the rate was 2.6. In 1944 provisional rates on maternal mortality show a rate of 2.3. I am taking these statistics from Britannica, 1945 yearbook, which also shows that whereas in 1940 only 2 States in the United States had maternal mortality rates less than 2.5, in 1942, 29 States had achieved this position.

A Children's Bureau publication, No. 229, on "Comparability of Maternal Mortality Rates in the United States and Certain Foreign Countries" states that statistical procedures are inconsequential after a study of methods, of assignments of causes of death in various countries, and yet on page 5 of this pamphlet is shown a difference of 20 percent in England and Norway as compared with the United States.

If the same standard in compiling statistics were used in America, the United States would not be lower than fifth place.

In 1941 the Children's Bureau distributed a map which delineated maternal and child-health activities administered or supervised by State health departments, and this map designated those States held to be below average in all selected activities by a blackened area of the map. This map showed that Connecticut was one of the "dark spots." Connecticut had to report "no admissions" to this service as the State health department in our State does not administer nor supervise prenatal clinics which are conducted at the various hospitals. However, there were 6,711 admissions to prenatal clinics throughout the State for which Connecticut received no credit on this map which I refer to.

This is merely an illustration of the point I make that we cannot place too much faith in the testimony which we count on statistics to give unless the statistics are truly comparable.

On this point of the prenatal clinics, it may be interesting to note that Prof. Ira V. Hiscock of Yale University estimates that 20 percent of pregnant women need to be registered at prenatal clinics besides those women under the care of private physicians. Connecticut has by a conservative estimate more than 20 percent admitted to prenatal clinics. Only South Carolina and the District of Columbia had a higher rate of admissions for ante-partum care than Connecticut, and yet Connecticut was considered below average in all selected activities in spite of the fact that her maternal and infant mortality rates were among the lowest in the country. In fact, today Connecticut is one of the brightest spots in the world on this one point.

Having expressed myself about proper consideration of statistics, I think it may be helpful to introduce some tables which will show that the countries with compulsory health insurance plans including those which are most often cited by the proponents of this bill as having a record to which we ought to aspire in this country have not made as good a showing in the reduction of maternal mortality as this country where the integration of medical science and medical facilities has brought about a tremendous reduction in maternal mortality rates.

Maternal mortality in countries with voluntary health insurance or none

Country	From	Rate	To	Rate	Increase	Percent reduction
Australia.....	1919-21	4.8	1938-40	4.3	-0.5	-10.4
Belgium.....	1919-21	6.3	1935-37	4.3	-2.0	-31.8
Canada.....	1921-23	5.4	1938-40	4.1	-1.3	-24.1
Mexico.....	1922-24	8.7	1938-40	5.5	-2.2	-25.3
New Zealand.....	1919-21	5.6	1938-40	3.5	-2.1	-37.5
Scotland.....	1919-21	6.3	1938-40	5.1	-1.2	-19.1
Sweden.....	1919-21	2.8	1937-39	2.6	-.2	-7.2
Union of South Africa.....	1919-21	4.0	1937-39	3.9	-.1	-2.5
Uruguay.....	1919-21	3.0	1938-40	2.8	-.2	-6.7
United States.....	1919-21	7.4	1938-40	4.1	-3.3	-44.6

GROUP 2.—Maternal mortality in countries with compulsory health insurance plans

Year started	Country	From	Rate	To	Rate	Increase	Percent reduction
1924	Chile.....	1919-21	8.3	1938-40	8.4	+0.1	+1.2
	Denmark.....	1920-22	2.1	1938-40	2.8	+ .7	+33.3
1911	England and Wales.....	1919-21	4.2	1935-38	3.4	-.8	-19.0
1930	France.....	1919-21	4.8	1933-35	2.4	-2.4	-50.0
1883	Germany.....	1919-21	5.0	1934-36	4.0	-.1	-2.0
1891	Hungary.....	1919-21	3.0	1937-39	3.7	+ .7	+23.3
	Italy.....	1919-21	2.8	1936-38	2.7	-.1	-3.6
1922	Japan.....	1920-22	3.5	1934-36	2.8	-.7	-20.0
1929	Netherlands.....	1919-21	2.6	1935-37	2.8	+ .2	+ 7.7
1909	Norway.....	1919-21	2.7	1935-38	2.7	0	0
1911	Switzerland.....	1919-21	5.7	1938-40	3.7	-2.0	-35.1

United States decrease during periods of compulsory insurance in other countries

Country	From	Rate	To	Rate	Increase	Percent reduction
Chile.....	1923-25	6.6	1938-40	4.1	-2.5	-37.9
France.....	1929-31	6.8	1933-35	6.0	-.8	-11.8
Netherlands.....	1928-30	6.9	1935-37	5.6	-1.3	-18.8
Italy ¹						
England ¹	1919-21	7.4	1936-38	5.0	-2.4	-32.4
Norway ¹						
Germany ¹	1919-21	7.4	1934-36	5.8	-1.6	-21.6
Japan ¹	1921-23	6.7	1934-36	5.8	-.9	-13.4

FOR CHILE, FRANCE AND THE NETHERLANDS, THE FIGURES FOR COMPARISON ARE LISTED BELOW

Chile.....	1923-25	6.5	1938-40	8.4	1.9	23.1
France.....	1929-31	2.7	1933-35	2.4	-.3	-11.1
Netherlands.....	1928-30	3.3	1935-37	2.8	-.5	-15.1

¹ Comparison over comparable years of these countries can be made with the figures for these countries shown in group No. 2.

Source: U. S. Bureau of the Census. J. Yerushalmy: *Annals American Association of Political and Social Science*.

General death rates per 1,000 population

Country	From	Rate	To	Rate	Increase	Percent reduction
United States.....	1911-13	14.1	1942	10.4	-3.7	-26.2
England and Wales.....	1911-13	13.9	1942	11.8	-2.1	-15.1
Italy.....	1911-13	19.4	1942	14.0	-5.4	¹ -27.8
Germany.....	1911-13	15.9	1942	12.2	-3.7	-23.3
France.....	1911-13	18.2	1942	16.2	-2.0	-12.3
Hungary.....	1911-13	22.9	1942	14.5	-8.4	² -36.7
Japan.....	1911-13	20.4	1941	15.6	-4.8	-23.5
Denmark.....	1911-13	13.0	1942	9.6	-3.4	-26.2
Chile.....	1911-13	31.0	1942	20.2	-10.8	¹ -34.8
Norway.....	1911-13	13.3	1941	10.4	-2.9	-21.8
Switzerland.....	1911-13	14.8	1942	11.0	-3.8	-25.7
Netherlands.....	1911-13	13.1	1942	9.5	-3.6	² -27.5

¹ Greater reduction than United States.

² Greater reduction.

Source: U. S. Bureau of the Census.

I should like to quote at this point Jacob Yerushalmy, Ph.D., principal statistician in the United States Public Health Service, Bethesda, Md., who said, as reported in "The Annals of the American Academy of Political and Social Science" Philadelphia, January 1945, "In consideration of future accomplishments in the field of maternal and infant hygiene, it is necessary to distinguish between countries whose present rates are high and those who have attained certain low levels. As to the former—and they constitute a majority of the countries—no reason can be advanced why they could not bring their rates down to the level of more fortunate countries. In the final analysis, it is merely a question of time. The countries now enjoying low rates were only several decades ago on the same high plane of infant and maternal mortality. Whether the time interval could be shortened is more a social economic than a medical problem. The reductions thus far attained are primarily from conditions and causes which are environmental in nature; consequently they result from general improvements in sanitary conditions and the elevation of the standard of living."

This supports the point which I make that we are making the greatest progress in the world in the reduction of maternal mortality under the procedure which the medical profession in this country is following, and therefore, the vast changes which are proposed by this bill not only are unnecessary to accomplish the objective of improved national health upon which we all agree, but that the present program might well be impeded or destroyed.

Comparisons with conditions in Britain are likely to furnish little support for the proponents of this bill and as an example of what I mean, I recall that Mrs. Marjorie D. Spikes, who is an attaché of the British Embassy at Washington, and who spoke on January 10, 1946, to the Service Bureau for Women's Organizations on "Britain's Postwar Plans for Children and the Home" at Hartford in my State, said that Britain's greatest problem was revealed when the children of the slums were evacuated to the country to protect them from the bombing raids during the war. Mrs. Spikes said the squalor of these slum houses and their overcrowding was so grave that a health program was considered useless until the housing problem could be solved.

Another item of testimony which surely does not offer much assurance that compulsory health insurance in the countries where it has been tried for many years is hitting the mark is that by Dr. Percy Stokes, medical statistician of the Ministry of Health for Britain and Wales, speaking at the Sterling Hall of Medicine at Yale University, on February 20, 1946, on "The Future of Medical Statistics" when he said:

"As far as the magnitude of the health problem is concerned in relation to economic conditions, the incidence of sickness is evenly distributed among rich and poor alike. Once stricken, however, the fatality rate is much higher among

the poorer classes and is directly attributable to housing conditions and sanitation."

Have we a problem in maternal and infant care? Yes, a very definite one. Regardless of our splendid record of the past 10 years, we can do better. There are certain areas in this country, mostly in the South, where maternal mortality rates are still high and indeed improvement in many Northern and Western States is possible. But we are on the right track now, and I think we know how to reach our goal.

The medical profession wholeheartedly endorses the program of improvement in maternal and child health and the extension of the service to all mothers and children where payment for such services would be a hardship. The medical profession has repeatedly stressed the social economic factor in the whole problem of improved health.

Dr. SENSENICH. And also a statement from the Council on Medical Service and Public Relations of the American Medical Association relative to nonprofit prepayment medical service plans.

Some of those questions were asked me this morning.

The CHAIRMAN. Both statements may be carried in the record.

(The document referred to is as follows:)

NONPROFIT PREPAYMENT MEDICAL SERVICE PLANS SPONSORED BY MEDICAL SOCIETIES,
SUBMITTED BY COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS, AMERICAN
MEDICAL ASSOCIATION

Payment for the costs of medical care by prepayment or budgeting through voluntary medical society sponsored plans is rapidly expanding in areas of operation, numbers of persons protected, in types of service provided, in popular acceptance by the public and physicians.

The popular movement in this field began about 1940. The organizations of plans beginning at about that time was the result of studies and small scale experiments which had been carried on by medical societies for some years—since 1925 in the State of Michigan, for example.

Attached hereto, marked "Exhibit A," is a chart reflecting the growth in numbers of plans organized and operating from 1939 to 1946. Also attached is a chart marked "Exhibit B," reflecting the number of persons protected by such plans. Also attached is exhibit C, indicating the States in which plans are now operating.

Such plans have utilized legal means of organization, depending on State statutory requirements. However, the basic principles and objectives have been almost identical. These are the provisions of certain specified services of physicians in cases of illness or injury of catastrophic proportion as to cost at the lowest possible expense with the greatest possible return in benefits to the beneficiary member consistent with sound financial practice.

Inherent in the operation of these plans is the principle of noninterference with the patient's choice of legally qualified physician or hospital and noninterference with the physician in his treatment of the patient.

Usually these plans are incorporated either under nonprofit statutes or under special enabling legislation, and sometimes under insurance statutes. Beneficiary members are provided with services or payment for services of qualified physicians in accord with schedules of fees established by the medical profession in the area of operation of the plan.

In most plans complete service under the subscriber's contract is provided by the physician participating in the plan. Extra charges may be made under certain specified conditions to beneficiary members whose incomes normally exceed a moderate amount or who may demand and occupy luxury type of accommodations in the hospital. In any event, beneficiary members receive benefits equal in cash value as credit against the physician's fee.

Accumulated experience in coverages such as offered by these plans has made possible a gradual expansion and extension of benefits. Early efforts were toward complete medical care, including such services as physical examinations, refractions, home and office calls, etc. No experience being available at that time (or at present in adequate volume) as to the possible utilization of such services when available without penalty or imposed controls, there resulted errors in rates or premiums and withdrawal of such comprehensive efforts. Experience

gained in these trials indicates costs of such magnitude, due to unrestrained utilization of benefits, as to make such programs unacceptable by the public.

Most plans now in operation have made beginnings with fairly restricted coverages such as services for surgical cases, obstetrical cases, X-rays, and anesthesia in hospitalized cases. Some have successfully initially offered care for hospitalized medical cases.

Almost without exception, plans that have been in operation for more than 2 or 3 years have been able to broaden benefits as experience has been gained to the point where at least all services in cases so severe as to require hospitalization are now covered, as well as many of the more serious cases usually cared for in physicians' offices.

Availability of the protection of such plans to all persons becomes increasingly possible as experience is accumulated in enrollment and underwriting techniques. Originally offered in most cases only to employed or common-interest groups, present practice in older plans permits enrollment of individuals under methods developed through trial-and-error experiments steadily being broadened and expanded. Also programs and methods have been utilized and are being expanded to make possible enrollment in rural areas of individuals and farm families with considerable success.

Arrangements have been made, and others are possible, to care for special categories and groups such as disabled war veterans and for care of indigents under local welfare boards, etc. Statutes under which many of these plans operate specifically provide for the making of contracts with various governmental and nongovernmental organizations and units for provision of care either on the basis of contribution (that is, subscription rate or premium payment), or a lump sum for all members of the group involved, or on the basis of costs plus a fixed fee. There is no category or type of service which cannot be provided under such arrangement through these voluntary plans.

While there are many such plans in operation with considerable variation in costs and benefits and enjoying varying degrees of success as to numbers of persons enrolled and financial experience, Michigan Medical Service, of Detroit, Mich., is indicative of what can be accomplished by these medical-society-sponsored plans. The following statements are based on filed official statements of Michigan Medical Service or can be confirmed at the home office of the company in Detroit, Mich.

Michigan Medical Service was authorized under a special enabling act, copy of which is attached hereto, by the insurance department of the State of Michigan and commenced business March 1, 1940.

Enrollment of beneficiary members in Michigan at December 31 of each year was as follows:

1940	114, 627
1941	407, 052
1942	409, 716
1943	571, 015
1944	717, 420
1945	858, 235

Payments to physicians for services to subscribers were as follows:

1940	\$172, 115. 00
1941	789, 254. 88
1942	2, 208, 623. 42
1943	2, 876, 547. 90
1944	3, 437, 265. 50
1945	4, 155, 422. 68

13, 639, 229. 38

Percentage of income paid for administration by years since inception was as follows:

	Percent
1940	20
1941	15.56
1942	15.4
1943	12.06
1944	11.76
1945	11.21

Almost without exception these medical-society-sponsored plans provide benefits to the dependents in the same manner and in the same amount as to contract holders. This is important in that experience in Michigan Medical Service indicates that wives and children of contract holders receive service aggregating approximately 80 percent of all services provided, both as to the number of services and the costs therefor.

It is entirely possible that, in the course of the next few years, this type of prepaid medical care can be made available to all citizens of the State of Michigan who desire it at costs not to exceed the present cost to subscribers, and possibly lower. It will be seen by reference to the figures quoted above that there is a direct relationship between volume of beneficiary members covered and administrative expense, which can be reduced as volume increases.

Possibly additional benefits may be granted as experience in methods and techniques is gained through operation, so that in the near future coverage may be extended to include all types of conditions of a catastrophic nature as to cost, as well as most conditions requiring more than the ordinary home and office calls of a physician. Such services as the home and office calls of physicians can be included in such a program, either voluntary or compulsory, only if controls are instituted to eliminate abusive utilization at the demand of the patient. Apparently S. 1606 recognizes this problem by attempting to outline methods of control which will guard against abuse in utilization of the physician's services by imposing cash penalties on the patients. The imposition of cash penalties, such as part payment of each fee, or total payment for first calls, in any illness would be ineffective in controlling such abuses unless penalties are so severe as to inhibit legitimate demands for medical care. The only alternative would be a compulsory examination of each individual patient to determine the necessity for medical care. Such examinations would be intolerable to both the physician and the patient.

One of the important considerations in regard to either a voluntary or compulsory program of health insurance is the attitude of physicians who are rendering the service to the contributors or subscribers. Real dissatisfaction results unless the program is simple in operation, effective in application to the patient and his relation to the physician. Statements have been made by proponents of S. 1606 that red tape will be reduced to a minimum; that there will be no interference in the physician-patient relationship; that there will be considerable savings in time and effort to the physician in that it will not be necessary for him to maintain patient accounts and collections.

If cash payments are imposed to control abuses on home and office services of physicians, the physician will, of necessity, maintain patient accounts and will be required to enforce collections of the cash payments. This would increase necessary accounts and collections since Government would be a third party in the situation. In fact, the percentage cost of collections would conceivably rise due to the small amount per patient's call involved.

If abusive use of medical care is to be controlled by the necessity for justification in the nature of documentary proof or otherwise, the physician is likely to become dissatisfied with the necessity for completing detailed forms, requisitions, and authorization. Examples of such red tape are the forms utilized by present Government bureaus dealing with medical care—the Veterans' Administration, the emergency maternity and infant care program, etc.—with which the physicians have had experience.

The problems of extending coverage and controlling utilization within the financial framework of a compulsory health insurance program are identical with the problems under a voluntary program, except that the compulsory plan brings the Government as a third party into every arrangement.

Considerable experience has been had by the Michigan Medical Service in this matter of abusive utilization without imposed controls in the operation of its original complete medical care contract. Utilization of physicians' services for home and office calls rose under this prepayment contract to approximately four and one-half times normal. It is impractical to look to the physician to enforce voluntary controls, as any attempt on his part results in ill will toward him on the part of the patient who has demanded service. Patients demanded attention

of the physicians at the home for conditions which ordinarily, without prepayment, would have been completely ignored or adequately treated with home remedies.

Serious doubt exists as to whether there are, even in normal times, enough physicians in practice in the United States to provide the home and office care which would be demanded by contributors to a health insurance program if such services were included without controls which would undoubtedly be resented, create ill will, and make difficult the physician's relation with his patient.

Attention of the committee is drawn to the experience of the health insurance program of New Zealand in regard to abusive utilization.

Serious conditions and the more serious illnesses do not present this problem to as great an extent due to the natural disinclination for surgery and the discomfort of long-drawn-out hospitalization.

Compulsory governmental health insurance programs can hardly be operated at as low a cost as a voluntary program. Regulations of the financial or budgetary departments of the Government have required, in other operations of this nature, such vouchering and documentary proof of services delivered as to create a cost far in excess of that enjoyed by similar voluntary or nongovernmental operations on a nonprofit basis with large volumes.

Statements have been made by proponents of S. 1606 that such a program would provide an answer to the problem of distribution of physicians to sparsely settled or rural areas. This result is not likely as no provision is contained in the health insurance portion of the bill which would encourage physicians to change their locations except under salary employment arrangements. It is evident that the local communities to which the physician would be assigned would be unable otherwise to support a physician. This indicates the only advantage of a compulsory over a voluntary system—that is, the ability of the governmental compulsory insurance program to distribute the costs of medical service between high economy and low economy areas.

Recently, operating plans throughout the United States have organized an association to obtain widespread distribution of voluntary sickness insurance, and efforts are being made on a national scale through the American Medical Association's Council on Medical Service and Public Relations, Division of Prepayment Medical Care Plans to encourage and assist the organization and development of such plans in every community in the United States.

Such organized efforts will produce a much more rapid acceleration of growth both as to number of plans and the number of persons provided protection as compared to the already encouraging rapidity of growth as evidenced by the exhibits A and B attached hereto.

In addition to the medical society sponsored medical care plans, consideration should also be given to the other methods of providing for costs of medical and hospital care. While this statement is not intended to cover these other methods, they include the commercial insurance assureds, which have been estimated at approximately 40,000,000 persons; and the subscribers to voluntary hospital service plans (Blue Cross), estimated at approximately 21,000,000 persons; as well as the beneficiaries of other organizations such as mutual beneficiary societies, estimated at from 4 to 8 million persons.

For the information of the committee, there are also attached as additional exhibits the following Michigan Medical Service forms:

Medical-Surgican Benefit Certificate.

Surgical Benefit Certificate.

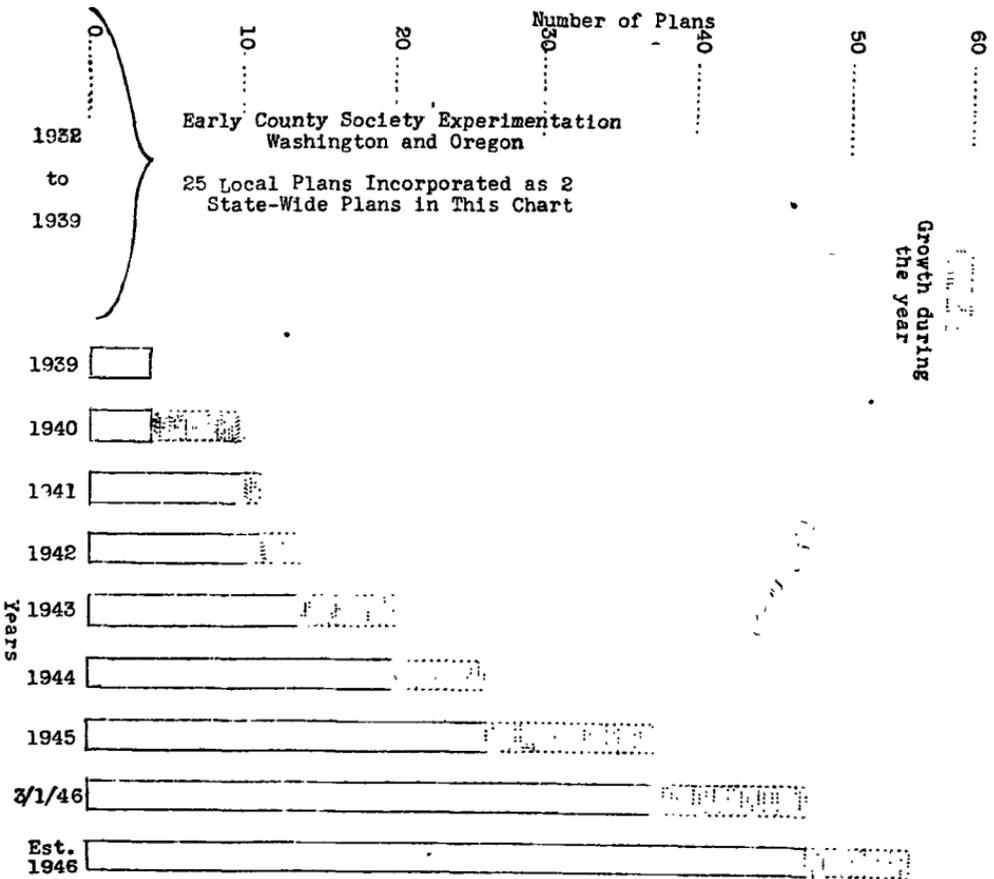
Community Enrollment Certificate.

Schedule of Benefits.

Financial Statement as of December 31, 1945.

Articles of Incorporation and Bylaws.

CHART A
GROWTH IN NUMBER OF PLANS, 1939-46



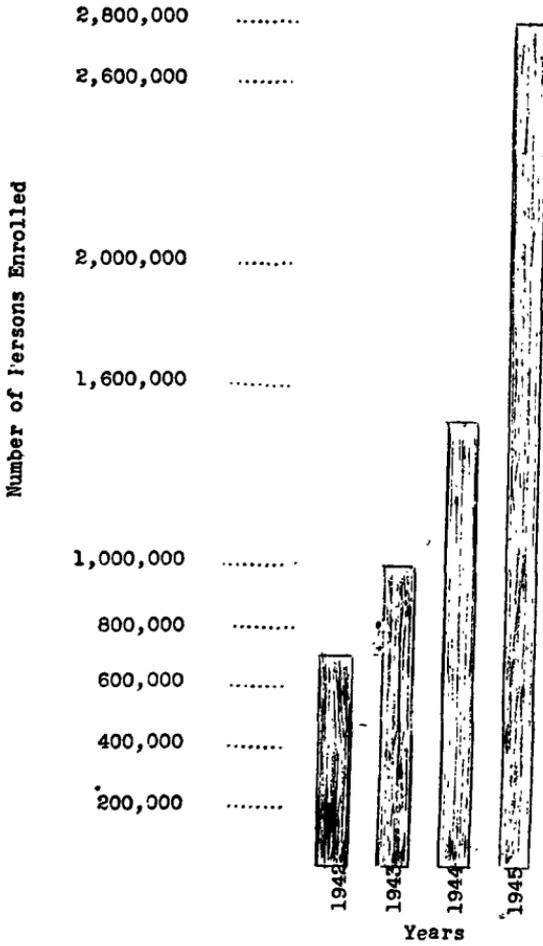


CHART C.—Prepayment plans by States, Apr. 1, 1946

State	Number of plans	Type ¹	Date organized
Alabama.....	1	3	1945.
California.....	3	4	1934, 1941, and 1943.
Colorado.....	1	3	1942.
Delaware.....	1	3	1943.
Florida.....	1	3	1946.
Iowa.....	1	3	1945.
Kansas.....	1	3	1946.
Louisiana.....	1	1	1945.
Massachusetts.....	1	3	1942.
Michigan.....	1	3	1940.
Missouri.....	2	4	1943 and 1945.
Montana.....	1	3	1946.
Nebraska.....	1	3	1945.
New Hampshire.....	1	3	1944.
New Mexico.....	1	3	1946.
New York.....	5	2	1939, 1940, 1944, 1945, 1946.
North Carolina.....	3	2	1940, 1941, 1943.
Ohio.....	3	4	1944, 1945, 1946.
Oklahoma.....	1	3	1945.
Oregon.....	² 1	2	1933-41.
Pennsylvania.....	1	3	1940.
Texas.....	2	4	1940 and 1945.
Utah.....	1	3	1946.
Virginia.....	2	2	1944 and 1945.
Washington.....	³ 1	2	1913-46.
West Virginia.....	6	2	1940-46.
Wisconsin.....	2	4	1943 and 1946.
New Jersey.....	1	3	1942.

¹ 1, local plans; 2, local plans covering the State; 3, State-wide plans; and 4, State-wide plans plus local plans.

² 5 local.

³ 20 local.

States with plans in process of organization: Arizona, Connecticut, Idaho, Illinois, Indiana, Maryland and Minnesota.

Michigan Medical Service financial statement, Dec. 31, 1945

	Dec. 31, 1944	Dec. 31, 1945
ASSETS		
Bonds.....	\$500,000.00	\$900,000.00
Cash on hand and in banks.....	609,828.01	638,480.60
Subscription fees receivable.....	47,658.59	76,379.34
Accounts receivable.....	37,865.87	38,950.79
Accrued interest.....	2,019.23	3,010.39
	1,197,371.70	1,656,821.12
LIABILITIES		
Reserve for payments to doctors for services rendered subscribers (see note).....	596,990.09	739,852.59
Reserve for unearned subscription fees and fees paid in advance.....	272,393.58	207,557.02
Reserve for canceled checks.....	836.60	1,666.50
Accounts payable:		
Employees.....	4,668.19	2,302.24
Miscellaneous.....	10,922.02	10,267.80
	885,810.48	961,646.15
Reserve for repayment of contributed surplus.....	117,544.45	
Reserve for contingencies.....	194,016.77	695,174.97
	1,197,371.70	1,656,821.12
NOTE: Reserve for payment to doctors for services rendered subscribers:		
Reported.....	246,990.09	624,852.59
Unreported (estimate).....	350,000.00	475,000.00
	596,990.09	739,852.59

Gain and loss exhibit

	1944		1945	
	Amount	Percent	Amount	Percent
Subscription fees earned.....	\$4,512,755.87	100.00	\$5,395,251.50	100.00
Services rendered.....	3,525,263.35	78.12	4,298,285.18	79.87
Administration expense.....	987,492.52	21.88	1,096,966.32	20.33
Operating gain.....	515,291.69	11.43	610,907.47	11.32
Miscellaneous income.....	471,570.83	10.45	486,058.85	9.01
Income from investments.....	25.10		5.00	
Contributed surplus.....	4,993.25		25,094.35	
Reduction voluntary reserve.....	100,000.00			
	50,000.00			
Less:	626,589.22		511,158.20	
Repayment 1941 pro ration.....	128,785.29			
Reserve for repayment of contributed surplus.....	117,544.45			
Contribution Michigan Foundation for Medical and Health Education.....			10,000.00	
Net addition reserve for contingencies.....	380,259.48		501,158.20	

Administration expense

	1944		1945	
	Amount	Per-cent of income	Amount	Per-cent of income
Investigations.....	\$93.50			
Salaries.....	120,092.43	2.66	\$138,073.63	2.56
Expenses—officers and committees.....	4,714.06	.10	6,322.40	.12
Expenses—representatives.....	2,087.46	.05	3,716.82	.07
Insurance—department fees.....	3,116.62	.07	206.73	
Audit.....	2,530.00	.06	3,050.00	.06
Rent.....	8,260.26	.18	10,837.35	.20
Publicity.....	701.36	.02	660.31	.01
Printing and stationery.....	9,951.04	.22	13,252.59	.25
Postage.....	92.75		106.81	
Freight and express.....	82.88		57.14	
Telephone and telegraph.....	79.54		74.85	
Bureau and association dues.....	5,050.00	.11	5,000.00	.09
Furniture and equipment.....	5,680.89	.13	6,761.37	.13
Rental and repair (furniture).....	6,891.23	.15	7,952.20	.15
Bonds and insurance premiums.....	1,173.72	.03	1,175.56	.02
Legal expense.....	1,991.63	.04	1,406.33	.02
Books.....	99.10		86.90	
Office supplies.....	2,316.79	.05	3,069.36	.06
Miscellaneous.....	2,894.86	.06	3,637.95	.07
Light and power.....	622.82	.01	850.59	.02
Taxes.....	4,554.19	.10	5,120.51	.09
Total direct expense.....	183,077.13	4.06	211,419.40	3.92
Joint expenses.....	*332,844.56	7.37	399,488.07	7.40
Total.....	515,921.69	11.43	610,907.47	11.32
Adjustment* in joint expense (1944) made in 1945 of \$15,000.....	347,844.56	7.71	384,488.07	7.13
Adjustment of total.....	530,921.69	11.76	595,907.47	11.06

ARTICLES OF INCORPORATION OF MICHIGAN MEDICAL SERVICE

These articles of incorporation are signed and acknowledged by the incorporators for the purpose of forming a nonprofit corporation under the provisions of act No. 108, of the public acts of 1939, as follows:

ARTICLE ONE

The name of this corporation is Michigan Medical Service.

ARTICLE TWO

The purposes of this corporation are as follows:

To establish, maintain, and operate a voluntary nonprofit medical care plan, whereby medical care is provided at the expense of this corporation to such persons or groups of persons as shall become subscribers to such plan, such medical care to be furnished under written contracts, providing definite medical and surgical care, appliances and supplies by licensed and registered doctors of medicine in the offices of such doctors, or in hospitals, or in the home of such subscribers:

To supply to the subscribers to any such plan such other similar or related benefits, not including hospital service, as the board of directors of this corporation shall designate and as shall have the prior approval of the commissioner of Insurance of this State as to the character thereof and as to the financial ability of this corporation to carry out its agreements with respect thereto:

To cooperate with any other corporation organized under the provisions of for the benefit of public health or improvement of the health of the people of this state:

To cooperate with any other corporation organized under the provisions of this or any similar act in establishing and operating nonprofit medical care plans and to contract with such, or other corporations, or agencies, or other associations or persons with reference to the furnishing of medical care in connection with such plans, provided that all such contracts and/or plans of the corporation shall be approved by the said commissioner of insurance.

To collect in connection with the operation of the plan statistics and data and to compile reports which may be deemed of value to the community, to the medical profession, and to the furtherance of the plan; to be of assistance in the promotion of such benevolent, scientific, educational, relief, and other activities as are considered to be for the best interests of the community in relation to the health and welfare of the people, and to carry out all other objects of this corporation.

ARTICLE THREE

The location of the principal office of this corporation shall be in Detroit, Mich.

ARTICLE FOUR

Membership in this corporation shall be as follows:

The membership of this corporation shall be composed of the persons who are members of the house of delegates of the Michigan State Medical Society, while said persons are members of said house of delegates, persons elected directors of this corporation, while directors of this corporation, and such other persons not practicing a healing art whom the board of directors shall elect to membership in this corporation: *Provided, however,* That not more than ten percent (10%) of the membership of this corporation shall be composed of such other persons not practicing a healing art.

The annual meeting of this corporation shall be held in September of each year, on such day as may from time to time be fixed by the board of directors.

The corporation shall be organized upon a nonstock basis.

The assets of the corporation are as follows:

Real property, none.

Personal property, none.

This corporation shall be financed as follows: Each person with whom this corporation agrees to pay for medical care furnished to such person shall pay such monthly, quarterly, or annual rate as the board of directors shall from time to time establish.

ARTICLE FIVE

Any other provisions to the contrary notwithstanding, the board of directors of this corporation shall consist of not less than (11) nor more than thirty-five (35) persons, at least two thirds ($\frac{2}{3}$) of whom shall be doctors of medicine duly licensed and registered to practice medicine in the State of Michigan. The

board of directors shall have authority to delegate its powers to committees, officers, agents, and representatives.

ARTICLE SIX

The term of existence of this corporation shall be in perpetuity.

ARTICLE SEVEN

The board of directors may adopt, alter, or amend the bylaws of this corporation.

The names and places of residence or business of each of the incorporators are as follows:

A. S. Brunk, M. D., 58 Martin Place, Detroit.
 Henry R. Carstens, M. D., 1447 David Whitney Building, Detroit.
 Burton R. Corbus, M. D., Metz Building, Grand Rapids.
 L. Fernald Foster, M. D., 328 Shearer Building, Bay City.
 Wilfrid Haughey, M. D., 610 Post Building, Battle Creek.
 William A. Hyland, M. D., Metz Building, Grand Rapids.
 Henry A. Luce, M. D., 629 David Whitney Building, Detroit.
 Vernor M. Moore, M. D., Metz Building, Grand Rapids.
 Ralph H. Pino, M. D., 1001 David Whitney Building, Detroit.
 Philip A. Riley, M. D., 500 South Jackson Street, Jackson.
 Paul R. Urmston, M. D., Davidson Building, Bay City.

ARTICLE NINE

The names and addresses of the first board of directors are as follows:

A. S. Brunk, M. D., 58 Martin Place, Detroit.
 Henry R. Carstens, M. D., 1447 David Whitney Building, Detroit.
 Burton R. Corbus, M. D., Metz Building, Grand Rapids.
 L. Fernald Foster, M. D., 328 Shearer Building, Bay City.
 Wilfrid Haughey, M. D., 610 Post Building, Battle Creek.
 William A. Hyland, M. D., Metz Building, Grand Rapids.
 Henry A. Luce, M. D., 629 David Whitney Building, Detroit.
 Vernor M. Moore, M. D., Metz Building, Grand Rapids.
 Ralph H. Pino, M. D., 1001 David Whitney Building, Detroit.
 Philip A. Riley, M. D., 500 South Jackson Street, Jackson.
 Paul R. Urmston, M. D., Davidson Building, Bay City.
 Dora H. Stockman, LL. D., 555 East Grand River, East Lansing.
 Wm. J. Burns, LL. B., 727 East Capitol Avenue, Lansing.

ARTICLE TEN

These articles of association may be amended at any annual meeting of the corporation or at any special meeting, provided that 15 days' notice of the proposed amendment has been given to the members. No such amendment shall be effective until it has the written approval of the commissioner of insurance.

ARTICLE ELEVEN

Each medical-care certificate issued by this corporation shall provide that this corporation will, in accordance with the terms of the certificate and its by-laws and regulations, compensate participating licensed and registered doctors of medicine, of the subscriber's choice, for services rendered to that subscriber.

This corporation shall not assume, and no contract or certificate shall impose upon this corporation any liability of a physician arising from or growing out of the doctor-patient relationship. This corporation shall not assume, and no contract or certificate shall impose upon this corporation, responsibility or liability for any act, negligence, or failure to act of any person furnishing medical care to any subscriber, or for the failure to furnish medical care to any subscriber, nor shall this corporation for any reason be held to any such responsibility or liability.

Nothing in these articles shall be construed to prevent employees, groups of employers, or other agencies from underwriting or contributing in part or in full to the costs of this corporation for the benefit of all or certain of its subscribers.

ARTICLE TWELVE

No dividends shall be paid by this corporation. Members or other persons may be repaid, in whole or in part, their contributions to the capital of the corporation, but all shall be paid at the same rate and only upon the written approval of the insurance department of the State of Michigan. Except in the event of liquidation, such payments shall be made only out of accumulated surplus earnings of the corporation that have not been used for the creation of reserves.

ARTICLE THIRTEEN

The reserve funds of the corporation may be invested in such securities as are permitted as investments by the laws of this State for life insurance companies.

MICHIGAN MEDICAL SERVICE

SCHEDULE OF BENEFITS

The Schedule of Benefits of Michigan Medical Service is composed of the frequent and common surgical procedures. The Medical Advisory Committee recognizes that it would be futile to attempt to list each possible surgical operation or combinations of operations. The amount, therefore, shown in the schedule is the average payment for the average case.

If the surgeon feels that a particular case deserves particular consideration, he is invited and encouraged to augment his regular report with a letter explaining the details of the case, or, if possible, forward a copy of the operative record.

Where the operation is one not recorded in the Schedule, a complete description of the operation should be forwarded to Michigan Medical Service.

To facilitate payment to the doctors, the Medical Advisory Committee has formulated certain basic regulations to permit prompt authorization for services. This applies particularly to multiple surgical procedures.

A great number of combination surgical operations that are commonly performed in the same operative field have been grouped into classifications and a lump sum is paid for the particular classification. This primarily relates to abdominal and vaginal operations, as well as the incidental appendectomy performed at the same time as another major abdominal operation.

The Schedule of Benefits as printed in this booklet provides only for the individual operation. While it is possible for the doctor to perform three distinct operations listed in this Schedule, it does not necessarily follow that the amount of payment will be the total sum of the benefits listed separately for each operation.

The Surgical Certificate of Michigan Medical Service provides for the following services:

(a) Surgical services (operative and cutting procedures for the treatment of disease or injury and treatment of fractures and dislocations) rendered by the doctor of medicine in charge of the case.

(b) Maternity services, i. e., childbirth, but not until after the certificate has been in force nine consecutive months.

(c) Diagnostic X-ray services not in excess of the value of Fifteen Dollars (\$15.00), as set forth in and limited by the Michigan Medical Service Schedule of Benefits, between the effective date of this certificate and the first anniversary hereof or during any succeeding twelve-month period.

(d) Anesthesia services rendered by a doctor of medicine not in charge of the case when in connection with services in the hospital where the subscriber is a patient.

(e) Emergency surgical services not requiring bed care rendered in a regularly accredited hospital by a doctor of medicine during the first twenty-four hours following accidental injury.

It is a primary consideration that the patient must be a **BED PATIENT** in a regularly accredited hospital before any benefits are payable under the certificate. This is essentially necessary inasmuch as the subscription rate paid by the subscriber contemplates only those necessary surgical services requiring hospitalization.

There are certain exclusions under the certificate which are as follows:
No benefits will be paid for:

1. Hospital, dental, or nursing services.
2. Medicines, drugs, appliances, materials, or supplies.
3. Services for industrial injuries or diseases, or services from any government agency, which are, or to the extent such services can be, obtained by the subscriber without cost to him by compliance with laws enacted by any federal, state, municipal, or other legislative body.
4. Prenatal or other medical or surgical service in the home or office.
5. Plastic operations for cosmetic or beautifying purposes.

(NOTE.—Many subscribers of Michigan Medical Service are also enrolled in Michigan Hospital Service, which provides for payment of the hospital bill.

Each subscriber is given an Identification Card at the time of enrollment. He is impressed with the necessity of presenting this card to the doctor when service is requested. Unfortunately, some subscribers do not do so, while others believe that the presentation of the card at the hospital admission desk is sufficient.

We recommend, therefore, that the doctor attempt to secure this information:

1. Name of the subscriber.
2. Name of the patient.
3. Service and contract number.
4. Group number or place of employment.
5. Address of the subscriber.

This permits prompt identification when the Doctor's Service Report is received and in turn facilitates handling and payment for the services.

A specimen of the Doctor's Service Report as printed on pages 10 and 11 will assist the doctor and his secretary in properly completing this report.

See pages 10 and 11 for reproduction of Doctor's Report.

1. Patient's name.
2. Subscriber's name. Give first and last name. As a rule, this is the father or husband. In some cases the wife or mother may be the subscriber. In any event, the Identification Card carries the subscriber's name. The reverse side of the Identification Card also carries a description of each service code.
3. Subscriber's address.
4. Relationship of patient to subscriber, e. g., son, daughter, wife, etc.
5. Group Number.
6. Service number (subscriber is eligible for surgical care only if the service number is from 11 to 19).
7. Certificate number.
- 8, 9, 10. Self-explanatory.

11. **Surgical Operation.** To be filled in by the **OPERATING SURGEON ONLY.** If it is an unusual operation, supplement with complete description, preferably a copy of operative record.

Permission is granted by the subscriber to release this information to Michigan Medical Service, on the application he signs at the time of enrollment.

This record of service is confidential and is discussed with no one other than the doctor submitting the report.

12. **OBSTETRICAL SERVICE.** To be completed by the doctor performing the delivery. If Caesarean Section, please state.

13. **X-RAY SERVICE.** As a rule this portion of report is completed by X-ray department of the hospital and sent directly to Michigan Medical Service. Report, however, must be signed by roentgenologist.

14. **ANESTHESIA.** Benefit available only when administered personally by a doctor of medicine not in charge of the case.

15. **DIAGNOSIS.** A separate report should be completed and signed by each doctor rendering the specific service, e. g., the operating surgeon should fill in item 11, sign the report, and forward it to Michigan Medical Service, and the roentgenologist should complete item 13 and forward it to Michigan Medical Service.

This is necessary inasmuch as the Enabling Act, under which Michigan Medical Service operates, requires that payments for services rendered to subscribers be made directly to the doctor rendering such service. Consequently, confusion

arises if the referring doctor completes the report rather than the operating surgeon, or if the surgeon indicated that he also took X-rays.

- 100-199 General Surgery
 100-129 Infections and Traumata
 130-139 Cysts
 140-149 Tumors
 150-154 Biopsy
 155-159 Glands
 160-164 Thyroid
 165-169 Breast
 170-179 Miscellaneous
 180-189 Casts
 190-199 Anesthesia
 200-649 Special Surgery
 200-219 Thoracic Surgery
 220-289 Abdominal Surgery
 290-319 Proctology
 320-359 Urology
 360-419 Obstetrics and Gynecology
 420-459 Ophthalmology
 460-469 Otology
 470-489 Nose and Throat
 490-509 Neuro-Surgery
 510-649 Bone, Joint, Tendon Surgery
 510-539 Simple Fractures
 540-569 Compound Fractures
 570-589 Dislocations
 590-599 Joint Resections
 600-619 Orthopedic
 620-649 Amputations
 800-998 Radiology
 860-829 Head and Neck
 830-849 Chest
 850-869 Spine and Pelvis
 870-889 Upper Extremities
 890-909 Lower Extremities
 910-929 Gastro-Intestinal
 930-939 Urological
 940-949 Obstetrics and Gynecology
 950-959 Fluoroscopic and General
 999 Services Not Otherwise Classified

100-199 GENERAL SURGERY

100-129 Infections and Traumata

100	Superficial abscesses and boils, incision-----	\$5. 00
101	Deep abscess (including ischiorectal)-----	40. 00
103	Carbuncle, surgical treatment ¹	
106	Ulcer, excision-----	10. 00
112	Tendon of hand, drainage-----	25. 00
118	Traumatic wounds, suturing ²	
121	Debridement ²	
123	Scar tissue, excision ²	
126	Grafts, pinch-----	15. 00
127	Grafts, fascial-----	25. 00

130-139 Cysts

130	Cysts, sebaceous, removal-----	10. 00
133	Dermoid cyst-----	50. 00
134	Pilonidal cyst or sinus-----	50. 00
135	Thyroglossal cyst, removal-----	100. 00
136	Branchial cyst, removal-----	100. 00

¹ Dependent on extent of service.

² Dependent on area involved.

140-149 Tumors

422	Foreign body, removal from cornea.....	\$15.00
141	Tumors, complicated, removal.....	25.00
142	Tumor, vocal cord, removal.....	50.00
143	Epulis, removal.....	15.00
144	Paratoid tumor, removal.....	75.00

150-154 Biopsy

150	Biopsy, superficial.....	10.00
151	Biopsy, bone.....	15.00
152	Biopsy, via scopes.....	25.00

155-159 Glands

155	Glands, superficial removal.....	10.00
-----	----------------------------------	-------

160-164 Thyroid

160	Thyroid gland, simple ligation.....	75.00
161	Thyroidectomy, subtotal.....	125.00
162	Lobectomy.....	100.00
163	Thyroidectomy, two-stage, subtotal.....	150.00
164	Parathyroidectomy.....	

165-169 Breast

165	Breast abscess, drainage.....	25.00
166	Breast tumor, removal.....	50.00
167	Breast, radical removal.....	125.00
168	Breast, simple removal.....	50.00

170-179 Miscellaneous

170	Ligation, saphenous vein, low.....	25.00
171	Ligation, saphenous vein, high.....	40.00
172	Phlebitis, paravertibreal, each treatment.....	15.00
174	Varicose veins, injection of.....	3.00
175	Toe nail, ingrown, removal.....	10.00

180-189 Casts

(Medium not included)

180	Chest.....	15.00
181	Spine.....	25.00
182	Torso.....	25.00
183	Entire Body.....	50.00
184	Extremities, upper.....	10.00
185	Extremities, lower.....	10.00

190-199—ANESTHESIA

190	Anesthesia for first hour.....	10.00
	Anesthesia for each additional hour or fraction thereof.....	5.00

*200-249 SPECIAL SURGERY**200-291 Thoracic Surgery*

200	Bronchoscopy.....	\$40.00
201	Bronchoscopy, subsequent.....	20.00
202	Pleura, paracentesis.....	5.00
203	Empyema, closed drainage.....	40.00
204	Empyema, rib resection.....	60.00
205	Pneumonectomy.....	150.00
206	Pneumothorax, artificial.....	* 15.00
207	Pneumothorax, refills, each.....	* 10.00
208	Pneumolysis, extra or introleural.....	100.00

* Maximum of \$45.

209	Phrenic nerve, operation	\$30.00
213	Thoracoplasty	125.00
215	Lobectomy	125.00
217	Pericardium, paracentesis	25.00
218	Cardiotomy	
219	Aneurysmorrhaphy	

220-289 *Abdominal Surgery*

220	Abdomen, paracentesis	10.00
221	Abdomen, peritoneoscopy	25.00
224	Herniotomy, diaphragmatic	100.00
227	Herniotomy, single	75.00
228	Herniotomy, bilateral	125.00
230	Esophagoscopy	40.00
232	Esophagus, dilatation	30.00
233	Esophagotomy	
235	Rammstedt for infant pyloric stenosis	125.00
236	Gastrosocopy	40.00
237	Gastrotomy	100.00
238	Gastric ulcer, excision	125.00
239	Gastrectomy	150.00
240	Gastro-enterostomy	135.00
241	Gastrostomy	
244	Peptic ulcer, perforated, closure	125.00
247	Duodenal ulcer, excision	125.00
250	Intestines, anastomosis	120.00
251	Intestines, resection	150.00
253	Volvulus, reduction	
254	Intussusception, reduction	
256	Adhesions, freeing of	
260	Colon, resection	150.00
261	Colostomy	75.00
264	Appendectomy	75.00
265	Diverticulum, intestinal	100.00
266	Appendiceal abscess, drainage	75.00
267	Appendecostomy	
269	Epiploric appendectomy	100.00
273	Liver abscess, drainage	115.00
274	Cholecystotomy	100.00
274	Cholecystectomy	140.00
276	Cholecystostomy	
278	Choledochotomy	140.00
280	Pancreas, drainage	
286	Splenectomy	135.00

290-319 *Proctology*

292	Hemorrhoidectomy, external*	25.00
293	Hemorrhoidectomy, internal	50.00
296	Fistulectomy	50.00
298	Fissurectomy	25.00
300	Polypectomy	25.00
302	Abscess, ischio-rectal, drainage	40.00
304	Carcinoma of rectal, extirpation	150.00
308	Peri-rectal abscess, drainage	5.00
311	Prolapsd rectum, repair	
313	Mucosa, excision of redundant	

320-349 *Urology*

320	Cystoscopy	20.00
321	Cystoscopy, with pyelogram	25.00
322	Cystoscopy, operative	45.00

323	Circumcision, child	\$10.00
324	Circumcision, adult	15.00
326	Stricture, dilatation	5.00
327	Stricture, cutting	
328	Urethrotomy, external	75.00
329	Urethrotomy, internal	50.00
331	Prostatic abscess	50.00
332	Prostatectomy, perineal	150.00
333	Prostatectomy, suprapubic, one or two stages	150.00
334	Prostatectomy, transurethral	100.00
336	Tunica vaginalis, paracentesis	5.00
337	Hydrocele, aspiration	5.00
338	Hydrocele, radical operation	50.00
340	Epididymectomy	65.00
342	Varicocelectomy	50.00
344	Orchidotomy	
345	Orchidopexy	75.00
346	Orchidectomy	50.00
348	Cystotomy or cystostomy	50.00
349	Calculus, removal—	
	By cystotomy	75.00
	By cystoscope	45.00
350	Lithotripsy, with cystoscopy	70.00
353	Bladder tumor, removal	
355	Uretero-lithotomy	125.00
356	Nephrotomy	135.00
357	Nephrectomy	135.00
358	Nephropexy	100.00

360-419 Obstetrics and Gynecology

360	Pregnancy, delivery (all types except Caesarean) (office calls are not covered in certificate)	40.00
370	Miscarriage—	
	To 6 months	20.00
	To 6 months (with D. and C.)	30.00
	After 6 months (including D. and C.)	40.00
384	Caesarean section, vaginal	100.00
385	Caesarean section, abdominal	100.00
388	Pregnancy, ectopic (also ruptured)	125.00
390	Bartholin's gland, incision	10.00
391	Bartholin's gland, excision	30.00
392	Urethral caruncle, removal	15.00
393	Labial tumors and cysts, removal	25.00
394	Atresia of vagina, correction of	50.00
395	Perineorrhaphy, including rectocele	50.00
396	Colporrhaphy, anterior	30.00
399	Fistula, recto-vaginal	100.00
400	Fistula, vesico-vaginal	100.00
402	Cul-de-sac, drainage	30.00
403	Cauterization of cervix	20.00
404	Dilatation and curettage	30.00
405	Tubal inflation	15.00
406	Uterine Polypi, removal	25.00
407	Trachelorrhaphy	50.00
408	Conization	20.00
409	Cervix, amputation	50.00
410	Hysterectomy, vaginal	150.00
411	Hysterectomy, abdominal	150.00
412	Myomectomy	100.00
413	Uterine flexions, etc., correction	100.00
415	Oophorectomy	100.00
416	Ovariectomy	75.00
417	Salpingectomy with or without oophorectomy	100.00

420-459 Ophthalmology

422	Foreign body, removal from cornea.....	\$15.00
423	Foreign body, interior eye, removal.....	100.00
424	Conjunctiva, suture.....	15.00
425	Conjunctival flap for corneal ulcer, etc.....	25.00
426	Chalazion.....	5.00
428	Lachrymal duct stenosis, probing.....	5.00
429	Lachrymal sac, removal.....	60.00
430	Entropion or ectropion, Ziegler's puncture.....	30.00
431	Entropion or ectropion, plastic operation.....	50.00
432	Keratitis, sicca, occlusion lachrymal puncta.....	10.00
435	Symblepharon, release.....	30.00
436	Pterygium.....	30.00
437	Trichiasis, electrolysis.....	15.00
438	Canthotomy.....	5.00
441	Corneal ulcer, cautery.....	5.00
442	Corneal ulcer, delimitating keratotomy.....	25.00
443	Cornea, paracentesis.....	10.00
444	Tarorrhaphy, orbicularis paralysis.....	30.00
445	Ptosis.....	75.00
446	Strabismus, one stage.....	50.00
447	Strabismus, two or more stages.....	75.00
449	Cataract, needling.....	50.00
450	Cataract, removal.....	100.00
451	Iridectomy.....	50.00
453	Glaucoma, filtering operation.....	100.00
454	Enucleation.....	75.00
455	Enucleation and implantation.....	75.00
457	Tumor, exenteration of orbit.....	100.00
458	Trachoma, operation.....	

460-469 Otology

461	Paracentesis, tympani.....	5.00
463	Mastoidectomy, acute.....	100.00
464	Mastoidectomy, radical.....	125.00

470-489 Nose and Throat

470	Nasal polyps, removal.....	20.00
472	Turbinectomy.....	10.00
474	Antrum, puncture.....	10.00
475	Antrum, Caldwell-Luc.....	80.00
476	Antrum window.....	25.00
477	Ethmoidectomy, radical.....	75.00
478	Frontal sinus, radical.....	100.00
479	Sphenoidal operation.....	
480	Submucous resection.....	50.00
481	Palatorrhaphy.....	100.00
482	Tonsillectomy and adenoidectomy.....	30.00
483	Uvulectomy.....	5.00
484	Abscess, peritonsillar, incision.....	10.00
485	Larynx, intubation.....	20.00
486	Larynx, polyp, removal.....	50.00
487	Laryngectomy.....	150.00
488	Laryngoscopy—	
	Diagnostic.....	10.00
	Operative.....	25.00
489	Tracheotomy.....	35.00

490-509 Neuro-Surgery

490	Encephalogram (X-ray extra).....	25.00
491	Ventriculogram (X-ray extra).....	40.00
492	Trephine, subdural hematoma.....	75.00
494	Decompression, subtemporal.....	100.00
495	Craniotomy, tumor or abscess.....	150.00

497	Skull defect, plastic operation.....	\$100. 00
498	Section, 5th nerve (tri-geminal neuralgia).....	100. 00
499	Section, 8th nerve (Meniere's syndrome).....	100. 00
500	Section, anterior scalenus (Scalenus syndrome).....	50. 00
501	Laminectomy, cord tumor or nucleus pulposus.....	125. 00
502	Spine or neck, fracture or dislocation.....	(⁴)
503	Chordotomy, unilateral.....	100. 00
504	Chordotomy, bilateral.....	100. 00
505	Splanchnicectomy.....	125. 00
506	Nerve anastomosis.....	⁵ 100. 00
509	Lumbar puncture.....	5. 00

*501-619 Bone, Joint, Tendon Surgery**510-539 Simple Fractures*

510	Skull.....	25. 00
511	Nose.....	15. 00
512	Mandible ⁶	75. 00
513	Maxilla, superior ⁶	75. 00
516	Vertebra, one or more.....	50. 00
517	Transverse process.....	10. 00
518	Sternum.....	25. 00
519	Rib, one or more.....	10. 00
521	Clavicle.....	25. 00
522	Scapula.....	25. 00
523	Humerus.....	50. 00
524	Olecranon.....	35. 00
525	Radius or ulna (Colles' Fracture).....	35. 00
526	Metacarpal bone, one.....	15. 00
527	Carpal bone, one.....	30. 00
528	Finger.....	10. 00
530	Pelvis.....	50. 00
531	Femur.....	85. 00
532	Patella.....	25. 00
535	Tibia or fibula (including Pott's fracture).....	50. 00
536	Metatarsal bone, one.....	15. 00
537	Tarsal bone one.....	15. 00
538	Toe, one.....	10. 00

540-569 Compound Fractures

540	Skull, vault.....	100. 00
541	Nose.....	25. 00
542	Mandible.....	80. 00
546	Vertebra, one or more.....	125. 00
548	Sternum.....	60. 00
549	Rib, one.....	15. 00
551	Clavicle.....	40. 00
552	Scapula.....	45. 00
553	Humerus.....	75. 00
554	Olecranon.....	52. 50
555	Radius or ulna.....	55. 00
556	Metacarpal bone, one.....	25. 00
557	Carpal bone, one.....	45. 00
558	Finger.....	20. 00
560	Pelvis.....	80. 00
561	Femur.....	125. 00
562	Patella.....	50. 00
563	Tibia.....	60. 00
564	Fibula.....	40. 00
565	Tibia and fibula (including Pott's fracture).....	75. 00
566	Metatarsal bone, one.....	25. 00
567	Tarsal bone, one.....	45. 00
568	Toe, one.....	20. 00

⁴ Individual consideration.⁵ And down.⁶ Wiring if necessary.

570-589 Dislocations

570	Spine.....	
572	Mandible.....	\$10. 00
573	Clavicle.....	25. 00
574	Shoulder.....	30. 00
575	Elbow.....	25. 00
576	Wrist.....	
577	Metacarpal bone, one.....	15. 00
578	Carpal bone, one.....	25. 00
579	Finger, one.....	5. 00
580	Hip.....	60. 00
581	Knee.....	30. 00
584	Metatarsal bone, one.....	15. 00
585	Tarsal bone, one.....	25. 00
586	Toe, one.....	5. 00

590-599 Joint Resections

590	Shoulder joint, resection.....	150. 00
591	Elbow joint, resection.....	100. 00
592	Wrist joint, resection.....	75. 00
595	Hip joint, resection.....	150. 00
596	Knee joint, resection.....	100. 00
596	Ankle joint, resection.....	100. 00

600-619 Orthopedic

600	Spinal fusion.....	150. 00
601	Bone graft (long bone).....	150. 00
604	Talipes.....	50. 00
605	Tenotomy.....	35. 00
606	Tenorhaphy.....	35. 00
608	Arthrotomy, knee.....	75. 00
609	Sequestrum, removal (deep).....	50. 00
610	Coccyx, excision of.....	50. 00
615	Aspiration of joint.....	

620-649 Amputations

620	Shoulder.....	100. 00
621	Arm.....	70. 00
622	Elbow.....	
623	Forearm.....	70. 00
624	Hand.....	65. 00
625	Finger.....	20. 00
630	Hip.....	125. 00
631	Thigh.....	90. 00
632	Knee.....	
633	Leg.....	85. 00
634	Toe.....	20. 00
635	Foot.....	65. 00

800-998 RADIOLOGY

800-829 Head and Neck

800	Skull.....	10. 00
801	Skull, including paranasal sinuses.....	15. 00
802	Paranasal sinuses.....	10. 00
803	Encephalography.....	15. 00
804	Encephalograph, including preliminary skull.....	* 25. 00
805	Ventriculography.....	15. 00
806	Ventriculography, including preliminary skull.....	* 25. 00
807	Sella Turcica.....	10. 10
808	Eye for foreign body.....	10. 00

* Under surgical benefit certificate \$15 maximum benefit only available.

809	Eye for localizing foreign body (extra).....	\$15.00
810	Mastoids (a) Regular.....	10.00
811	Mastoids, including pitrous pyramids.....	10.00
812	Nose.....	10.00
813	Maxilla and facial bones.....	10.00
814	Mandibles, each.....	10.00
815	Teeth, single.....	2.00
816	Teeth, one-fourth set.....	4.00
817	Teeth, one-half set.....	5.00
818	Teeth, complete set (periapical examination).....	10.00
819	Teeth, bitewing examination.....	5.00
820	Esophagus (only).....	10.00
821	Sialography (without medium).....	10.00
822	Optic Foramina.....	15.00
823	Neck for soft tissue.....	10.00

830-849 Chest

830	Thorax-Ribs.....	10.00
831	Sternum.....	10.00
832	Lungs, stereoscopic, posterior-anterior.....	10.00
833	Lungs, fluoroscopic examination.....	5.00
834	Heart, complete fluoroscopic-radiographic studies.....	10.00-15.00
835	Heart, single teleo roentgenograms.....	10.00-15.00
836	Kymograph (chest or abdomen).....	7.50
837	Chest for thymus, fluoroscopy, and films.....	10.00
838	Bronchography.....	
839	Bronchography, including injection by radiologist.....	† 25.00
840	Chest, flat film.....	5.00

850-869 Spine and Pelvis

850	Spine, cervical.....	10.00
851	Spine, thoracic.....	10.00
852	Spine, lumbar.....	10.00
853	Spine, lumbar and pelvis.....	15.00
854	Spine, sacrum and coccyx.....	10.00
855	Spine, any two of the above areas.....	15.00
856	Spine, entire.....	† 25.00
857	Myelography.....	† 20.00
858	Pelvis.....	10.00

870-889 Upper Extremities

870	Shoulder girdle.....	10.00
871	Clavicle.....	7.50
872	Shoulder joint.....	7.50
873	Humerus (shaft).....	10.00
874	Elbow.....	7.50
875	Forearm.....	10.00
876	Wrist.....	7.50
877	Hand.....	5.00
878	Finger.....	5.00

890-909 Lower Extremities

890	Hips.....	10.00
891	Smith-Peterson Nail.....	† 25.00
892	Femur.....	10.00
893	Knee.....	7.50
894	Semilunar cartilage of both knees.....	15.00
895	Tibia and Fibula.....	10.00
896	Ankle.....	7.50
897	Foot.....	7.50
898	Toes.....	5.00

† Under surgical benefit certificate \$15 maximum benefit only available.

910-929 *Gastro-Intestinal (Not including medium)*

910	Gastro-intestinal tract by barium meal with preliminary films of abdomen.....	⁷ \$35.00
911	Gastro-intestinal tract by barium meal and enema.....	⁷ 35.00
912	Gastro-intestinal tract (barium meal) and gallbladder (dye) and colon (enema).....	⁷ 50.00
913	Stomach and duodenum only.....	15.00
914	Stomach, duodenum, and gallbladder (dye).....	⁷ 25.00
915	Gallbladder by dye method.....	15.00
916	Colon by barium enema and contrast study.....	15.00
923	Fistulae—contrast study.....	15.00

930-939 *Urological*

930	Pyelography, intravenous.....	⁷ 25.00
931	Pyelography, retrograde.....	15.00
933	Kidney, Ureter and bladder.....	10.00
934	Urethro-cystography.....	10.00

940-949 *Obstetrics and Gynecology*

940	Pregnancy—with measurements.....	⁷ 20.00
941	Pregnancy—without measurements.....	10.00
942	Utero-salpingography.....	⁷ 30.00
943	Mammary gland study.....	15.00

950-998 *Fluoroscopic and General*

950	Reduction of fractures.....	5.00
951	Foreign body detection.....	5.00
952	Foreign body removal.....	5.00-10.00
953	Foreign bodies in esophagus or respiratory tract.....	⁸ 10.00
954	Portable examination in hospital—add.....	5.00
956	Fluoroscopic—chest or abdomen.....	5.00

⁷ Under surgical benefit certificate \$15 maximum benefit only available.

⁸ And up.

999 *Services Not Otherwise Classified*

MEDICAL SURGICAL BENEFIT CERTIFICATE

Effective

MICHIGAN MEDICAL SERVICE

DEFINITIONS AND BENEFITS

1. *Definition.*—The term "professional services" as used herein is defined to mean services rendered to the subscriber, in a regularly accredited hospital, by doctors of medicine registered as participating with Michigan Medical Service, of the subscriber's own choice, for illness or injury requiring care as a bed patient in such hospital, to the extent and subject to the limitations set forth below.

(a) *Medical and Surgical Services.*—Medical (nonsurgical) services, limited to a total of thirty days of such care between the effective date of this Certificate and the first anniversary hereof or during any succeeding twelve-month period, rendered by the doctor of medicine in charge of the case. Surgical services (operative and cutting procedures for treatment of disease and injuries, and the treatment of fractures and dislocations), rendered by the doctor of medicine in charge of the case.

Determination of Michigan Medical Service as to whether or not services rendered are medical or surgical shall be conclusive.

(b) *Maternity Services.*—Maternity services, i. e. childbirth, but not until after the certificate has been in force nine consecutive months.

(c) *X-Ray Services.*—Diagnostic x-ray services not in excess of the value of Fifteen Dollars (\$15.00), as set forth in the Michigan Medical Service Schedule of Benefits, between the effective date of this certificate and the first anniversary hereof or during any succeeding twelve-month period.

(d) *Anesthesia Service.*—Anesthesia services rendered by a doctor of medicine not in charge of the case when in connection with services otherwise provided hereby in the hospital where the subscriber is a patient.

(e) *Emergency Service.*—Emergency surgical services not requiring bed care rendered by a doctor of medicine in a regularly accredited hospital during the first twenty-four hours following accidental injury.

2. *General Limitations.*—The benefits as set forth above shall not include the following:

(a) Hospital, dental, or nursing services.

(b) Medicines, drugs, appliances, materials, or supplies.

(c) Services for industrial injuries or diseases, or services from any government agency, which are, or to the extent such services can be, obtained by the subscriber without cost to him by compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body.

(d) Prenatal or other medical or surgical services in the home or office.

(e) Plastic operations for cosmetic or beautifying purposes.

(f) Medical services (as defined in Section 1 (a) above) in excess of thirty days of such services.

3. *Services Not Provided.*—Michigan Medical Service does not undertake to supply a doctor of medicine for the subscriber.

4. *Service in Full.*—Doctors of medicine participating with Michigan Medical Service and rendering to the subscriber such services as herein provided shall make no charge to the subscriber therefor except:

(a) *Exception to Full Service.*—To an unmarried subscriber whose average annual income exceeds Two Thousand Dollars (\$2,000.00) or to married subscriber whose average annual income, together with the income of his spouse or family members, exceeds Two Thousand Five Hundred Dollars (\$2,500.00), these average annual incomes to be determined on the basis of income for the three-year period immediately preceding the date of service; or

(b) *Exception to Full Service.*—To a subscriber who shall request and occupy private-room accommodations in the hospital. This exception (b) shall not apply to a subscriber who is involuntarily compelled by nature of illness and on the order of his physician to be placed in private-room accommodations.

Partial Service.—In the event services covered by this certificate are rendered to subscribers subject to exception (a) or (b) above, the doctor of medicine participating with Michigan Medical Service may make an additional charge to the subscriber, such additional charge, if any, shall be the liability of the subscriber and not of Michigan Medical Service.

Disputed Income Classification.—In the event of any dispute between the doctor and the subscriber with respect to the application to such subscriber of the provisions of subdivision (a) of this section, the same shall be submitted to and determined by Michigan Medical Service, whose determination shall be conclusive upon the parties.

SERVICES BY NONPARTICIPATING PHYSICIANS

5. *Services by Non-Participating Physician.*—If, in an emergency, services covered by the certificate are rendered by a physician not participating with Michigan Medical Service, it will pay its then prevailing rate for such services.

PAYMENT OF RATE, TERM, AND TERMINATION

6. *Subscription Rates.*—The subscriber agrees to pay Michigan Medical Service monthly, unless otherwise provided, for the services checked in his Application Card at the following rates:

Employee-----	\$
Employee and Souse (or employee and unmarried child up to 19 years of age)-----	2. 20
Employee, spouse, and unmarried children up to 19 years of age----	3. 25

Michigan Medical Service reserves the right to change the above rate on thirty days' written notice to the subscriber; such change of rate shall become effective on the date fixed in the notice, unless the subscriber notifies his employer in writing any time not less than ten days prior to the effective date of such notice of his decision to discontinue this certificate.

7. *Term and Termination.*—This contract shall constitute an agreement for one month from its effective date and shall be renewed thereafter each month, unless

notice of election to terminate the same is given by the subscriber to Michigan Medical Service, or by Michigan Medical Service to the subscriber, not less than thirty days prior to the date of termination.

Michigan Medical Service shall not terminate this certificate (except for non-payment of the monthly charge) as long as the subscriber is a member of the original group through which he enrolled and is making payment through payroll deduction and Michigan Medical Service elects to continue to protect the group under the plan.

Failure to pay the rate provided in Section 6 shall constitute immediate termination of this contract and all benefits hereunder.

8. *Discontinuance of Group Membership.*—In the event the subscriber temporarily leaves the group through which he enrolled, this certificate may be kept in force if the subscriber continues to make payment at the rate for the group.

In the event the subscriber terminates employment in the group through which he is enrolled, this certificate may be kept in force upon payment of the subscription rate for the group or classification to which he is transferred.

GENERAL CONDITIONS

9. *Reports of Service.*—Doctors of medicine participating with Michigan Medical Service are required to furnish reports to Michigan Medical Service, which shall remain confidential, relative to diagnosis and services given the subscriber entitled to or claiming such service under this certificate, and it is agreed that request for such service is authorization to the doctors of medicine to make such reports.

10. *Identification.*—*The subscribers' Identification Card must be presented to the doctor of medicine when service is requested.*

11. *Assignment.*—The services to be provided under the certificate are for the personal benefit of the subscriber and cannot be transferred or assigned; any attempt to assign this certificate shall automatically terminate all rights thereunder.

12. *Contest.*—No action or suit at law or in equity shall be commenced until thirty days after written notice of claim has been given by the subscriber to Michigan Medical Service, nor shall such action be brought at all later than two years after such claim has arisen by acceptance of service.

13. *Contract Continuity of Benefits.*—The application submitted by the subscriber and this certificate shall constitute the entire contract between the parties. No agent or employee is authorized to vary, add to, or change this contract as set forth in any manner or degree. The issuance of this certificate cancels all previous certificates then in force and all rights thereunder between the subscriber and Michigan Medical Service, except that, so long as this certificate remains in force and until the expiration of the period of 10 consecutive months from the date of issuance hereof, the subscriber shall continue to be entitled to the maternity services provided for by said cancelled certificate, if any.

14. *Headings.*—The catchline headings in no way shall be considered to be a part of this certificate, but are inserted only for purposes of convenience.

This is your Certificate. Read it carefully.

Identify yourself as a Subscriber by presenting your Identification Card when service is first requested from a doctor of medicine.

Benefits include medical and surgical services, diagnostic X-rays, maternity services, and anesthesia—rendered by a doctor of medicine when you are a bed patient in a hospital, as well as surgical services in hospital outpatient department following accidental injury.

Sponsored by the Michigan State Medical Society
The Professional Association of Doctors of Medicine in Michigan

A Non-Profit Medical Service Plan, Organized Under Michigan Laws and Licensed by the
Department of Insurance of the State of Michigan

MICHIGAN MEDICAL SERVICE, DETROIT, MICHIGAN

MEDICAL-SURGICAL CERTIFICATE

THIS CONTRACT, made between the Subscriber named in the application and MICHIGAN MEDICAL SERVICE, a nonprofit corporation.

ENTITLES the Subscriber, in consideration of payments at the subscription rate indicated in the application, to have Michigan Medical Service pay for professional services of doctors of medicine, as hereinafter defined, rendered to the Subscriber, and, if listed on the application, the spouse and unmarried dependent children until the end of the calendar year in which they attain nineteen years of age, for a period of one month next following the date of execution, upon and subject to the terms and limitations hereinafter set forth.

In Witness Whereof, Michigan Medical Service by its agent duly authorized in the premises has executed this Certificate.

MICHIGAN MEDICAL SERVICE,
JAY C. KETCHUM,
Executive Vice President.

MEDICAL-SURGICAL BENEFIT CERTIFICATE

SURGICAL BENEFIT CERTIFICATE

Effective -

MICHIGAN MEDICAL SERVICE

(Participating)

DEFINITIONS AND BENEFITS

1. *Definition.*—The term "professional services" as used herein is defined to mean services rendered by doctors of medicine registered as participating with Michigan Medical Service, of the subscriber's own choice, to the subscriber for illness or injury requiring and resulting in admission and care as a bed patient in a regularly accredited hospital, to the extent and subject to the limitations set forth below.

(a) *Surgical Services.*—Surgical service (operative and cutting procedures for the treatment of disease or injury and treatment of fractures and dislocations) rendered by the doctor of medicine in charge of the case.

(b) *Maternity Services.*—Maternity services, i. e. childbirth, but not until after the certificate has been in force nine consecutive months.

(c) *X-Ray Services.*—Diagnostic x-ray services not in excess of the value of Fifteen Dollars (\$15.00), as set forth in and limited by the Michigan Medical Service Schedule of Benefits, between the effective date of this certificate and the first anniversary hereof or during any succeeding twelve month period.

(d) *Anesthesia Service.*—Anesthesia services rendered by a doctor of medicine not in charge of the case when in connection with services otherwise provided hereby in the hospital where the subscriber is a patient.

(e) *Emergency Service.*—Emergency surgical services not requiring bed care rendered in a regularly accredited hospital by a doctor of medicine during the first twenty-four hours following accidental injury.

2. *General Limitations.*—The benefits as set forth above shall not include the following:

(a) Hospital, dental, or nursing services.

(b) Medicines, drugs, appliances, materials or supplies.

(c) Services for industrial injuries or diseases, or services from any government agency, which are, or to the extent such services can be, obtained by the subscriber without cost to him by compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body.

(d) Prenatal or other medical or surgical services in the home or office.

(e) Plastic operations for cosmetic or beautifying purposes.

3. *Services Not Provided.*—Michigan Medical Service does not undertake to supply a doctor of medicine for the subscriber.

4. *Service in Full.*—Doctors of medicine participating with Michigan Medical Service and rendering to the subscriber such services as herein provided shall make no charge to the subscriber therefor except:

(a) *Exception to Full Service.*—To an unmarried subscriber whose average annual income exceeds Two Thousand Dollars (\$2,000.00) or to a married subscriber whose average annual income, together with the income of his spouse or family members, exceeds Two Thousand Five Hundred Dollars (\$2,500.00), these average annual incomes to be determined on the basis of income for the three year period immediately preceding the date of service; or

(b) *Exception to Full Service.*—To a subscriber who shall request and occupy private room accommodations in the hospital. This exception (b) shall not apply to a subscriber who is involuntarily compelled by nature of illness and on the order of his physician to be placed in private room accommodations.

Partial Service.—In the event services covered by this certificate are rendered to subscribers subject to exception (a) or (b) above, the doctor of medicine participating with Michigan Medical Service may make an additional charge to the subscriber; such additional charge, if any, shall be the liability of the subscriber and not of Michigan Medical Service.

Disputed Income Classification.—In the event of any dispute between the doctor and the subscriber with respect to the application to such subscriber of the provisions of subdivision (a) of this section, the same shall be submitted to and determined by Michigan Medical Service, whose determination shall be conclusive upon the parties.

SERVICES BY NONPARTICIPATING PHYSICIANS

5. *Services by Non-Participating Physician.*—If, in an emergency, services covered by the certificate are rendered by a physician not participating with Michigan Medical Service, it will pay its then prevailing rate for such services.

PAYMENT OF RATE, TERM, AND TERMINATION

6. *Subscription Rates.*—The subscriber agrees to pay Michigan Medical Service monthly, unless otherwise provided, for the services checked in his application card at the following rates:

Employee.....	\$0. 60
Employee and spouse (or employee and unmarried child up to 19 years of age).....	1. 60
Employee, spouse, and unmarried children up to 19 years of age.....	2. 25

Michigan Medical Service reserves the right to change the above rate on 30 days' written notice to the subscriber; such change of rate shall become effective on the date fixed in the notice, unless the subscriber notifies his employer in writing any time not less than 10 days prior to the effective date of such notice of his decision to discontinue this certificate.

7. *Term and Termination.*—This contract shall constitute an agreement for 1 month from its effective date and shall be renewed thereafter each month, unless notice of election to terminate the same is given by the subscriber to Michigan Medical Service, or by Michigan Medical Service to the subscriber, not less than 30 days prior to the date of termination.

Michigan Medical Service shall not terminate this certificate (except for non-payment of the monthly charge) as long as the subscriber is a member of the original group through which he enrolled and is making payment through pay-roll deduction and Michigan Medical Service elects to continue to protect the group under the plan.

Failure to pay the rate provided in section 7 shall constitute immediate termination of this contract and all benefits hereunder.

8. *Discontinuance of Group Membership.*—In the event the subscriber temporarily leaves the group through which he enrolled, this certificate may be kept in force if the subscriber continues to make payment at the rate for the group.

In the event the subscriber terminates employment in the group through which he is enrolled, this certificate may be kept in force upon payment of the subscription rate for the group or classification to which he is transferred.

GENERAL CONDITIONS

9. *Reports of Service.*—Doctors of medicine participating with Michigan Medical Service are required to furnish reports to Michigan Medical Service, which shall remain confidential, relative to diagnosis and services given the subscriber entitled to or claiming such service under this certificate, and it is agreed that

request for such service is authorization to the doctors of medicine to make such reports.

10. *Identification.*—The subscribers' identification card must be presented to the doctor of medicine when service is requested.

11. *Assignment.*—The services to be provided under the certificate are for the personal benefit of the subscriber and cannot be transferred or assigned; any attempt to assign this certificate shall automatically terminate all rights thereunder.

12. *Contest.*—No action or suit at law or in equity shall be commenced until 30 days after written notice of claim has been given by the subscriber to Michigan Medical Service, nor shall such action be brought at all later than 2 years after such claim has arisen by acceptance of service.

13. *Contract Continuity of Benefits.*—The application submitted by the subscriber and this certificate shall constitute the entire contract between the parties. No agent or employee is authorized to vary, add to, or change this contract as set forth in any manner or degree. The issuance of this certificate cancels all previous certificates then in force and all rights thereunder between the subscriber and Michigan Medical Service, except that, so long as this certificate remains in force and until the expiration of the period of nine consecutive months from the date of issuance hereof, the subscriber shall continue to be entitled to the maternity services provided for by said canceled certificate, if any.

14. *Headings.*—The catch-line headings in no way shall be considered to be a part of this certificate, but are inserted only for purposes of convenience.

PARTICIPATION

15. *Participation in Surplus.*—It is agreed that after provision for proper reserves as approved by the Commissioner of Insurance of the State of Michigan, subscribers may share after 12 consecutive months, at the discretion of the board of directors of Michigan Medical Service and as approved by said Commissioner of Insurance, in the divisible surplus of Michigan Medical Service through reduction of rates or increase of services or both, in proportion to the divisible surplus created by the employee group to which the subscriber belongs. This paragraph shall be effective only while the subscriber is employed by the present employer and has been a subscriber for not less than 12 consecutive months. It is further agreed that if the certificate is terminated for any reason, that the subscriber shall forfeit his right to participate in any such surplus.

This is your certificate. Read it carefully.

Identify yourself as a subscriber by presenting your identification card when service is first requested from a doctor of medicine.

Benefits include surgical services, diagnostic X-rays, maternity services, and anesthesia—rendered by a doctor of medicine when you are a bed patient in a hospital.

Sponsored by the Michigan State Medical Society

The Professional Association of Doctors of Medicine in Michigan

A Non-Profit Medical Service Plan, Organized Under Michigan Laws and Licensed by the Department of Insurance of the State of Michigan

MICHIGAN MEDICAL SERVICE, DETROIT, MICHIGAN

SURGICAL BENEFIT CERTIFICATE

THIS CONTRACT, made between the Subscriber named in the application and MICHIGAN MEDICAL SERVICE, a nonprofit corporation.

ENTITLES the Subscriber, in consideration of payments at the subscription rate indicated in the application, to have Michigan Medical Service pay for surgical and other services, as hereinafter defined, rendered to the Subscriber and, if listed on the application, the spouse, and dependent children until the end of the calendar year in which they attain nineteen (19) years of age, for a period of one month next following the date of execution, upon and subject to the terms and limitations hereinafter set forth.

In witness whereof, Michigan Medical Service by its agent duly authorized in the premises has executed this Certificate.

MICHIGAN MEDICAL SERVICE,

JAY C. KETCHUM,

Executive Vice-President.

SURGICAL BENEFIT CERTIFICATE

SURGICAL BENEFIT CERTIFICATE FOR COMMUNITY ENROLLMENT

MICHIGAN MEDICAL SERVICE

DEFINITIONS AND BENEFITS

1. *Definition.*—The term "professional services" as used herein is defined to mean services rendered by doctors of medicine registered as participating with Michigan Medical Service, of the subscriber's own choice, to the subscriber for illness or injury requiring and resulting in admission and care as a bed patient in a regularly accredited hospital, to the extent and subject to the limitations set forth below.

(a) *Surgical Services.*—Surgical services (operative and cutting procedures for the treatment of disease or injury and treatment of fractures and dislocations) rendered by the doctor of medicine in charge of the case.

(b) *X-Ray Services.*—Diagnostic X-ray services not in excess of the value of Fifteen Dollars (\$15.00), as set forth in and limited by the Michigan Medical Service Schedule of Benefits, between the effective date of this certificate and the first anniversary hereof or during any succeeding 12-month period.

(c) *Anesthesia Service.*—Anesthesia services rendered by a doctor of medicine not in charge of the case when in connection with services otherwise provided hereby in the hospital where the subscriber is a patient.

(d) *Emergency Service.*—Emergency surgical services not requiring bed care rendered in a regularly accredited hospital by a doctor of medicine during the first twenty-four hours following accidental injury.

2. *General limitations.*—The benefits as set forth above shall not include the following:

(a) Maternity services.

(b) Hospital, dental, or nursing services.

(c) Medicines, drugs, appliances, materials, or supplies.

(d) Services for industrial injuries or diseases, or services from any government agency, which are, or to the extent such services can be, obtained by the subscriber without cost to him by compliance with laws or regulations enacted by any Federal, State, municipal, or other governmental body.

(e) Medical or surgical services in the home or office.

(f) Plastic operations for cosmetic or beautifying purposes.

3. *Services Not Provided.*—Michigan Medical Service does not undertake to supply a doctor of medicine for the subscriber.

4. *Service in Full.*—Doctors of medicine participating with Michigan Medical Service and rendering to the subscriber such services as herein provided shall make no charge to the subscriber therefor except:

(a) To an unmarried subscriber whose average annual income exceeds two thousand dollars (\$2,000) or to a married subscriber whose average annual income, together with the income of his spouse or family members, exceeds two thousand five hundred dollars (\$2,500), these average annual incomes to be determined on the basis of income for the three-year period immediately preceding the date of service; or

(b) *Exception to Full Service.*—To a subscriber who shall request and occupy private room accommodations in the hospital. This exception (b) shall not apply to a subscriber who is involuntarily compelled by nature of illness and on the order of his physician to be placed in private room accommodations.

Partial Service.—In the event services covered by this certificate are rendered to subscribers subject to exception (a) or (b) above, the doctor of medicine participating with Michigan Medical Service may make an additional charge to the subscriber; such additional charge, if any, shall be the liability of the subscriber and not of Michigan Medical Service.

Disputed Income Classification.—In the event of any dispute between the doctor and the subscriber with respect to the application to such subscriber of the provisions of subdivision (a) of this section, the same shall be submitted to and determined by Michigan Medical Service, whose determination shall be conclusive upon the parties.

SERVICES BY NONPARTICIPATING PHYSICIANS

5. *Services by Nonparticipating Physician.*—If, in an emergency, services covered by the certificate are rendered by a physician not participating with Michigan Medical Service, it will pay its then prevailing rate for such services.

PAYMENT OF RATE, TERM, AND TERMINATION

6. *Subscription Rates.*—The subscriber agrees to pay Michigan Medical Service quarterly unless otherwise provided, for the services checked in his Application Card at the following rates:

Subscriber	\$2. 10
Subscribe and Spouse (or employee and unmarried child up to 19 years of age)	5. 25
Subscriber, spouse, and unmarried children up to 19 years of age.....	7. 25

Michigan Medical Service reserves the right to change the above rates on 30 days' written notice to the subscriber; such change of rate shall become effective on the date fixed in the notice.

7. *Term and Termination.*—This contract shall constitute an agreement for 1 month from its effective date and shall be renewed thereafter each month, unless notice of election to terminate the same is given by the subscriber to Michigan Medical Service, or by Michigan Medical Service to the subscriber, not less than 30 days prior to the date of termination.

Failure to pay the rate provided in section 7 shall constitute immediate termination of this contract and all benefits thereunder.

GENERAL CONDITIONS

8. *Reports of Service.*—Doctors of medicine participating with Michigan Medical Service are required to furnish reports to Michigan Medical Service, which shall remain confidential, relative to diagnosis and services given the subscriber entitled to or claiming such service under this certificate, and it is agreed that request for such service is authorization to the doctors of medicine to make such reports.

9. *Identification.*—The subscribers' Identification Card must be presented to the doctor of medicine when service is requested.

10. *Assignment.*—The services to be provided under the certificate are for the personal benefit of the subscriber and cannot be transferred or assigned; any attempt to assign this certificate shall automatically terminate all rights thereunder.

11. *Contest.*—No action or suit at law or in equity shall be commenced until 30 days after written notice of claim has been given by the subscriber to Michigan Medical Service, nor shall such action be brought at all later than 2 years after such claim has arisen by acceptance of service.

12. *Contract Continuity of Benefits.*—The application submitted by the subscriber and this certificate shall constitute the entire contract between the parties. No agent or employee is authorized to vary, add to, or change his contract as set forth in any manner or degree. The issuance of this certificate cancels all previous certificates then in force and all rights thereunder between the subscriber and Michigan Medical Service.

13. *Headings.**—The catchline headings* in no way shall be considered to be a part of this certificate, but are inserted only for purposes of conveniences.

This is your certificate. Read it carefully.

Identify yourself as a subscriber by presenting your Identification Card when service is first requested from a doctor of medicine.

Benefits include surgical services, diagnostic x-rays and anesthesia—rendered by a doctor of medicine when you are a bed patient in a hospital.

MATERNITY SERVICES ARE NOT A BENEFIT UNDER THIS CERTIFICATE.

Sponsored by the Michigan State Medical Society, the Professional Association of Doctors of Medicine in Michigan

A Non-Profit Medical Service Plan, Organized Under Michigan Laws and Licensed by the Department of Insurance of the State of Michigan

MICHIGAN MEDICAL SERVICE, DETROIT, MICHIGAN

SURGICAL BENEFIT CERTIFICATE

THIS CONTRACT, made between the Subscriber named in the application and MICHIGAN MEDICAL SERVICE, a non-profit corporation.

ENTITLES the Subscriber, in consideration of payments at the subscription rates indicated in the application, to have Michigan Medical Service pay for surgical and other services, as hereinafter defined, rendered to the Subscriber and, if listed on the application, the spouse and unmarried dependent children until the end of the calendar year in which they attain nineteen (19) years of age, for a period of one month next following the date of execution, upon and subject to the terms and limitations hereinafter set forth.

In WITNESS WHEREOF, Michigan Medical Service by its agent duly authorized in the premises has executed this Certificate.

MICHIGAN MEDICAL SERVICE,
JAY C. KETCHUM,
Executive Vice President.

SURGICAL BENEFIT CERTIFICATE

MATERNITY SERVICES ARE NOT A BENEFIT UNDER THIS CERTIFICATE

The CHAIRMAN. Thank you.

Dr. SENSENICH. May I introduce Dr. Victor Johnson, secretary of the Council on Medical Education and Hospitals of the American Medical Association and professorial lecturer in physiology of the University of Chicago.

**STATEMENT OF VICTOR JOHNSON, PH. D., M. D., SECRETARY,
COUNCIL ON MEDICAL EDUCATION AND HOSPITALS OF THE
AMERICAN MEDICAL ASSOCIATION**

Dr. JOHNSON. Unlike my two predecessors I do not practice medicine. My professional career has been in teaching, in medical education and in research.

THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

My official position in the American Medical Association is that of executive officer, or secretary, of the Council on Medical Education and Hospitals. This council consists of seven national leaders in medical education and hospital matters, under the distinguished chairmanship of Dr. Ray Lyman Wilbur of California.

The work of the Council (and earlier, the committee) on Medical Education and Hospitals in the past century is generally conceded to be a major factor in the high standards of medical and hospital care now obtaining in this country, since the quality of a physician's services can be no better than the quality of his education as an undergraduate in medical school and after graduation in a hospital internship or residency. After the turn of the century there were increased efforts to improve medical education in this country. Some of the medical schools were still operated primarily for the financial profit of the faculty and provided exceedingly inferior instruction. At the instigation of the council, the Carnegie Foundation conducted a survey of medical schools under the direction of Abraham Flexner and with the collaboration of council representatives. The findings in this survey, constituting the classic publication generally known

as the Flexner Report, resulted in the closing of a number of the medical schools of the country; these were schools scarcely deserving the name, producing graduates entirely unqualified to treat the sick. This effect of the Flexner Report is astonishing, since the report carried no legal or governmental authority, but produced results entirely through its influence on public opinion.

Through the ensuing years to the present time, the recommendations of the Council on Medical Education and Hospitals still derive their effectiveness, not from legal authority, but from public opinion, lay and professional, which recognizes the objectivity of the conclusions of the council in its efforts to improve medical education and, as a consequence, the quality of medical care. In carrying out this work, the council, with the approval of the house of delegates of the American Medical Association, has established standards of education for medical schools and for hospitals offering internship and residency training to medical school graduates, as well as standards for schools in technical fields related to medicine, such as physical therapy, medical record libraries, X-ray, occupational therapy, and clinical laboratory work.

Annually, the council publishes three special numbers of the Journal of the American Medical Association dealing with statistics, problems, and information on medical education, hospital care, and medical licensure, as well as revised lists of medical schools, hospitals, and other institutions adhering to the high educational standards which have been established. These publications are for the guidance of prospective individual students, physicians, hospitals, various Government agencies, and the public.

In my prepared statement I describe a number of publications by the council which are employed by prospective medical students, Government agencies, and the public, and if the committee wishes I can leave for any possible reference they wish to make to this material these publications for the files of the committee.

The CHAIRMAN. You may submit them for the committee records.

This work of the council has been a major factor in warranting the following recently expressed judgments by experts that medical education in this country is unexcelled anywhere in the world and that the low death rate of our armed forces from disease and wounds was due primarily, not to plasma, penicillin, or sulfa drugs, but to the high quality of the medical education of our medical officers.

The legislative measure under consideration deals only briefly in a direct way with medical education and medical research—

The CHAIRMAN. I would like to ask you there, Doctor, if it is true that the general practitioner of medicine in the United States is a graduate of a recognized college and medical school.

Dr. JOHNSON. The vast majority of them are.

The CHAIRMAN. Very few men are allowed to practice medicine in the United States nowadays who are not really qualified to practice.

Dr. JOHNSON. In two States of the Union, Illinois and Massachusetts, graduates of so-called unapproved medical schools have eligibility for license. It has recently been changed in Massachusetts.

The CHAIRMAN. But it still exists in Illinois?

Dr. JOHNSON. Illinois, yes. The school does not adhere to the standards, and the graduates are eligible.

The CHAIRMAN. Was that due to a shortage of physicians?

Dr. JOHNSON. That school has been in existence for a number of years, certainly since long before the war, so that the war shortage had nothing to do with it.

The CHAIRMAN. But the reason for permitting them to be licensed was the fact that the shortage of physicians made it necessary to undertake to get more doctors licensed to carry on medical practice?

Dr. JOHNSON. I cannot say with certainty what the exact origin of that medical school was, but I do not believe it was a matter of any acute deficiency.

The CHAIRMAN. But generally the doctors that are practicing medicine in the United States are qualified?

Dr. JOHNSON. Yes, generally they are graduates of approved medical schools.

The CHAIRMAN. Very well.

A NATIONAL SCIENCE FOUNDATION PREFERABLE TO S. 1606

Dr. JOHNSON. The legislative measure under consideration deals only briefly in a direct way with medical education and medical research directly, which are inseparable in any sound program. Section 213 provides for "Grants-in-aid for Medical Education (and) Research * * *." The desirability of such aid has been recognized by the house of delegates and by the Council on Medical Education and Hospitals of the American Medical Association. These bodies have endorsed such Federal support provided it is organized and administered soundly, as is the case in certain of the proposals now before Congress. There are several bills calling for the establishment of a national science foundation to administer funds and programs for research and scholarships in the sciences, including medicine. The administrative arrangements provided by certain of these bills (the Magnuson bill, S. 1285, and the Kilgore-Magnuson bill, S. 1850) are sounder by far than that of S. 1606, and promise greater success in achieving the desired ends than is the case with the measure under consideration. The Kilgore-Magnuson bill wisely limits the authority of the director, appointed by the President, and places considerable authority in the hands of the members of the foundation, who are to be scientists of repute, functioning not simply as advisors to the administrator, but possessing the authority to initiate positive action in some instances, and to veto the decisions of the administrator in other cases. In contrast to this arrangement, under S. 1606 the Surgeon General of the Public Health Service is required to seek only the advice of the National Advisory Medical Policy Council, which advice he is free to follow or not, as he chooses.

Safeguards for the preservation of independence of research workers and institutions are provided in the Kilgore-Magnuson bill in a manner which promises effectiveness. Such safeguards, which are indispensable for productive research, are almost entirely lacking in the reasearch section of S. 1606.

In the Kilgore-Magnuson bill the scholarship program is carefully worked out in considerable detail. In the bill under consideration virtually no organized program is set forth in the scholarship field.

DISTRIBUTION OF HOSPITALS

In any program for the extension and improvement of medical care, hospitals occupy a key position, because modern medicine cannot be practiced except with the diagnostic, therapeutic and other facilities which hospitals provide for the use of physicians. The Council on Medical Education and Hospitals has long been interested in the number, distribution, and quality of hospitals in general. Besides the assistance it renders, upon request, to hospitals operating educational programs for medical-school graduates at the internship and residency levels, the council also serves hospitals in general, in efforts to improve the quality of hospital services. This it does by establishing standards of hospital care (as set forth in one of the documents I will submit for your records), providing free consultation services to such hospitals as request them in their efforts to achieve these standards, and maintaining a list of "registered hospitals," revised annually, which meet these standards.

I then quote certain figures which we need not go into unless you wish to know them concerning the number of hospitals, admissions to them, and the bed capacity in the United States.

At present about 78 percent of the bed capacity of this country is in hospitals operated by some Government unit, Federal, State, county, or municipal. However, these hospitals, about half of which are for nervous and mental cases, account for only 40.8 percent of the total hospital admissions. Nongovernmental hospitals provide only 22 percent of the hospital beds of the country but they account for nearly 60 percent of the patient admissions.

Over the years, the increase in hospital beds in this country has been phenomenal, independent of the great wartime increase in the Federal hospital bed capacity of the armed forces and the Veterans' Administration. Hospital beds have multiplied far more rapidly than has the population. Hospital beds have tripled in number from 1909 to 1940. The population did not double during those years. During that time hospital beds were provided more than one and one-half times as rapidly as the population has grown.

The percentage occupancy of hospital beds in the various States displays a phenomenon difficult to interpret. If the States are arranged in the order of increasing number of hospital beds per 1,000 population, we find that this order is also approximately that of increasing percent of beds occupied in general hospitals. That is, the States with the fewest beds per 1,000 of the population use those beds least; those with most beds use them most. For example, 3 States having less than 2 beds per 1,000 people (in 1940) had an average bed occupancy of 62 percent; 16 States having 3 to 4 beds per 1,000 people occupied over 70 percent of them; while in the District of Columbia, with 10 beds per 1,000 people, the occupancy was still higher.

Several factors may be involved. Perhaps the people in States unable to provide adequate hospital facilities are financially unable to take full advantage of these facilities. Perhaps the quality of these hospitals and the means of transportation to them are inferior to those in States with more hospitals. However, there is probably also the factor of lack of education of the public to the use of such health

facilities as do exist. This factor must be considered in any program for the improvement of the people's health. To be successful, such a program must educate the people to know the health facilities and stimulate their use.

There has been much discussion of inadequate distribution of hospital beds, especially in rural or economically ill-favored areas or States. Frequently this inadequacy is expressed in terms of the large number of counties in this country possessing no hospital. Such figures present an entirely erroneous picture, since the natural unit is not the county but the trade area, and distance of people's homes from a hospital is more important than artificial boundary lines. In 1938 an extensive study by the Council on Medical Education and Hospitals of the American Medical Association revealed that over 98 percent of the population of the United States lived within 30 miles of a hospital, a distance of rapidly shrinking significance, with modern roads and transportation. The accompanying map on the next page shows in white all areas within 30 miles of a hospital, and in black all areas not within 30 miles of a hospital. In determining these shaded areas such special institutions as mental, maternal, tuberculosis, and other restricted hospitals were not considered and hospitals under construction were excluded. The shaded areas are almost entirely limited to sparsely settled areas.

This distribution picture would be somewhat improved by the hospital construction since that time and considerably improved in the years immediately ahead, since vast programs of hospital construction are contemplated. It has been estimated that existing registered hospitals will spend about a billion dollars for expansion, improvement, and replacement. The volume of construction of entirely new non-governmental hospitals is not known, but will probably be tremendous.

It is recognized that the mere existence of a general hospital within 30 miles does not indicate that hospital facilities are adequate in that area. The bed capacity may be inadequate for the population of the area and the hospital plant and equipment may be inferior and obsolete. Recognizing this, the American Medical Association has lent strong support to the Hill-Burton Hospital Survey and Construction Act in actions by its board of trustees and house of delegates and in testimony before two committees of the Congress.

In drafting and revising the Hill-Burton bill expert professional advice was sought from a number of qualified organizations. An important provision of this measure, which has passed the Senate, is that surveys of existing hospital facilities shall be conducted by the States, and comprehensive plans developed relieving deficiencies in areas needing hospitals and able to maintain them, before Federal aid to States for hospital construction will be provided. This is an approach to the problem of extending and improving medical care in accordance with the scientific method, which should be employed not only in solving medical problems of the cause and control of disease, but also in our efforts to evolve programs for providing a high quality of medical and hospital care to all people of this country who need and desire it.

THE CHAIRMAN. Thank you, Doctor. Do you care to ask any questions, Senator?

Senator DONNELL. I do not think so, Mr. Chairman.

The CHAIRMAN. Thank you, Doctor. Dr. Kennedy.

Dr. SENSENICH. Mr. Chairman, may I ask, because I may have to go to the train, that the secretary be authorized to permit us to see the proof of the transcript before it is printed?

The CHAIRMAN. Yes.

Dr. SENSENICH. We appreciate the opportunity to be here, and as we have promised, we would be happy to give you any information and our best judgment at any time.

The CHAIRMAN. Thank you, Doctor.

Dr. SENSENICH. If anything occurs in the later hearings and you wish to have us again, we will be happy to come again.

The CHAIRMAN. Thank you.

Dr. SENSENICH. May I introduce Dr. Walter V. Kennedy, of New Castle, Ind., who is in the active practice of medicine?

STATEMENT OF DR. WALTER V. KENNEDY, PRESIDENT, INDIANA MUTUAL MEDICAL CARE, INC.

Dr. KENNEDY. This will be a short and practical expression from personal observations of Government control of medicine in England and Germany.

I have seen the workings in practically all the other continental countries, but because those were the outstanding plans of those two types, my remarks are based upon those alone.

The CHAIRMAN. Do you intend to describe those plans in detail, Doctor?

Dr. KENNEDY. I do not, sir. I speak from the observations resulting from seeing them. It is quite short.

The CHAIRMAN. Neither of those plans are as comprehensive as the plan we have here provided in S. 1606?

Dr. KENNEDY. Not quite. They differ in some details.

The CHAIRMAN. They differ in some respects?

Dr. KENNEDY. Yes.

The CHAIRMAN. And they have not worked out satisfactorily, you think?

Dr. KENNEDY. No.

The CHAIRMAN. You may proceed.

EUROPEAN STANDARDS OF MEDICAL CARE

Dr. KENNEDY. Observation of standards of medical care in continental Europe and the British Isles, excluding Russia and Spain between 1904 and 1939, while on nearly yearly visits, is the basis for a definite impression and a considered opinion as to the changes which have occurred since adoption by these countries of some form of direct governmental participation on medical practice. The sources of information covered every level of the plans. Through the assistance and courtesy of the American diplomatic corps, interviews were had with cabinet ministers, with executive and administrative chiefs of health services, with controlling heads of hospitals, with hospital medical personnel, with medical practitioners of the higher ranks, and with general practitioners who largely attended to the medical care of the general public and with members of the public in the various

economic strata. The inquiries are not at the direction of or at the expense of anyone else or to establish any preconceived opinion.

As trends appeared to develop it became more interesting to verify them and the scope of the inquiries was widened so that more complete information might be obtained. It is desirable to here note that the trends following the introduction of such plans have a marked similarity and it has been interesting to observe how sequences might be predicted.

It has been noted that the introduction of every plan has been coincident with political needs. In no instance, to my knowledge, have such plans been a considered conclusion of a widely expressed public demand or at the suggestion of the medical profession, who ought to be most conversant with need of such plans.

All of the plans have had an imposing facade of humanitarianism though the ultimate results to the intended beneficiaries have lacked much of the expressed hopes of the originators, the actual beneficences apparently being in augmented political power and prestige of the proposers.

LOW STANDARDS OF LIVING

If such plans have value, the social and economic conditions of Europe would appear to offer every likelihood of success.

The standards of living in all but the high-income classes everywhere in Europe has been low, low to a degree inconceivable to those accustomed to our American standards. It might fairly be said that the mass of European population lived on standards equivalent to our near indigent class, which to us represents a relatively small layer. And while the near indigent of the European population represents the largest single economic class, they have small opportunity and little inclination to rise economically. The American near indigent has every opportunity and because of the American habit of initiative and self-dependency, much inclination to rise, and this European ingrained acceptance and resignation to the status quo lends itself readily to regimentation and particularly to acceptance of paternalism which always inhibits initiative and progress.

The actual living conditions of great masses of Europeans, housing, clothing, food, sanitation, and amusement have been incredibly bad and if free or nearly free medical care made available by Government was the sole or even principal requirement for solution of the health problem, these European medical plans ought to have produced greater results than have been apparent.

On the contrary, the immediate prewar reports indicated a rising loss by days per year by illness, though the trend in the United States without governmental medical plans has been downward.

The medical profession believes in good medical care, but it also clearly recognizes that without proper sanitation, satisfactory housing, adequate food, sufficient clothing, and reasonable recreation, medical care, no matter how freely available, cannot achieve its goals of the highest attainable public health. And the notable achievements in betterment of the health of our country, now with the highest standards of any land, were accomplished by the American medical profession on its own initiative, with its tested and proven methods quite without governmental aid or direction.

INFERIOR MEDICAL TRAINING IN EUROPE

The question then arises as to relative efficiency of our methods and those of Europe. If medical care freely supplied by the Government is the method of Europe, and yet our progress is markedly better, there seems to be fault in the plan or incompetence in personnel. No one will claim that lower standards of medical training are the rule in the European countries. Their graduates, who are not participants in medical service plans, are recognized in the scientific world as being as competent as our leading men.

Then is it possible that constant participation in the plans lower efficiency? Long and continued observation have firmly fixed in my own mind that this is true.

As corroborative evidence let the end result of such service be stated. In the original German system, the ostensible object was providing medical care for the near indigent at governmental expense. No one of ordinary humanity, then or now, would object. It may here be stated that it is even yet, as it has been for centuries, the privilege as well as the duty of a physician to care for the indigent without expectation of recompense.

After the German profession unworthily accepted this plan, in succession, the higher economic layers, demanded under political pressure similar grants from the Government. The end after years of gradual encroachment was the inclusion of the entire populations. Originally the physician's fee was a reduced one, paid by Government with a slight contribution by the public in sickness tax. The amount required to supplement the contribution became so onerous to the Government that its share became inadequate. Economies were imperative. Administrative personnel were political factors and could not have reduced pay. The physicians began having reduced partial settlements. In time the absurdity of paying 75 percent and promising 25 percent was apparent. Then 75 percent of the original became the standard. Later other reductions came. Since by this time practically all the population was enrolled in the plan, physicians, except a tiny number of university professors, had no other clientele.

The basic necessities of life require a minimum income. To attain that minimum, the only answer was a greater number of patients. There being but 24 hours in the day, the time allotted to any one was shortened. The standard of individual care was dropped. There was no other solution. In the years prior to the last war, Germany became infested with pseudopractitioners of bizarre cults. The public health index dropped sharply. There were insufficient medical men even for their armed forces, with the natural result of decreased military efficiency. In this case, the lower standards were inducted by the economic faults of the plan.

DETERIORATION OF QUALITY

The English, about 1911, as a purely political coup, adopted a medical-care plan associated with a group of collateral measures. Here it was a capitation plan. Beginning with income limits around \$500, an annual fee of some \$225 was paid physicians for full medical coverage of the members of the covered group.

Patients were assigned to panels of about 1,000 persons.

At succeeding times and after much conflict, the annual capitation fees were raised to \$2.50 and then to \$2.75, but also the income limits were increased so that in 1937 over 20 million of their 45 million were included; and, true to form, the current proposal is to include the entire population, to take over all hospitals and their endowments, and to make Government employees of all physicians who apply.

Since there are a very limited number of people able or willing to pay for services outside the plan, physicians must lose their individuality and govern their professional relations by prescribed rules, a condition completely destructive of the fundamental need of the use of the untrammled judgment of the physician for the peculiar and special needs of the individual. But for these past years, the bulk of the English general practitioners have been compelled by economic need to belong to the government medical plan.

The plan simply gave the patient license to demand unlimited care, domiciliary or office, substituting quantity for quality.

There is a fundamental human inclination to demand everything they are entitled to whether really needed or not. The result is again overcrowding, superficial examinations, erroneous snap diagnoses, unnecessary and incorrect treatment, lack of personal interest and from continually repeated habit, a lowered standard of medical care which is frankly admitted by many. And what is more ominous for the future, the press of overwork robs the physician of his required study, reading and thought, so that instead of improving efficiency by experience, there is a constant deterioration of his ability, and what is of basic importance, a growing disinclination to be concerned with his patient's welfare.

The CHAIRMAN. Doctor, might I interrupt you there. Those objections, could they be urged also against voluntary systems as well as compulsory systems.

Dr. KENNEDY. If the men had to carry the work imposed upon them by the State methods they would be.

The CHAIRMAN. If a person has insurance and can get service when he wants it, do you think he would be inclined to ask for it when he did not need it?

Dr. KENNEDY. There is always that inclination in anything that is made available.

The CHAIRMAN. I do not know. It may be an inclination to some people.

Anybody that holds insurance in the United States, and by that I mean life insurance, is entitled to go to the insurance company and get a medical examination. I have talked to agents of insurance companies; and I have policies in several big insurance companies, and I have never applied for a free medical examination. The agents told me that they could not understand why more people did not avail themselves of that opportunity. Other people carry other policies of insurance that enable them to get examinations and do not avail themselves of that at all.

I do not understand how it could be said that merely because a person has a right to demand medical service that they are going to ask for it regardless of whether they need it or not, unless they are mentally affected or "cranks" on the subject.

Dr. KENNEDY. So far as the English system and my observations are concerned, they do ask for it.

The CHAIRMAN. They do.

Dr. KENNEDY. Whether we will in America or not I do not know.

The CHAIRMAN. Well, I quoted a little while ago a little statement from the British Medical Association in which they state that "despite its defects this service has been an undoubted success." And proposals are now pending over there for an extension of the service. They are opposing, of course, some of the provisions of the extension, but they are in favor of an extension of the service.

Dr. KENNEDY. I did not get that reaction from the statements made in the London Times of March 22, which I have here, which carries a full copy of the proposed bill. I should be glad to leave it with you, if you care to read it, sir.

The CHAIRMAN. If you care to leave it I would be glad to have it put in the record.

Dr. KENNEDY. I thought you would be interested in this.

The CHAIRMAN. Yes.

(The article referred to is as follows:)

GOVERNMENT SCHEME FOR NATIONAL HEALTH—HOSPITALS TO BE TRANSFERRED TO THE STATE

ANNUAL COST OF £152,000,000

The state scheme of national health, which will be available to everyone free and without qualification or limitation, was made known yesterday when the Government bill for England and Wales was published. It is the intention to put it into operation early in 1948.

The estimated cost in the early years will amount to £152,000,000 a year. It is proposed that the Government should take over the voluntary and municipal hospitals, and that doctors and dentists should be free to join the scheme or not as they choose.

OUTLINE OF THE SCHEME—DEBATE BEFORE EASTER

(From our Parliamentary correspondent)

With the publication yesterday of the national health service bill, a measure of 74 clauses and 10 schedules, together with a white paper (Cmd. 6761 3d.) summarizing and explaining the main proposals, the Government gave legislative form to their plans for promoting a comprehensive health service in England and Wales. This impressive scheme has grown out of the proposals made by the war-time coalition which were published in the white paper of February 1944. It is now presented in all its essentials with the intention of putting it into operation early in 1948. Within the main structure much is left for the Minister of Health to decide by regulation. The Government hopes to have the bill debated on second reading before Easter and to pass it into law by the autumn. A bill for Scotland is to follow.

The proposed main services are:

Health centers and family doctor service: Personal health service and treatment by doctors and dentists whom the patient chooses will be available at health centers, at home, or at the doctor's own surgery. Doctors may choose whether or not they join the service and joining it will not debar them from receiving fees from patients who do not wish to take advantage of the State scheme which will be available to every one, free and without qualification or limitation.

Hospital and consultant service: All forms of general and specialist hospital care and treatment, both in-patient and out-patient, are included. Specialist opinions and treatment of all kinds will be available at hospitals, institutions, clinics, and also at health centers and in the patient's home. The Minister of Health will be responsible for this service which will be administered by regional boards. The Minister will take over voluntary and public hospitals and others if necessary, the teaching hospitals being given special treatment.

Supplementary services: These include midwifery, maternity and child welfare, home nursing, a priority dental service for children and expectant and nursing mothers, and domestic help when needed on health grounds. These services

will be administered by the county and county borough councils, which will be known as the local health authorities.

COST OF THE SCHEME

The cost of the scheme in the early years is estimated at £152,000,000 a year and, allowing for a contribution of £32,000,000 from the national insurance fund and for savings on present grants, the net annual additional Exchequer expenditure is estimated at £95,000,000. The Government will bear the full cost of the hospital and specialist services—estimated at £87,000,000—and of the family doctor, dentist, pharmaceutical services—estimated at £45,000,000—and will also pay about £6,000,000, or roughly half, of the cost of the services to be administered by the local health authorities. The transfer of the cost of local authority hospital services from the ratepayers to the taxpayers will entail important changes, now under review, in the system of Exchequer grants to local authorities.

The proposed services will be administered by a number of bodies whose duties are broadly defined by the bill and all branches of the service will be inter-related. While, in general, the aim will be to give a considerable degree of local autonomy, the Minister of Health will exercise supervisory power by regulation. He assumes direct power for the hospital and specialist services, and the regional hospital boards which will administer them will be established in between 16 and 20 regions. Hospital management committees will be set up for each large hospital or related group of hospitals. The teaching hospitals will not come within this system, but will have separate boards of governors.

Interesting proposals are made for dealing with hospital endowments. In the case of voluntary teaching hospitals these will pass directly to the new boards of governors, who will be free to use them as they think fit. The endowments of other voluntary hospitals will pass to a new hospital endowment fund, which the Minister will administer. The capital value of the fund will be apportioned among the regional boards, and the income from each portion will pass to the boards. Detailed arrangements for the fund will be made by regulation. Both types of board will be free to receive gifts or legacies.

DOCTORS TO CHOOSE

The service of family doctors, dentists, and chemists is to be organized by local executive councils and based upon the health centers. The members of these councils will be nominated in equal numbers by the major local authorities and the Minister and by the local practitioners. All doctors who choose to join the service will be in contract with the councils, and each doctor will have his own list of patients whom he has agreed to attend, and will be able, as will dentists, to use the health centers in place of surgeries. The patients' freedom in the choice of doctor is not canceled, neither will there be a general direction of doctors. There will, however, be a certain amount of control of their movement within the national service. Payment of doctors will be by part-salary and capitation fees.

The sale of practices which are wholly or partly within the national health service will be prohibited, and compensation will be paid to present practitioners for loss of selling values. In agreement with the doctors' representatives a figure of £66,000,000 has been fixed for the capital value involved, of which £58,500,000 is estimated to apply to England and Wales. The distribution of compensation will be left to the profession, and the Minister will accept any reasonable proposals within the total sum. Normally compensation will be paid on retirement or death.

To meet the needs of areas which are short of doctors payment to doctors will be adjusted to induce them to enter these areas, and a mainly professional body, the medical practices committee, will be set up to regulate the succession to old or the opening of new practices within the service.

THE SERVICE IN DETAIL

Future of the hospitals: The following is a more detailed summary of the main proposals:

Hospital and specialist service: This part of the service covers hospital and consultant services of all kinds. The existing premises and equipment of voluntary and public hospitals are transferred to the Minister, and he is empowered

also to acquire by purchase, if necessary, other hospitals and their equipment which may be required for the purposes of the new service. If in any particular case he is satisfied that the transfer of a hospital is not in fact necessary for the new service he can, with that institution's concurrence, except it from transfer. The general transfer of hospitals includes the present mental hospitals and mental deficiency institutions.

The endowments of voluntary teaching hospitals—defined in the bill to mean, broadly, all their property other than buildings and their contents—will pass, not to the Minister, but directly to the new boards of governors, who are to be free to use them as they think best, but are required, so far as practicable, to see that the purposes for which they were previously usable are still observed.

The endowments of other voluntary hospitals are to pass to a new hospital endowment fund which the minister is to set up and administer. He is first to meet from the fund, to such extent as may be settled by subsequent regulations, existing debts and liabilities attaching to the voluntary hospitals concerned. He is then to apportion the capital value of the fund among the several regional hospital boards and, as it were, to earmark to each a portion. The income of each portion will then pass automatically to each board, and it will be free to use it as it wishes within such general conditions as may be prescribed. Any board will be able also at any time to draw on its portion of the capital for any purpose which the minister approves. The boards, and the boards of governors of teaching hospitals, will be able to receive gifts or legacies, and to hold any property on trust, for any purposes connected with the hospital or health services.

Hospital administration: The regional hospital boards will be set up for hospital service regions—each region being such that its services can conveniently be associated with a university medical school. Each board will be composed of people chosen and appointed by the minister for their individual suitability for the task, but before making the appointments the minister is to consult any university with a medical school in the region, bodies representative of the medical profession, the local health authorities of the area, and others concerned including, initially, those with experience of the voluntary hospital system. The boards are to include some members with experience of the mental health services.

Each board will appoint local hospital management committees, one for each large hospital or related group of hospitals forming a reasonably self-contained hospital service unit. Each of these management committees will contain members appointed after consulting the major local authorities in its area, the executive councils for the general practitioner services in its area, the senior medical and dental staff of the hospitals concerned, and others, including those with experience in voluntary hospitals.

It will be the duty of the regional boards, within the scope of general regulations and such particular directions as the minister may give, to undertake on his behalf the general administration of the hospital and specialist services in their regions. With the minister, and in collaboration with the teaching hospitals, each board will plan, and execute the plan for, a coordinated hospital and specialist service for its region. The management committees will carry out day-to-day management of the particular hospitals under their control—within limits prescribed by the minister.

It is intended that the regional boards, with their local management committees, shall enjoy a high degree of independence and autonomy within their own fields. For the general financing of their hospital services, they will look to the Exchequer and they will be given as much financial freedom—by a system of block annual budgets or otherwise—for local initiative and variety of enterprise as general principles of Exchequer responsibility make possible.

Teaching hospitals: Special arrangements are provided for teaching hospitals which will enable any hospital or group of hospitals to attain teaching status whether it is already a teaching hospital at the outset of the scheme or not. The general system of regional boards and management committees will not cover the teaching hospitals. The minister is to constitute for each such hospital or group of hospitals its own separate board of governors, including members nominated by the university, the regional board for the area, and the senior staff of the hospital itself and members appointed after consultation with the major local authorities and other organizations concerned, including the previous governing bodies. The board of governors of a teaching hospital will be responsible generally for administering their hospital on the minister's behalf.

For the general financing of their services they will look to the Exchequer. It is intended to keep in the forefront the special position of these hospitals as the centers of clinical teaching and technical experiment and innovation. The fact

that special administrative and financial arrangements may be made for teaching hospitals does not mean, however, that these hospitals are not to form an integral part of the hospital service as a whole. They will be joined with the minister and the regional boards in the general planning and arrangement of the hospital services of each region, and the regional boards will be represented on their boards of governors.

Medical and dental schools: Medical and dental schools are not to be transferred to the minister or to the board of governors of the teaching hospital with which they are associated. No property which is held for the purposes of these schools is to be transferred. The schools will continue to be owned and administered, in London, by their own governing bodies, and elsewhere by the governing bodies of the universities of which they form part; and the bill provides for the transfer of any existing hospital property held for school purposes to these governing bodies. The bill contains also a special provision relating to medical and dental schools, based on recommendations of the Goodenough committee. Any medical or dental school of London University which is not yet a body corporate is required, within 6 months of the passing of the bill, to become incorporated.

Hospital staffs: The staff of all hospitals in the service will be in the employment of the regional boards or boards of governors of teaching hospitals. Specialists taking part in the service, whole-time or part-time, will be attached to the staff of hospitals. Part-time participation in the service will not debar the specialists from continuing any private practice outside the service. Special provision is to be made by regulations affecting the appointment of senior medical and dental staff employed on the staff of hospitals. The regional board or the board of governors is to advertise vacancies and to constitute an expert advisory appointments committee.

The boards will determine the terms of engagement of any staff employed in the hospital service. The minister, however, is empowered to make regulations governing the qualifications, conditions of service, and remuneration of any or all classes of hospital staff—as of the staff engaged in any other part of the health service. Hospital officers employed on a paid whole-time basis are to be protected, either by being transferred to the new bodies or by compensation if they are not transferred or are reemployed on less favorable terms than before.

Pay-bed accommodation: Where there are single bedrooms or small wards in hospitals the minister is empowered to make them available to patients who wish to buy greater privacy by paying the extra cost; but this is to be subject always to the requirements of patients who need such accommodation on medical grounds, and they will be able to have it without payment.

In addition, the Minister is empowered to provide separate pay-bedrooms or blocks for which people can pay the whole cost privately and in which part-time specialists within the service can treat private patients. This power is subject to the Minister's deciding, in each hospital, whether it is reasonable to provide such private accommodation having regard to the needs of the general service, and it is also subject to the overriding right of other patients to be admitted to it, without payment, if medical considerations urgently require it. Private patients using the accommodation will pay their own specialists' fees, but the bill enables the Minister to prescribe maximum fees which specialists may charge in these circumstances.

Other centralized services: The Minister is made directly responsible for the provision of two other services, both of them developed from services which have grown up during the war. The first is a bacteriological service for the control of the spread of infectious diseases, including, in particular, the provision of laboratories. These will be operated—at least in the first instance—by the medical research council on the Minister's behalf and their services can be made available to medical men and others who wish to make use of them.

The second is a blood-transfusion service—including mobile transfusion teams which will be on call for hospitals not possessing facilities of their own and for specialists and general practitioners. The Minister is also expressly empowered to conduct research, and to give financial help to voluntary agencies conducting research, into any question relating to the prevention, diagnosis, or treatment of illness or mental defectiveness. Boards of governors of teaching hospitals and regional boards are also empowered to conduct research.

GENERAL PRACTITIONER SERVICES

Health centers: A main feature of the personal practitioner services is to be the development of health centers. The object is that the health center system,

based on premises technically equipped and staffed at public cost, shall afford facilities both for the general medical and dental services and also for many of the special clinic services of the local health authorities, and sometimes also for outpost clinics of the hospital and specialist services. Besides forming a base for these services the centers will also be able to serve as bases for various activities in health education.

The county and county borough councils will provide, equip, staff, and maintain the new health centers. The local authorities will directly administer such of their own local clinic facilities as they may provide in the centers. Doctors and dentists, however, who use the new centers while participating in the general personal practitioner service will be in contract only with the new executive councils, and it will be for those councils to arrange with the local authorities for the use of the centers' facilities by those doctors and dentists. In the case, for instance, of doctors in the general practitioner service the centers will, in effect, stand in place of the doctors' own surgeries, and the doctors' responsibilities to their patients on their personal lists are not affected by whether a doctor practises from a health center or not.

Family doctor service: All doctors will be entitled to take part in the new arrangements in the areas where they are already practising when the scheme begins. Taking part will not debar them from also continuing to make private arrangements for treating such people as still wish to be treated outside the service instead of taking advantage of the new arrangements, provided that such persons are not on their lists as public patients or on the lists of their partners in a health center. People will be free to choose their own doctor (including their present doctor) subject to the doctor's consenting and being in a position to undertake their care.

All doctors taking part in this part of the new service will be in contract with the executive council for the area in which they practise. The executive council will be required to draw up and publish lists of all general practitioners who wish to participate. People will then choose their doctor and each doctor will have his own list of the people whom he has agreed to attend. There will be machinery for allocating among the doctors concerned such people as wish to take advantage of the service but have not chosen a doctor for themselves or have been refused by the doctor chosen by them.

The detailed terms and conditions for doctors joining in the service or the doctors' remuneration will be settled by regulations to be made in consultation with the doctors' professional representatives. It is, however, the intention that remuneration should take the form of a combination of fixed part-salary and of capitation fees, the latter varying with the number of persons whose care is undertaken by each doctor and being so graduated as to diminish in scale as the total number of patients rises. Variations of the fixed part-salary will be possible so as to take account of different circumstances and experience and the differing conditions of practice in particular areas. It is intended also to institute, under powers contained in the bill, a contributory superannuation scheme for doctors taking part in the new arrangements. Actual rates of remuneration for doctors can be determined, in consultation with the profession, only after the report has been received of the Spens committee.

Distribution of practices: To help underdoctored areas it is intended to adjust the scales of remuneration of doctors so as to provide additional inducement to practise in less attractive areas. A new body, the medical practices committee, mainly professional in composition, is to be appointed to regulate in future the succession to old, or the opening of new, practices within the service.

An appointed day will be fixed and all doctors then in practice will have the right to have their names included on the lists drawn up by the executive councils. After the appointed day any doctor who wishes either to join the public service for the first time or, if he is already in it, to go and practise in a new area will need to obtain the consent of the medical practices committee. He will normally ask to have his name included in the list of the executive council for the area of his choice and that council will inform the committee. The committee may give consent either unconditionally or subject to a condition as to the general part of an executive council's area in which he practises. They will not be able to withhold consent on any ground except that there are already enough doctors practising in the public service in the area in question. If, when a practice becomes vacant, there is more than one applicant for taking it over, the committee will decide to which doctor the necessary consent is to be given. A doctor whose application to practise in a particular area is refused, or granted only subject to conditions, is given the right to appeal to the Minister.

Sale and purchase of practices: The control of succession to, or opening of practices will apply to all practices which are wholly or partly within the service. It will, therefore, make the sale of the good will of such practices inappropriate, and the bill prohibits the sale of such practices in future and provides for compensation to existing practitioners for loss of selling values.

Doctors who join the public service at the outset will be entitled to compensation in respect of loss incurred through being unable thereafter to sell their practices. In addition, any doctor who dies or retires from practice between the passing of the act and the appointed day, and whose practice has not been sold in the meantime, will qualify for compensation. If he is compensated, his practice will be regarded as having come within the service at the appointed day.

The total amount of compensation to be made available to the profession under the bill is a sum of £66,000,000 for England and Wales and Scotland, and the appropriate proportion of this is authorized to be paid in England and Wales under the present bill. Provision is made for the total sum to be reduced if the number of practitioners taking part in the service falls substantially short of the expected total.

Regulations will govern the detailed method of apportioning the global sum among the doctors. It is intended that the settling of the apportionment of compensation among the individual doctors shall be left in the main to the profession itself and the Minister will accept any reasonable proposals within the total sum. Normally, compensation is to be payable on the retirement or death of a doctor, through payment at an earlier date will be arranged where hardship (e. g., through outstanding debts) would otherwise arise. In the meantime interest on the compensation due is to be paid each year to the doctor at the rate of 2¾ percent a year.

Drugs, medicines, and appliances: These who use the general-practitioner service will be entitled up to the supply, free of charge, of necessary drugs, medicines, and appliances. Every properly qualified pharmacist who wishes to join in the new service will have the right to do so. The executive council in each area is to draw up and publish a list of pharmacists who join in the service, and patients will be able to obtain their supplies on the prescription of their doctor either from the shops or other premises of a pharmacist or from any health center where dispensing services are provided, as the patient chooses. Drugs, medicines, and appliances required for hospital purposes will be supplied as part of the hospital service.

Dental service: The arrangements for dental services will be on rather a different basis from the family-doctor service. Priority will be given to expectant mothers and young people. This is to be done through the local health authority's maternity and child welfare service (which the bill expressly provides is to include dental care) and through the school health services under the Education Act, 1944. Outside the priority arrangements there will be a general dental service, but there will not at first be any guaranty that all people will be able to obtain full dental care without waiting. Any dentist who wishes to participate in the general dental service will have the right to do so.

The object will be to develop general dental services in the health centers, or corresponding dental centers, as much and as quickly as possible. In the centers it is intended that dentists shall be able to participate either whole-time or part-time, and shall be remunerated by appropriate salaries for the amount of time which they give to the new service. Outside the centers it will be open to anyone to arrange with any dentist in his own surgery who agrees to undertake his or her dental care. The dentist will normally be able to start treatment without further reference and subsequently to submit a claim for payment from public funds. For certain forms of treatment, however, the dentist will submit an estimate to a new professional body established by the bill—the dentist-estimates board. The board will have branch offices, which will have to approve dentists' estimates for treatment to be given or appliances to be supplied. Payment will be made to the dentist by the executive council in accordance with a prescribed scale of fees or, in some cases, on special estimates determined by the dental-estimates board.

Eye services: The object is to secure that the care of the eyes, with sight testing and the supply of spectacles, is carried out in special ophthalmic departments and clinics forming part of the hospital and specialist service. These clinics will be in the charge of specialist medical ophthalmologists, and in them the qualified sight-testing opticians will also play their proper professional part. While this full eye clinic system is developing, however, a supplementary eye

service is to be arranged by the executive councils in each area. Their arrangements are to be made with suitably qualified general medical practitioners, sight-testing opticians, and dispensing opticians who undertake the supply of spectacles. The whole of the arrangements are to be entrusted by each executive council to a special committee—an ophthalmic services committee.

Efficient service: A special tribunal is to be set up to investigate cases where it is claimed—either by the executive councils or otherwise—that the continued inclusion of any doctor, chemist, dentist, or optician in the lists drawn up by the executive councils would be prejudicial to the efficiency of the service. The tribunal will have a legal chairman appointed by the Lord Chancellor and will in each case include a member of the same profession as the person whose case is being investigated and one other—the latter two being appointed by the Minister. Where it is satisfied that the representations are justified, the executive council will be directed to remove from the list the name of the doctor, dentist, chemist, or optician, who is given the right to appeal to the Minister. Where the tribunal so decides a similar direction can be applied to all lists in all areas, with the same right of appeal.

Local government services: This part of the health service comprises the local and domiciliary services which are appropriate to local government, rather than to central government or to any specially devised machinery. The bill unifies these services in the existing major local authorities—the county and the county borough councils—and provides for the formation of joint boards wherever, exceptionally, this may be found desirable.

The various functions comprised in the local government part of the health service are summarized as follows:

Maternity and child welfare: The bill makes it the duty of every local health authority to make arrangements for the care of expectant and nursing mothers and of children under 5 years of age who are not attending school. The bill transfers these functions from such of the present “minor” authorities—the noncounty boroughs and the district councils—as are at present exercising them. But, for coordination with the school health services, provision is made for delegating child welfare to “district executives” in the same way—and with the same rights for the minor authorities—as is done for the school health service under the Education Act, 1944.

The county and county borough councils are also made responsible for a complete midwifery service for mothers who are confined at home. The midwives are to be employed either by the local health authority itself or by voluntary organizations with whom the authority comes to an appropriate arrangement.

Health visiting and home nursing: The local health authority will provide for a full health visitor service for all in their area who are sick, or expectant mothers, or those with the care of young children. This widens the present conception of health visiting (as concerned with mothers and children) into a more general service of advice to households where there is sickness or where help of a preventive character may be needed. The authority will also provide a home nursing service for those who—for good reason—need nursing in their own homes. In both of these activities the local authority can, if it likes and if the Minister approves, make all or part of its provision by arrangement with voluntary organizations to act on its behalf.

Local mental health services: The main mental treatment and mental deficiency services are to be part of the new hospital and specialist arrangements. Local health authorities, however, are given responsibility for all the ordinary local community care in the mental health service. This part of the service covers also the initial proceedings for placing under care those who require treatment under the Lunacy and Mental Treatment Acts.

Vaccination and immunization: Compulsory vaccination is abolished by the bill, but it will be the duty of the local health authority to provide free vaccination and diphtheria immunization. This service the authority will provide by making arrangements with doctors who are taking part in the general practitioner service—paying appropriate fees to those who undertake it.

Ambulance service: Apart from vehicles which may need to be provided as part of the hospital service, the provision of the main ambulances and hospital transport required for the health service becomes the duty of the local health authorities, either directly or by arrangement with voluntary organizations. In future the local health authority's ambulances may—and must, if necessary—operate outside their own area.

Care and after-care of the sick: Local health authorities are given a new power to make approved arrangements for the prevention of illness and the care and after-care of the sick. This can include the provision of special foods, blankets, extra comforts, and special accommodation for invalids and convalescents, and the making of grants to voluntary organizations doing work of this kind (but it does not include cash allowance to individuals or families, which is the function of national insurance). A charge may be made in appropriate cases.

Domestic help: Under existing law local authorities provide home helps as part of their maternity and child welfare functions and, during the war, this power has been extended by temporary enactment to enable them to provide domestic help in a wider range of circumstances. The bill makes this power permanent and extends it to cover the provision of domestic help, subject to the Minister's approval, to any household in which it is needed on grounds of ill-health, maternity, age, or the welfare of children. The authority will be allowed to charge for this service.

Health committees: Local health authorities will appoint statutory health committees (comparable in many ways to their statutory education committees) and refer to them all matters relating to the discharge of their functions under the bill. The health committees may be authorized to exercise functions on behalf of their parent authorities and there is discretion to appoint by co-option expert members who are not members of the authority itself.

ADMINISTRATION

Central health services council; The members are to be doctors, dentists, nurses, and other professional people concerned with the different parts of the service, together with people having experience of hospital management, of local government and of mental health services. The presidents or chairmen of six of the principal medical bodies in the country are also to serve on the council, ex officio. The council will be free to advise the Minister of its own initiative on any expert aspects of the services, as well as on matters expressly referred to it by him.

Default powers of Minister: The Minister is given default powers against local health authorities and any of the bodies constituted by the bill if they are not carrying out their functions satisfactorily. He can make an order directing them to do whatever may be necessary and then, if still not satisfied, he may take over their functions, permanently or temporarily, himself.

Position of officers: Regulations made by the Minister may lay down the qualifications and conditions of service of any or all of the officers and employees of all bodies (including voluntary organizations) concerned with providing services under the bill. In regulating conditions of service or remuneration, it will be his object to use appropriate machinery of discussion and negotiation with representatives of those affected. The Minister is empowered to establish contributory superannuation arrangements for the staffs of hospitals including the specialist services), executive councils, the bacteriological and blood transfusion services, and doctors and dentists in the general practitioner services. The employees of local health authorities will be entitled to the benefits of the existing local government superannuation scheme, which can be modified by regulations under the bill for staff in the health services in order to secure the maximum of interchangeability with other parts of the general service. The employees of local voluntary organizations can be brought within local superannuation schemes. Protection is given to existing officers of voluntary hospitals, insurance committees, and local authorities whose functions are transferred or extinguished by the bill, by providing for their transfer and re-employment by the appropriate authority under the new service or for their compensation if they were previously employed whole-time and suffer loss as a result of the changeover.

FINANCE

The expenditure of local health authorities on their services—including any payments which they make to voluntary organizations for services on their behalf—is to rank for exchequer grant, calculated in accordance with regulations to be made under the bill. The grant is to be on a "weighted" 50 percent basis, with no local health authority receiving more than three-quarters or less than three-eighths of their expenditure.

The transfer of the cost of the local authority hospital service from the ratepayers to the taxpayers (together with other changes which are in contemplation outside the scope of this bill) must profoundly affect the present financial relations between the exchequer and local authorities. The primary financial effect of the transfer of hospital services from local authorities will be to benefit the richer areas appreciably more, generally speaking, than the poorer areas. Radical changes will be necessary in the general scheme of exchequer grants in aid of local authorities. Therefore, to secure that over-all the policy of the Government of concentrating those grants as far as possible where the need is greatest is further developed. The whole of this question is at present under consideration by the government, with a view to the introduction of a reformed scheme by the time the new health service comes into actual operation.

DOCTORS AND THE BILL

REACTION OF THE B. M. A.—VIEWS OF THE SCHEME

Preliminary objections to proposals in the new health bill were put forward yesterday at a Press conference held at the British Medical Association's headquarters in London.

Dr. Charles Hill, secretary of the association, announced that 56,000 copies of the white paper would be sent out to members as soon as possible, and today a document setting out the considered views of the association would be issued, with the full authority of the council. Subsequently, area meetings of doctors would be held, and a special representative meeting of about 250 delegates would be held in London on May 1 and 2 to consider what action should be taken. Doctors, said Dr. Hill, would never strike, but the profession might decide in the event of their feeling they could not cooperate in the scheme to offer their services to the public as individuals, apart from any particular scheme.

Dr. H. Guy Dain, chairman of the British medical council, said Mr. Anurin Bevan had taken an entirely different line from his predecessors. Members of the association had seen him only twice, and he had told them that he was not proposing in any sense to negotiate with them, but would take entire responsibility for the form of the bill. The association's view was that it was not in the public interest that doctors as a profession should become whole-time State servants, and part of the civil service. Doctors could be relied upon to see that patients got a fair deal. The Minister of Health proposed that he should take the responsibility of telling doctors where they should practice and what form of practice they should undertake. The profession realized that the distribution of doctors would require to be looked into, but proper distribution could be obtained by ordinary methods of choice and attraction rather than by direction. It should not be necessary for all doctors to be subject to the approval and consent of a government committee, either for practicing in a place or moving from one place to another. As to hospitals, the association had favored regional organization, but saw no reason whatever to attach to that the actual ownership of the hospitals by the State. They should be left to their present owners with regional arrangements for the organization of the work in a large area, the Minister having power over the cost of the service.

Dr. Hill said the association's immediate reaction to the proposals was that they would lead sooner rather than later to doctors becoming whole-time salaried servants of the State. That was a form of service they believed to be contrary to the public interest. Meetings of members and nonmembers would be called in every part of the country during the first fortnight of April. Delegates at the representative meeting, while they would not have exactly a mandate, would have instructions from their areas.

The chairman, in reply to questions, said that forms for the fighting fund which the associations proposed to launch would be sent out immediately. They had no idea what would be the response, but had already had encouraging signs, even some patients asking if they could join it.

Our Medical Correspondent writes: First thoughts on the health bill by *The Lancet*, the leading independent weekly medical journal, can be summed up as a cautious acceptance of the proposals. It points out that the regional scheme for hospitals is not integrated with either the general practitioner service or the local authority health services, and it emphasizes that "the quality of this vast service will depend upon how it is administered."

OPPOSITION POLICY—LINES OF CRITICISM FROM OUR PARLIAMENTARY CORRESPONDENT

Although time is required for a close study of the National Health Service bill, it is possible to distinguish already certain definite lines of criticism by members of the opposition. The bill will be considered in detail by the Conservative Party's health committee of which Mr. Richard Law is chairman and Mr. Willink a member, and general opposition policy will be settled by the conservative "shadow cabinet." It is thought that some of the more controversial proposals will be vigorously contested.

The government's decision to take over the voluntary hospitals, of which there are more than 900 in England and Wales, was not altogether unexpected in view of recent prophecies, but it is a distinct break with coalition policy and with some statements by Labor Ministers which envisaged these hospitals retaining their identity and autonomy. Their administration by 16 to 20 regional boards is thought to lend itself too much to remote control. Conservatives are also deeply concerned about the transfer of local authority hospitals and they do not like the proposed endowment funds.

The emphasis on health centers as the basis of the general practitioner services is regarded as excessive and it is felt that in this, as in other aspects of the scheme, a more gradual approach would be the wiser course since we have still much to learn in some departments of the health services. More caution would also have been preferred on the subject of prohibiting the sale of goodwill.

Another point which is likely to be taken up by the opposition is the payment of part salaries to doctors in the service and the prospect, in their view, that this and the controls proposed may lead to a State salaried service. The administration of the scheme will be closely scrutinized, and it has already been noted that there does not appear to be a body to advise the Minister of Health on the hospitals for which he is directly responsible.

OTHER OPINIONS

Lord Latham, leader of the London County Council, in a statement issued yesterday, said it was generally accepted that a national health service freely available to all was an essential part of any satisfactory scheme of social security and that such a service must include adequate facilities for hospital and similar treatment for all who needed it, wherever they might live.

The government had decided that it must take over the municipal as well as the voluntary hospitals as the only satisfactory way to secure an integrated hospital system. This would mean that the London County Council would lose its great system of municipal hospitals, which had been welded into a fine hospital service for Londoners, who were greatly attached to and rightly proud of them. It could, therefore, be appreciated with what feelings of regret they would see them pass from them to the ownership of the State.

Sir Bernard Docker, chairman of the British Hospitals Association, said: "In the interests of the patient we stand by the constructive plan we have put forward, which fully meets the requirements of a national hospital service free to all. If we understand the Minister's proposals aright we hope that they will be opposed by all sections of the community who, with us, believe that sickness is a personal, intimate thing and that above all the human touch must be preserved."

Mr. G. G. Panter, secretary of the Royal Northern Hospital, said yesterday that from a preliminary glance at the new bill it would appear that what the government proposed to do with the trust moneys of the voluntary hospitals amounted almost to confiscation. There were lots of trusts within the hospitals under which a sum of money had been given to endow a bed in memory of a fallen soldier. Under the new scheme, was the memory of such a soldier to be completely wiped out?

The CHAIRMAN. I might also ask to have inserted here some papers taken from the Journal of the American Medical Association, in which they discuss the status of the English doctor, and wherein communications from British medical men are carried pointing out some of the misunderstandings in this country regarding the English system.

I would ask that those be taken in the record at this time.

(The excerpts referred to are as follows:)

EXCERPTS FROM THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, VOLUME 130, NUMBER 11, MARCH 16, 1946

THE STATUS OF THE ENGLISH DOCTOR

In the Journal, January 26, page 226, appears a statement credited to Capt. Paul K. Maloney, M. C. A. U. S., entitled "The Status of the English Doctor." As was subsequently pointed out, this article was actually written by Maj. Clifford L. Graves to Captain Maloney. A letter from Dr. Charles Hill, secretary of the British Medical Association, has now been received in which he emphasizes some inaccuracies and misleading statements which are said to be present in the article. The letter follows:

DEAR SIR: My attention has been drawn to the article in your issue of January 26, 1946, entitled "The Status of the English Doctor," by Capt. Paul K. Maloney.

The article contains so many inaccuracies and misleading statements and gives such a false impression of national health insurance in Great Britain that I cannot let it pass without protest. It is quite obvious that Captain Maloney has entirely misunderstood the British scheme: both his facts and his inferences are wrong. In almost every line there is some statement that could be challenged, but if I am not to trespass on your space I must select for comment only a few of the more glaring errors.

Captain Maloney's statements about the financial arrangements of the scheme illustrate how misinformed he is and how many mistakes he can pack into a short paragraph. He says that the individual's contribution is 1/7d. a week, of which the employer pays 10d. and the employee 9d. Actually, the sum of 1/7d. a week is the contribution paid by a woman for both National Health Insurance and contributory pension. The combined contribution for a man is 2/-, but his weekly contribution to national health insurance alone is 11d. only. It is not true that an additional 3d. a week has to be paid to secure "a very small sickness benefit." Sickness benefit; that is, a cash benefit, is covered by the man's contribution of 11d. The sickness benefit is not 10/- a week as Captain Maloney states, but 18/- for a man and 15/- for an unmarried woman. He speaks of shopkeepers and pensioners paying 1/5d. a week, but in fact employers, self-employed persons and pensioners are not included in the national health insurance scheme at all.

Then Captain Maloney makes the astonishing statement that 84 percent of the funds of the scheme is allocated for administrative charges and 12.5 percent for the doctors' remuneration and warns his readers that this is what may be expected from a national scheme. The amount absorbed in administrative expenses is actually a little over 17 percent. Captain Maloney has forgotten to make allowance for the payment of sickness benefit, disablement allowance, maternity grant and other benefits. Moreover, the fund does not collect 82/- a year from each insured person. The total contribution of an insured man, his employer and the state amounts to 55/7d. a year.

Captain Maloney asserts that well over 90 percent of the population is insured under the scheme. The correct figure is about 45 percent. The dependents of insured persons are not included in the scheme.

The paragraph on the approved societies is completely inaccurate.

Captain Maloney's impression of the status of the insurance practitioner is not true to experience. There is no frequent or regular inspection of doctor's records. It is one of the many duties of the small number of Ministry of Health regional medical officers to call on doctors from time to time and satisfy themselves that proper medical records are being kept. The imposition of a penalty is a rare occurrence. During the last year for which statistics are available only 2 out of 20,000 insurance doctors were fined for failing to keep proper medical records, and the fines in these cases were quite small. Captain Maloney's picture of the doctor as the helpless victim of disgruntled patients is unfair. The doctors themselves generally approve the machinery for dealing with complaints against insurance practitioners, and there is full opportunity of appeal.

Captain Maloney makes much of the alleged limitation of the doctor's authority to prescribe drugs. It is not true that he may not prescribe expensive drugs. He may and does prescribe whatever drugs the patient's condition may require. Avoidance of extravagance is all that is asked, and one cannot, surely, object to

that. Captain Maloney is inaccurate in his instances. The injection treatment of hemorrhoids has for long been regarded here as within the general practitioner's range of service. The particular case of alleged excessive prescribing quoted by Captain Maloney was not "investigated by Parliament" and, in fact, half the penalty and costs were remitted after enquiry.

And so I could go on, but I think I have said enough to show that no credence should be given to Captain Maloney's presentation of the British national health insurance scheme. We know that the system is by no means perfect and that it has some serious defects, more especially the absence of provision for the dependents of insured persons and the exclusion of consultant and specialist treatment. But on the whole, and so far as it goes, it is a good scheme and works well, and British doctors have a right to expect that when a writer takes it upon himself to describe the scheme to the profession in another country he will make some effort to verify his facts.

CHARLES HILL, *Secretary,*
British Medical Association,
Tavistock Square, London, W. C. 1.

EXCERPTS FROM THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

January 26, 1946, Volume 130, No. 4

THE STATUS OF THE ENGLISH DOCTOR

(The following article was submitted by Capt. Paul K. Maloney, M. C. A. U. S., a member of the Kings County Medical Society in New York, to the bulletin of that medical society. It is here reprinted for the general information of American physicians as to the present technic of operation of the panel system in Great Britain.—Ed.)

This material was obtained from one of the general practitioners in Kidderminster, a city with a prewar population of 30,000 which has now risen to 60,000. He is a man who has practiced "panel medicine" for 10 years and has made a success of it, as far as that is possible. He has answered all questions frankly and analytically without trying to cover up the defects of the system.

This article will deal only with the practical aspects of the doctor-patient relationship and with the financial status of the doctor, rather than with the complicated and extensive administrative machinery that has come into existence. The object here is to outline how the average British citizen obtains medical care for himself and his family. For that reason the information is presented in three parts:

I. The machinery to provide the wage earner with ordinary general practitioner's care. This is called national health insurance and is regulated by law.

II. The machinery to provide the same thing for his dependents. This is a private venture, undertaken by a group of doctors who organize a "public medical society" for the purpose. Financial arrangements vary somewhat according to the charter of this society.

III. The machinery to provide consultant's services and hospitalization for both the wage earner and his family. This is undertaken by the "voluntary hospitals," which are run by the city or county and supported partly by private donations and partly by small subscriptions from those who wish to have a hospital insurance.

I. National health insurance

National health insurance has existed in England since about 1911, when it was passed under the sponsorship of the then Premier Lloyd George. At first it met with much opposition from the medical profession, and there were many doctors who refused to take on a panel. Wherever the system threatened to fail because of this, the Government placed young medical graduates in the recalcitrant locality. This was not difficult, because in England a doctor must buy a practice when he starts and there were plenty of young men who here saw a chance to acquire a practice (even though it was only a panel practice) without having to pay the usual sum of £3,000 to £10,000 for it. Since then, health insurance has been accepted by the vast majority of doctors as an inevitable institution. In Kidderminster, of a total of 13 doctors 11 practice panel medicine.

National health insurance will be discussed under the following headings:

1. What people are insured.
2. What service is provided.
3. Financial arrangements.
4. The "Approved Society."
5. The status of the doctor (a) financially, (b) professionally.

1. *What people are insured.*—The scheme includes every wage earner, male or female, married or single, between the ages of 14 and 64, with an income of less than £420 a year (until the war this figure was £250). The fees are deducted automatically from the pay check, so that the system may be said to be compulsory.

When the wage earner is temporarily unemployed, the state continues the payments for him, provided he is on the dole.

When the wage earner reaches the age of 64 he stops paying all fees, becomes entitled to the old-age pension and remains insured for the rest of this life.

When he stops paying before the age of 64 (this would be impossible with people getting regular pay checks, because the deductions are automatic) he remains insured for 2 years after his delinquency.

People whose income is not paid in the form of a wage, such as shopkeepers, farmers, and small pensioners, may make their payments quarterly. They do come within the provisions of the law, as long as their income is less than £420.

The £420 limit means that well over 90 percent of the population of England is included.

2. *What service is provided.*—This includes ordinary physician's care, office as well as house calls. No surgery except the most pedestrian kind, such as lancing a boil. The scheme also allows for some drugs, but only the less expensive ones. For those who belong to an "Approved Society" it is sometimes possible to get spectacles and dental and surgical appliances free of charge.

3. *Financial arrangements.*—Payments are made by the week or month. They are divided equally between the employee and the employer, with the employer paying the odd penny if there is one. The total weekly contribution for individuals of 18 and over is 1 shilling 7 pence (1/7), of which the employer pays 10 and the employee 9. For an additional 3 pence (/3) it is possible to secure a very small "sickness benefit," that is an allowance during illness, but it does not amount to more than 10/ a week and only for a limited time. The /3 is paid by the employee. Shopkeepers, farmers, and pensioners pay 1/5 a week, all themselves. The money is collected automatically by pay check deduction and a 1/7 stamp is pasted in a special card that is provided for this purpose. The stamps are bought at the post office.

Thus, the fund collects fifty-two times 1/7, or about 82/ a year. This is apportioned as follows:

For the doctor, 10/6, or 12.5 percent.

For drugs, 3/, or 3.5 percent.

For mileage fees at the rate of a shilling per mile per year, /6, or 0.5 percent.

For administrative overhead, 68/, or 84.0 percent.

Attention is called to the disproportion of what the doctor gets and what the State collects. Up until 1939, the Fund had accumulated a surplus of £144,000,000.

4. *The "approved society."*—This is a sort of private insurance company, organized to help administer the scheme and give certain extra advantages to the "good risks." Only those wage earners who make separate application and who can pass a physical examination are accepted (the National Health Insurance Act itself makes no mention of a physical). The Chief object of the approved society is to provide "sick benefits," that is, small weekly payments to those who are ill and cut off from their regular source of income. It has already been pointed out that for an additional /3 a week the insured person may get a government sickness benefit, but the payments are small (not more than 10/ a week) and last only as long as there is a cash balance in his particular account. The approved society, on the other hand, is authorized to collect 4/10 out of the 82 shillings that is taken in for each individual who is a member. For this it gives:

(a) A sickness benefit of from 18/ to 25 a/ week, which is paid as long as the illness lasts. The variation of 18 to 25 depends on the society. The better ones paid the larger amount.

(b) "Grants-in-aid," that is, spectacles, dental appliances and surgical appliances, but only in limited amounts. A certain sum is set aside at the beginning of each year and, when this is exhausted, no further grants can be made until the next year. Usually, the fund is used up long before the year is out.

The people who cannot belong to an approved society because of some disqualifying physical defect such as hypertension or diabetes are called deposit contributors. It is optional with them if they want to belong and pay the extra /3 a week.

5. *Status of the Doctor*—(a) *Financially*.—A successful busy practitioner can handle a panel of 2,000. The upper limit, fixed by law, is 2,500. A panel of 2,000 yields a yearly income of somewhat over £1,000. This may be increased slightly by the "certificates of disability" which the doctor writes for those whose illness compels them to stay away from work. Such a certificate costs the patient 1 shilling. Since 95 percent of the cases are ambulatory, the profits on this score are small.

In Kidderminster, with a panel of 2,000, the doctor sees an average of 30 patients a day, or 9,000 a year, so that his pay per office or house call is 2 shillings.

(b) *Professionally*—Professionally, the doctor's position is not a happy one for the following reasons:

Inspectors come around regularly to inspect his records. If these fail to pass, the doctor is fined without further process of law anything from £100 to £200. If a patient is disgruntled, he can report the doctor, and the doctor is then investigated by a board, made up partly of laymen, partly of doctors. Again, the penalty is in the form of a fine, although this sort of trouble is usually squelched before it reaches a board. The fact remains, however, that a crackpot patient can cause the doctors no end of unpleasantness.

More irritating is the limitation in the allowance for drugs. Only certain inexpensive items may be prescribed. When two doctors in London, unaware of this, ran a large-scale scientific experiment on their aged patients by giving them large doses of cod liver oil and malt extract (the doctors acted in good faith and accumulated valuable data), they were fined £1,000. This raised such a furor that the affair was investigated in Parliament. Regrettably, Parliament had to agree with the verdict because it was within the purview of the law.

Further, there is the limitation of what the doctor may do for his patient. The law says he may do only what is commonly considered to be within the province of the general practitioner. This definition has been tested repeatedly in court and has been very narrowly interpreted. For instance, a doctor may not inject hemorrhoids, give diathermy, remove polyps, or electrocoagulate warts. In fact, about the only thing he can do is to prescribe some inferior drug, and he resorts to that abundantly. If the patient needs a consultant or an operation, he must be sent to the hospital. The practitioner then loses track of his patient altogether, but a few with special training may apply for staff privileges. In Kidderminster, out of a total of 13 physicians, there are only 2 who may operate. These are paid a small fee when they operate on a panel patient. An appendectomy nets them £1.

The average office call for a panel patient lasts 3 minutes: 1 minute to usher the patient in and out, 1 minute for the questioning and examination, and 1 minute for the writing of the prescription and the records. Since the doctor also sees many "club patients," his average daily quota of patients is from 60 to 70, about three-quarters office work and one-quarter house calls. His day lasts from 9 in the morning till 8 in the evening. He takes one afternoon a week off, plus his Sunday, and a 2 to 3 weeks' vacation every year.

II. The public medical society

To provide the wage earner's dependents with the same sort of care, doctors organize locally what is called a public medical society, or "club." They hire an accountant, collectors and typists for the bookkeeping and take on a certain number of people on a sort of private panel. The average number per doctor is 1,000. The cost is 4 pence a week per individual up to a maximum of 1/4 for a single family. After that there is no further increase, so that very large families are not unduly penalized. The distribution of the profits is very interesting when compared with those of the national health insurance. It is as follows:

- For the accountant, 7.5 percent.
- For the collectors, 12.5 percent.
- For the doctors, 80 percent.

The main lesson to be learned here is that, when the state operates the system, the doctors get 12.5 percent, but when the doctors themselves operate the system they get 80 percent.

By having 1,000 "club patients," a practitioner can further increase his income about £660 a year. The subscribers are, of course, mainly women and children. Although they represent only half the size of the regular panel, they account for fully as many office calls, an average of 30 a day. Add to this 30 panel patients and the total becomes 60. A very ambitious man such as the one interviewed also sees about 10 private patients a day, who add some £400 to £2,000 a year to his income. Consequently, his total income is about £2,000 a year, which is not had even at home, but it must be remembered that he is now at the top of the heap as far as panel practice is concerned.

III. The voluntary hospital contributory scheme

To provide hospital care for the wage earner and his family there is still another scheme. It is operated by the hospitals themselves, as far as they wish to, and most of them do. A voluntary hospital exists from two sources, each one of about equal size: (1) private donations and charity drives; (2) small subscriptions by individual workers.

The fee for one wage earner and his family is 4 pence a week, to which the employer adds 1 penny, making a total of 5. There is no compulsion about it as there is about national health insurance. The 5 pence a week yields 21/4 a year. The Kidderminster Hospital collected £18,000 this way last year, about half its total operating cost. By being a "voluntary contributor," the wage earner insures hospitalization for himself and his family for no matter that ailment or what operation, chronics excepted.

The hospital in Kidderminster has a staff with one specialist for each of the important departments, such as surgery, medicine, X-ray, and laboratory. None of these get paid, except for the surgeon, who gets £100 a year for being the head of the outpatient department. The radiologist gets no salary but has the privilege of using the department for his private patients. Consultants who must come from distant cities get a mileage fee of £100 a year.

Obstetrics, which is usually a large source of income for the general practitioner at home, is not so in England because 95 percent of the work on indigent patients is done by midwives. Doctors are called in only when there are complications. The scheme is administered by the county, which pays the doctor 2/6 for each antepartum office call and 5/ for a house call. If the doctor does the delivery himself he collects 3 guineas and his anesthetist 1 guinea. This is paid by the county after an investigator has certified that the patient cannot pay. If the patient can pay something the doctor gets a corresponding fraction of his 3 guineas. Even in the very active practice of our informant, however, obstetrics played only a minor part.

DISADVANTAGES OF SOCIALIZED MEDICINE IN ENGLAND

The chief disadvantages of panel practice appear to be from this superficial survey:

1. The impossibility of doing good work because of the volume of work.
2. The restrictions on what the doctor can do for his patient in the office.
3. The discrepancy between the 10/6 for the doctor and the 68/ for the overhead.

NOTE.—For readers in the United States the shilling is worth about 20 cents and is written with a / sign. Thus, 5 shillings 4 pence is written 5/4. There are 12 pence to the shilling and 20 shillings to the pound.

The CHAIRMAN. Doctor, do you approve of handling this problem we have in this country by a voluntary system?

Dr. KENNEDY. Yes; now.

The CHAIRMAN. Or do you think we could gradually work out of this situation without any system of any kind?

Dr. KENNEDY. I am in favor of a voluntary attempt to meet any demand, and as such on last Sunday I was elected president of the Indiana Mutual Medical Care, Inc., which is intended to offer insurance particularly to those of low-income classes.

The CHAIRMAN. Well, the general objection that has been urged against the voluntary systems is that it costs too much, imposes a lot

of conditions and requirements that prevent the people who most need insurance from being insured, and it is not a complete coverage, and therefore it does not cure the problem we have in this country of bringing adequate medical care to the American people. That is one of the main objections to it.

Dr. KENNEDY. We are attempting to find out the costs. We nor anyone else knows exactly what they will be. We hope by experimentation to find that out.

The CHAIRMAN. Well, I just merely called your attention to that. Some study has been already made of a number of these societies like the Michigan Medical Service, the Group Health Association here in the District of Columbia, the Southern Permanente Foundation of Kaiser Corp. in California, and the Ross-Loos Clinic in California; and each of those societies fail to supply or furnish a complete coverage, complete medical and hospital care, and other care that the present bill purports to offer to the American people.

Dr. KENNEDY. That is quite true. The American Medical Association has recently approved the formation of an organization of these different plans by which they might set up basic standards, and their operations will interchange information as to the costs and possible extensions of service. It is a matter relatively in its infancy. We will be unable to give definite findings on it until we have had time to work it out.

The CHAIRMAN. You think it might be possible, then, under a voluntary system, to cover the country to such a degree that the cost of complete medical care and hospitalization would be brought within the reach of the American people?

Dr. KENNEDY. We hope to.

The CHAIRMAN. Well, that is the great problem for us.

Dr. KENNEDY. Yes, sir.

The CHAIRMAN. The question is whether or not it can be done by a voluntary system or a compulsory system, and we are very glad to have your statement here, Doctor.

Senator DONNELL. May I ask a few questions, please?

The CHAIRMAN. Surely.

Senator DONNELL. Doctor, in England is there a British Medical Association and also an independent branch of physicians independent of the British Medical Association?

Dr. KENNEDY. I know of none.

Senator DONNELL. What I have in mind in this: I observe in this copy of the London Times that one mention is made here of the "Medical Correspondent":

First thoughts on the health bill by "The Lancet," the leading independent weekly medical journal, can be summed up as a cautious acceptance of the proposals. It points out that the regional scheme for hospitals is not integrated with either the general practitioner service or the local authority health services, and it emphasized that "the quality of this vast service will depend upon how it is administered."

Do you understand the Lancet is a publication of the British Medical Association?

Dr. KENNEDY. No; it is an independent paper.

Senator DONNELL. It is not a publication of the British Medical Association?

Dr. KENNEDY. It is not. They do not publish an official publication as we do.

Senator DONNELL. Doctor, I observe in this copy of the London Times that the article appearing in column 7 of page 8 starts this way:

DOCTORS AND THE BILL—REACTION OF THE BMA

That is the British Medical Association?

Dr. KENNEDY. Yes.

Senator DONNELL (reading as follows):

VIEWS OF THE SCHEME

Preliminary objections to proposals in the new health bill were put forward yesterday at a press conference held at the British Medical Association's headquarters in London.

Dr. Charles Hill, secretary of the association, announced that 56,000 copies of the White Paper—

What is the "White Paper"?

Dr. KENNEDY. A copy of the so-called Beveridge bill.

Senator DONNELL (reading as follows):

would be sent out to members as soon as possible, and today a document setting out the considered views of the association would be issued, with the full authority of the council. Subsequently, area meetings of doctors would be held, and a special representative meeting of about 250 delegates would be held in London on May 1 and 2 to consider what action should be taken. "Doctors," said Dr. Hill, "would never strike, but the profession might decide in the event of their feeling they could not cooperate in the scheme to offer their services to the public as individuals, apart from any particular scheme."

And so forth.

And then I observe, further down, quoting again from Dr. Hill:

Dr. Hill said the association's immediate reaction to the proposals was that they would lead sooner rather than later to doctors becoming whole-time salaried servants of the state. That was a form of service they believed to be contrary to the public interest. Meetings of members and nonmembers would be called in every part of the country during the first fortnight of April. Delegates at the representative meeting, while they would not have exactly a mandate, would have instructions from their areas.

The chairman, in reply to questions, said that forms for the fighting fund which the association proposed to launch would be sent out immediately. They had no idea what would be the response, but had already had encouraging signs, even some patients asking if they could join it.

And I observe somewhat similar language in the Daily Telegraph London, issued under date of March 22, in which it states:

"We have no idea what the response will be," said Dr. Guy Dain, chairman of the council, yesterday. "We have had encouraging signs for the fighting fund we proposed to launch. Even some patients have asked if they could join it."

and so forth.

I would ask that these two articles, which are not very long, being in the neighborhood of half a column each, should be set forth in the record.

The CHAIRMAN. All right. It is a pretty heavy record, but I believe it is important enough to have anything in the record that any Senator wishes.

Senator DONNELL. I think that is particularly important.

(The articles referred to are as follows:)

FREE HEALTH AID FOR ALL IN 1948—GOVERNMENT REVEALS £152,000,000 PLAN—
ALL HOSPITALS TO BE TAKEN OVER

PRIVATE PRACTICES TO STAY—PATIENTS HAVE CHOICE

From 1948 free medical, specialist, hospital, and dental treatment will be provided for every man, woman, and child, irrespective of means.

Details of the plan, which will cost £152,000,000 a year, were given in a summary of the national health service bill, presented to Parliament yesterday by Mr. Bevan, Minister of Health.

All hospitals, with few exceptions, are to be nationalized. Health centers in every town will form the base for medical treatment either at the center, at doctors' surgeries, or in patients' homes.

An outline of each section of the scheme is as follows:

Patients will be free to choose their own doctors, and doctors their patients. Doctors and specialists may join in the service or not as they choose, and may still engage in private practice.

Sale of practices will be prohibited, and £66,000,000 will be paid in compensation to doctors on death or retirement. Remuneration will be settled later, but will be on a part-salary and capitation basis.

Supplementary services will include maternity and child welfare, home nursing, domestic help, and after care. County and borough councils will provide these. Compulsory vaccination will be abolished.

Spectacles, dentures, and other appliances, with drugs and medicines, will be provided at hospitals, health centers, clinics, and chemists' shops.

Administration of all hospitals, other than teaching hospitals, is to be entrusted to regional hospital boards. Medical and dental schools will retain their present administration.

Endowments of voluntary teaching hospitals will pass to boards of governors, who will be free to use the money as they wish, but must bear in mind the purposes for which it was originally intended.

Any doctor wishing to enter the service after an appointed day will have to get permission, which may be refused only if there are already enough doctors in the area concerned.

FIRST COMMENTS ON PLAN

First reactions to the white paper last night included:

The British Medical Association is sending out 56,000 copies of the white paper with its comments. Dr. Charles Hill, the secretary, said that doctors would become salaried servants of the state, which the association believed against public interest. Doctors might decide to offer their service to the public apart from the scheme.

Hospitals: Sir Bernard Docker, chairman of the British Hospitals' Association, said that above all the human touch must be preserved.

Local authorities: Lord Latham, leader of the London County Council, said that the L. C. C. would lose its great system of municipal hospitals. It was with regret that the council saw them pass to state ownership, but it would support the main principles.

Chemists: Mr. H. Linstead, secretary of the Pharmaceutical Society of Great Britain, said that chemists would be faced with competition from local authorities.

Conservative Party: The second reading of the bill will be moved in the House of Commons in the week beginning April 15. Two days will be allowed for the debate. The Conservative party will attack the bill on the grounds that there has been no adequate effort to secure agreement with the medical profession, and that it will break down the traditions of the profession.

DOCTORS TO HOLD MASS MEETINGS

B. M. A. BUYS 56,000 COPIES OF PLAN

(Daily Telegraph Reporter)

The Stationery Office has received what must be one of the biggest individual orders for a white paper ever made. The British Medical Association has

bought, and is distributing at once, 56,000 copies of the national health service bill to its members at a cost of £3,500.

With each 1s 3d copy will go the comments of the council of the B. M. A. and an intimation that area meetings of the association are to be held during the first 2 weeks of April, to which nonmembers are also invited.

The recommendations and comments from those meetings will be voiced at a special representative meeting of the profession to be attended in London by 250 delegates on May 1 and 2.

Two of the most important meetings will be at Manchester on March 30 and Liverpool on March 31, and will be attended by representatives of 4,500 members of the Lancashire and Cheshire branch of the British Medical Association, the largest branch in the Provinces.

"We have no idea what the response will be," said Dr. Guy Dain, chairman of the council, yesterday. "We have had encouraging signs for the fighting fund we propose to launch. Even some patients have asked if they could join it." The special negotiating committee of the B. M. A. were considering the bill and its explanatory white paper last night. Today they will give the considered views and comments of the association on all aspects of the proposals

MR. BEVAN'S ATTITUDE

"We had lots of talks with Mr. Brown, Mr. Willink, and Mr. Johnston, Mr. Bevan's predecessors," Dr. Dain continued. "They brought their proposals along and asked what we thought about them, and as a result, they were modified. Mr. Bevan has taken an entirely different line." He saw us and said: "I do not propose in any sense to negotiate with you and shall take entire responsibility for the form the bill takes."

The association's view was that it was not in the public interest that doctors, as a profession, should become whole-time state servants and a part of the civil service.

Dealing with the Minister's proposals regarding hospital services, he said: "They should be left to their present owners, with regional arrangements for the organization of the work in a large area. The Minister should have power in his hands to distribute the costs of the services and as well ensure proper standards being maintained."

Dr. Charles Hill, secretary of the B. M. A., said that the first immediate reaction was that the proposals would lead sooner, rather than later, to doctors becoming whole-time salaried servants of the state. That was a form of service which the B. M. A. believed to be contrary to public interest.

Asked if it was likely that doctors would go on strike, he replied: "Doctors will never strike. But they are free like other citizens to decide whether they want to join any service or not.

"If the medical profession believe the Government scheme to be against the interests of the public it may be that doctors might decide to offer their services to the public apart from the scheme."

2-DAY DEBATE ON BILL

CONSERVATIVE CASE

(By our political correspondent)

The second reading of the national health service bill will be moved in the House of Commons in the week beginning April 15. Two days will be allowed for debate.

The Conservative "shadow cabinet" will decide during the next fortnight whether to table an amendment for rejection of the bill on the second reading, or whether efforts should be concentrated on amending it in committee.

The health committee of Conservative M. P.'s met yesterday as soon as copies of the bill and the white paper became available. The committee, of which Mr. Law is chairman and of which Mr. Willink, formerly Minister of Health, is a member, will examine the Government's proposals in detail and make recommendations to the "shadow cabinet."

It is already certain that the Government scheme will be attacked on two major points of principle: That it is to be arbitrarily imposed upon the country

without adequate effort to secure the maximum degree of agreement with the medical profession; and that it will break down, instead of building on, the traditions of medical service.

It is likely to be further alleged against the scheme that the £66,000,000 to be devoted to extinguishing private practice will be needlessly lavished; that the confiscation of the funds of voluntary hospitals will set an evil precedent; and that the inroad into the rights of local authorities is unwarranted.

The Conservative case is that the broad principles agreed within the coalition government and set out in its white paper should be adhered to; and that the voluntary hospitals, private general practice, and the municipal hospital and health services should all be allowed to make their contribution to the working of a national health scheme.

FULL SUMMARY OF PLAN

The total cost of the scheme, which is expected to come into operation early in 1948, is estimated at £152,000,000 a year. Of this, specialist and hospital services are expected to cost £87,000,000, and family doctor, dentist, pharmaceutical, and eye services £45,000,000.

Remuneration of doctors and specialists is not fixed by the bill; that will be settled later in consultation with the profession. It will be on a part-salary and capitation basis, the latter varying according to local conditions. To encourage doctors to serve in less attractive, under-doctored areas, special financial inducements will be offered.

Allowing for savings on existing grants and for a contribution of £32,000,000 from the National Insurance Fund, the net additional expenditure falling on the Exchequer is estimated to be £95,000,000 a year.

The scheme may roughly be summarized under four heads:

Health centers and family doctor services: These will maintain the existing personal relationship between doctor and patient, and provide treatment in the centers or outside.

Hospital and specialist services: All forms of hospital treatment, including specialist attention and treatment of all kinds, to be made available in hospitals, at the centers, in clinics and the home. These to be a national responsibility.

Supplementary services: These will include midwifery, maternity and child welfare, home nursing, a priority dental service for mothers and children, domestic help where needed and after care in illness, and will be the responsibility of county and borough councils.

Eyes, teeth, and medicines: Spectacles, dentures, and other appliances and all necessary drugs and medicines to be provided at hospitals, health centers, clinics, and chemists' shops.

AVAILABLE FOR EVERYONE—NO LIMITATIONS

All the service, or any part of it, is to be available to everyone in England and Wales—a bill to cover Scotland is to be introduced later. There is no limitation based on means, age, sex, employment, area of residence, or other qualification.

A proportion of the contribution to the national insurance scheme will be used to help to finance the Health Service, but benefits are not conditional upon insurance and there will be no waiting period.

There will be no fees or charges to patients with the following exceptions:

There will be some charges (to be prescribed later) for the renewal or repair of spectacles, dentures, or other appliances made necessary by neglect;

There will be charges, taking into account ability to pay, for domestic help provided under the bill and for certain goods, such as food or blankets provided for maternity, child welfare or after care; and

People may, if they wish, pay for additional amenities, such as articles or appliances of higher cost than those normally supplied. They may also pay for private rooms in hospitals, though these they will obtain free where privacy is medically necessary.

TRANSFER TO MINISTER—EXEMPTION POWERS

The most revolutionary part of the plan is that concerning the future administration of hospitals. Under this head are included general and special hospitals, maternity accommodation, sanatoria, isolation hospitals, provision for the chronic

sick, mental hospitals and institutions, convalescent homes and rehabilitation centers, as well as all forms of specialized treatment.

Existing premises and equipment of voluntary and public hospitals are transferred to the Minister under the bill. He is empowered, also, to acquire by purchase, if necessary, other hospitals and their equipment which may be required for the new service. The general transfer includes the present mental hospitals and mental deficiency institutions.

If, in any particular case, he is satisfied that the transfer of a hospital is not necessary for the new service, he can except it from transfer with that institution's concurrence.

Use of endowments

The endowments of voluntary teaching hospitals, defined broadly as all property other than buildings and their contents, will pass not to the Minister, but directly to their new boards of governors.

The boards are to be free to use the endowments as they think best, but are required, so far as practical, to see that the purposes for which they were previously usable are still observed.

The endowments of other voluntary hospitals, the total of which has not yet been ascertained, are to pass to a new hospital endowment fund which the Minister is to set up. Out of this fund he will first settle existing debts and liabilities attaching to the hospitals concerned.

He will then apportion the capital value of the fund among the regional hospital boards. The income of each portion will then pass automatically to each board, which will be free to use it as it wishes within certain conditions. Each board, also, will be able to draw on its portion of the capital for a purpose approved by the Minister.

The boards and the boards of governors of teaching hospitals, will be able under the bill to receive gifts or legacies and to hold any property on trust for any purpose connected with the hospital or the health service.

Administration of all hospitals other than teaching hospitals is to be entrusted to regional hospital boards. There will be 16 or 20 such regions, each associated with a university medical school. Members of such boards will be chosen for their individual suitability after consultations with universities and the profession.

Each board will appoint hospital management committees for each hospital or related group of hospitals in its region. Each board will execute the plan for coordinated hospital and specialist services in its region.

"It is the object that the regional boards, with their local management committees, shall enjoy a high degree of independence and autonomy within their own fields," states the white paper.

"Their use of existing voluntary hospital endowment has already been described. For the general financing of their hospital services, however, they will look to the Exchequer, and they will be given as much financial freedom—by a system of block annual budgets or otherwise—for local initiative and variety of enterprise as general principles of Exchequer responsibility make possible."

MEDICAL SCHOOL PROPOSALS—NOT TRANSFERRED

A different system will be provided for the teaching hospitals, which will be administered on behalf of the Minister by their own boards of governors on which will be members of the university concerned and of the regional boards.

Medical and dental schools are not to be transferred to the Minister or to the board of governors of the teaching hospital with which they are associated. They will continue to be owned and administered in London by their own governing bodies, and elsewhere by the governing bodies of the universities of which they form part.

EMPLOYMENT OF STAFFS

The staffs of all hospitals in the service will be employed by the regional boards of boards of governors. Specialists, whole-time or part-time, will be attached to the staff of hospitals, and part-time participation will not debar specialists from continuing private practice.

Vacancies in the senior medical or dental staff will be advertised and appointments will be made by the board after candidates have been reviewed by an expert appointments committee. Existing hospital officers will either be transferred to the new bodies or compensated for nontransfer or employment on less favorable terms.

FAMILY DOCTOR SERVICE—EXECUTIVE COUNCILS

Of more immediate concern to the public is the new family doctor service. This will be arranged by new bodies, to be called executive councils, in every county and borough area.

Half the members of each council will be appointed by local doctors, chemists, and dentists through their own representatives. The others will be appointed by the local authorities and the Minister, who will appoint the chairman.

The main feature of this service is the development of health centers which will be provided, staffed, equipped, and maintained by the local authorities.

The centers will stand in place of the doctors' own surgeries. Doctors' responsibility to patients on their personal lists, such as in visiting their homes, is not affected by whether a doctor practices from a center or not.

All doctors are to be entitled to take part in the new arrangements in the areas in which they are practising when the scheme begins. Taking part will not debar them from treating people who desire treatment outside the service, provided such patients are not on their lists as public patients.

Doctors taking part in this service will be in contract with their local executive council, which will draw up and publish lists of all general practitioners who wish to participate. People will then choose their own doctors, subject to his consent, and each doctor will have his own list of the people he had agreed to attend.

"The relationship of the doctor with any person on his list will be similar to the ordinary relationship of doctor to patient as it is now known," it is stated, "except that the doctor's remuneration will come from public funds and not from the patient."

The doctors' remuneration cannot be determined until the report of the committee set up under the chairmanship of Sir Will Spens has been completed. It is intended to institute a compulsory superannuation scheme for doctors taking part in the scheme.

PAYMENTS BY PATIENTS—EXTRA FACILITIES

Patients who wish may pay extra to secure private accommodation in hospitals where this available. This is to be subject always to the requirements of patients who need such accommodation on medical grounds, who will obtain it without payment.

Private pay bedrooms may be provided, where part-time specialists in the service can treat private patients, subject to the right of other patients who need it on medical grounds to use it without charge.

Private patients using the accommodation will pay their own specialists' fees, but the Minister will be empowered to prescribe a maximum for these.

Two other services, which have grown up during the war, are also made the responsibility of the Minister. The first is a bacteriological service for the control of infection, and the second the blood-transfusion service.

The Minister is empowered to conduct research and give financial aid to voluntary research bodies. Boards of governors and regional boards also are empowered to conduct research.

RIGHTS OF THE DOCTOR—LOCATION CONTROL

The location of practices is to be regulated by a new body, the Medical Practices Committee. To begin with, an appointed day will be fixed and all doctors will have the right to inclusion in the executive council's list for the area in which their practices are.

After that date, any doctor who wishes to enter the service, or to practice in a new area, will have to seek the permission of the Medical Practices Committee. The only ground upon which the committee may refuse is that there are already enough doctors in the area concerned. Right of appeal to the Minister is provided.

This control of succession to, or opening of, practices will apply to all practices wholly or partly within the service. It will, therefore, make the sale of good will inappropriate. The bill provides for the prohibition of such sale and for compensation to practitioners for loss of selling value.

Payment of compensation

The total compensation, as stated earlier, is estimated at £66,000,000, but this sum will be reduced if the number of doctors joining the service fall substantially short of the expected total.

The method and time for the apportioning of this sum among the doctors entitled to it will be laid down by regulation. The apportionment among individual doctors will be left mainly to the profession itself, and the Minister will accept any reasonable proposals within the total sum.

Payment may be made earlier than retirement or death of a doctor in cases where, as through outstanding debts, hardship would otherwise arise.

When the new health centers are developed, existing doctors in the area will be able to use the consulting rooms and other facilities so provided, so far as they are participating in the new service.

OTHER SERVICES—PHARMACY, DENTAL, OPHTHALMICS

Other services provided are:

Pharmacy.—Patients using the service will be provided free with the necessary drugs, medicines, and appliances. Every qualified pharmacist who wishes to join the new service will have the right to do so.

The executive council in each area will publish a list of the pharmacists who join the service. Patients will obtain supplies on presenting a prescription either at shops or from centers at which dispensing facilities are provided.

Conditions and remuneration under which pharmacists join the scheme will be fixed in consultation with the professional organizations concerned.

Dentistry.—Dental services will be on a different basis from the family doctor service, priority being given to expectant mothers and children. This will be done through local authorities, maternity and child welfare and school welfare services.

There will be a general dental service, but there will not at first be any guaranty that all people will be able to obtain full dental care without waiting. Any dentist who wishes to participate in the general dental service will have the right to do so, and lists will be published in each area.

The object is to develop general dental services in the health centers or in dental centers as quickly as possible. In the centers it is intended that dentists shall participate either whole or part time and, outside the centers, anyone may arrange for treatment in his own surgery by a dentist who agrees to undertake it.

The dentist will normally be able to start treatment without further reference, and subsequently to submit a claim for payment from public funds. For certain forms of treatment, however, estimates will have to be approved by a dental estimates board which will have branches in various parts of the country.

Ophthalmics.—Sight testing and the supply of spectacles will be carried out in special ophthalmic departments and clinics forming part of the hospital and specialist service. They will be in the charge of specialist medical ophthalmologists, and will also have qualified opticians.

Spectacles will be obtainable either at the clinics or at the premises of dispensing opticians taking part in the service. While this full eye clinic service is being worked out, a supplementary eye service will be arranged by the executive councils in each area.

LOCAL BODIES' NEW DUTIES

CARE OF MOTHERS AND CHILDREN: NURSING SERVICES: MIDWIVES AND HEALTH VISITORS

Through a special committee they will draw up lists of medical practitioners and opticians willing to participate. Patients will have freedom of choice among the doctors and opticians on the lists.

People will be entitled both to sight testing and the supply of spectacles free of charge either at the clinics or through the supplementary scheme. The latter will be discontinued as soon as the full clinical service is provided.

TRIBUNALS FOR DISCIPLINE—HEARING COMPLAINTS

A special tribunal is to be set up to hear complaints that the inclusion in the lists of any doctor, chemist, dentist, or optician is prejudicial to the efficiency of the service.

The tribunal will have a chairman appointed by the Lord Chancellor, and when it is satisfied that complaints are justified the tribunal can direct the name to be removed from the list. The person so named has the right of appeal to the Minister.

A doctor, chemist, dentist, or optician already disqualified from participation in the national health insurance service and whose disqualification has not been removed, will not be entitled to participate in the new service.

The Minister reserves power to take any steps he considers necessary if he is satisfied that the services provided by doctors, dentists, or chemists in any area are not adequate. He is also empowered to arrange with universities and medical and dental schools for the provision of refresher courses for doctors and dentists in the service.

He will contribute toward the cost of these courses and pay the expenses of doctors and chemists attending them.

LOCAL HEALTH AUTHORITIES—BIG RESPONSIBILITY

Heavy new responsibilities are laid upon local authorities on the local and domiciliary side of the scheme. All local health authorities are required to indicate to the Minister and to the boards and executive councils the steps they propose to take.

Maternity and child welfare

Every local authority has the duty of making arrangements for the care of expectant and nursing mothers and of children under 5 who are not attending school and who are therefore not covered by the school health service. These arrangements will include:

Antenatal clinics for the care of expectant mothers;

Postnatal and child welfare;

The provision of cod-liver oil, fruit juices, and other dietary supplements; and, in particular,

A priority dental service for expectant, and nursing mothers and young children.

The bill transfers these functions from those minor authorities, such as non-county boroughs and district councils, who are now exercising them. County and borough councils are also made responsible for a complete midwifery service for mothers who are confined at home.

Midwives are to be employed either by the councils themselves or by voluntary associations with which the local authorities come to an arrangement.

Attendance at the confinement will not be made the general duty of the doctor in the general practitioner service; but the midwife will have the right and duty to call a qualified doctor in case of need. The general practitioner's services will, nevertheless, be available to the extent of general advice and care before and after confinement as at any other time.

Mothers who have their confinements in hospital or maternity home will be in the care of the hospital and specialist service. The object will be to provide locally all specialist obstetric or gynecological care which may be needed.

Health visitor service

Local health authorities must provide a full health visitor service for all in their area who are sick or expectant mothers, or those with the care of young children. This widens the present conception of health visiting, as concerned with mothers and children, into a more general service of advice to households where there is sickness or where help of a preventive character may be needed.

It is also made the duty of a local health authority to provide a home nursing service for those who need nursing in their own homes.

Compulsory vaccination is to be abolished, but local authorities must provide free vaccination and diphtheria immunization for anyone who wishes.

For the prevention of illness and the care and after-care of the sick, local authorities are given new power and when the Minister so requires, new duties. This can include the provision of special foods, blankets, comforts, and accommodation for invalids and convalescents, and the making of grants to voluntary organizations doing work of this kind.

Under the existing law, local authorities are empowered to provide home helps as part of their maternity and child welfare services. During the war this power was temporarily extended.

The bill makes this power permanent, and extends it to cover the provision of domestic help to any household in which it is needed on the grounds of ill-health, maternity, age, or the welfare of children. The local authority will be allowed to make an appropriate charge for this service.

Local authorities will be required to appoint statutory health committees, comparable with their education committees, who may be authorized to act on behalf of the parent authorities.

ADVISERS FOR MINISTER—ADMINISTRATION AID

The Minister is given sweeping powers against any local authorities or any of the bodies constituted under the scheme, which fail to carry out their duties satisfactorily. He can make an order directing them to do whatever may be necessary and then, if not satisfied, he may take over their functions, temporarily or permanently himself.

To advise him generally on the administration of the service, the Minister is to have beside him a central health services council. The members are to be doctors, dentists, nurses, and other professional people concerned with the different parts of the service, together with people having experience of hospital management, local government, and mental health services.

All will be appointed by the Minister after consultation with representative organizations. The presidents or chairmen of six of the principal medical bodies in the country are also to serve on the council *ex officio*.

The council will advise the Minister on its own initiative, and its annual report to the Minister will be laid before Parliament. Provision is also made for various standing advisory committees representing different technical aspects of the service.

Superannuation schemes

Existing superannuation schemes for local government employees are to be modified to secure the maximum interchangeability with other parts of the service. The general object, it is stated, will be to secure freedom of movement between the central and local services, and between the new and existing services.

Protection is given to officers of voluntary hospitals, insurance committees and local authorities whose functions are extinguished under the bill. They will either be reemployed in the new service or compensated.

The new service is to be financed mainly from the Exchequer and partly from local rates. The cost to the local authorities of the services in existence in 1938-39 was about £4,600,000. The local authorities' share under the bill will amount to £12,000,000, of which about half will be met by Exchequer grant.

A clause in the bill provides that the grant shall be weighted in favor of the poorer authorities who will receive grants up to 75 percent of their expenditure. The richest will get not less than 37½ percent.

"The transfer of the cost of the local authority hospital services," the white paper states, "together with other changes which are outside the scope of this bill, must profoundly affect the financial relations between the Exchequer and local authorities.

"The primary financial effect of the transfer of hospital services from local authorities will be to benefit the richer areas appreciably more generally speaking, than the poorer areas.

"Radical changes will be necessary in the general scheme of Exchequer grants-in-aid to local authorities, therefore to secure, over all, the policy of the government of concentrating these grants as far as possible where the need is greatest.

"The whole of this question is at present under consideration by the government with a view to the introduction of a reformed scheme by the time the new health service comes into operation."

WIDESPREAD REACTIONS

Representative comments on the white paper made last night were:

HOSPITALS

Remote control

G. G. Pauter, secretary of the Royal Northern Hospital, Holloway, N. W.: "With regard to the proposed regional hospital boards, there is nothing that nurses so dislike as remote control, which leads to regimentation and delay.

"There is nothing that is so personal as the hospital service. Unless it is nationalized in a way that continues to provide that intimate association between the staff and management, it will only be to the detriment of the service."

Sir Bernard Docker, chairman of the British Hospitals Association: "The Minister's proposals are so worded that they could bear various interpretations. No doubt, however, his intention is to absorb the voluntary hospitals in a state service, transforming them in the process into state institutions.

"It is not in the interests of the patient to eliminate all sense of local pride, interest and responsibility in the work of the individual hospital as must be the case if new local management committees are to be autocratically appointed and made responsible only for the minor day-to-day affairs of a number of institutions.

"In the interests of the patient, we stand by the constructive plan we have put forward which fully meets the requirements of a national hospital service free to all.

"If we understand the Minister's proposals aright, we hope that they will be opposed by all sections of the community who, with us, believe that sickness is a personal, intimate thing, and that, above all, the human touch must be preserved."

LOCAL AUTHORITIES

Pride of ownership

Lord Latham, leader of the London County Council: "The London County Council will lose its great system of municipal hospitals, which has been welded into a fine hospital service for Londoners, who are greatly attached to and rightly proud of them. They regard them as their hospitals, and so they are.

"The London County Council has devoted much thought and effort toward making these hospitals the finest in the world. It can, therefore, be appreciated with what feelings of regret we shall see them pass from us to the ownership of the state and to their administration by regional boards.

"The majority party of the council will support the main principles of the government's proposals as regards taking over all the public hospitals, voluntary and municipal.

"The council will, of course, insist that the interests of the people of London are fully safeguarded; that there is adequate representation drawn from the council on the proposed regional hospital boards and local hospital management committees, and that in the future administration of the hospitals the needs of the people of London are properly provided for."

DOCTORS

"Soulless control"

Dr. E. F. S. Gordon, of Harley House, N. W., speaking as an individual general practitioner: "The public are offered a scheme effacing all medical tradition which with the present numbers of doctors available cannot be efficiently carried out. A soulless control of patients and doctors is outlined without negotiation with the profession.

"The bill is a cunningly devised document by Ministry of Health officials. Compensation of a sort is offered the doctor for a lifetime of direction, but there is no mention of his hours of work or remuneration. Is he also to work a 40-hour week?"

An official of the Socialist Medical Association: "We warmly welcome the bill as a whole. We know the public is behind this measure, and while it must have careful consideration in the Commons and in the country, we hope to see it become law very speedily.

"We feel that the Minister has gone even further than need be in making concessions to existing interests and institutions. We shall give him our full support in resisting any attempt to reduce the effectiveness of the bill by any further concessions. The proposals in regard to the payment of doctors fall short of the policy we have advocated, and which the Labor Party has in the past accepted. We shall watch the basic system very closely indeed."

CHEMISTS

"Becoming civil servants"

Mr. H. Linstead, secretary of the Pharmaceutical Society of Great Britain: "Given 30 or 50 years, one can see the present pharmaceutical services of the country passing into the hands of local authorities or the Minister of Health, and one more group of the public becoming civil servants. That is the tendency which we fear.

"It is in this respect that we have difficulty with the Minister—state dispensaries in open competition with the shops. It may not be noticeable in the early days, but if state dispensaries are to be set up without any regard to the needs of an area the situation is going to become difficult.

"Chemists who have put much capital into businesses will be faced with local authority competition. That we must watch very carefully, because the new

scheme will involve twice as much dispensing by chemists as at present, and will entail larger premises and bigger staffs. At the moment we seem to have no guaranty of security."

OPTICIANS

Mr. G. H. Giles, president of the British Optical Association: "What strikes me is that as matters stand we shall not be on the executive council. In anything we do, however, we want to be constructive, not destructive. While wishing to safeguard ourselves, we are perfectly willing, and happy, to work within the National Health Service.

Dr. KENNEDY. May I complete the reading of my statement?

The CHAIRMAN. Yes. I was going to suggest that, Doctor. I am sorry to have interrupted you.

Dr. KENNEDY. In the English case, the standards were lowered by overworking primarily, and also economic needs as a contributing cause.

And as a logical sequence, there appears justice in our claim that governmental plans have not in Europe secured the benefits of improved public health.

In America, on our own initiative, handicapped as well by deficiencies of sanitation, of housing, of food, and of recreation, we have progressed and, with our accustomed methods of proving things, we hope to bring to every American the utmost in good health.

We approve and solicit governmental aid and support in securing better living conditions and will wholeheartedly support health education, wider sanitation, better housing, and all such measures as may aid in improving the public health and be outside the practice of medicine.

The CHAIRMAN. Thank you very much, Doctor.

Senator DONNELL. Mr. Chairman, there is one further question I would like to ask the doctor.

Doctor, have you observed what Government records doctors are required to keep in Germany and Great Britain?

Dr. KENNEDY. I have seen them in Germany, but I have not a very clear recollection of the precise forms. I have a rather clear recollection of some of the British forms, because I have seen them filled out under rather an amusing system if it had not been so potentially dangerous.

A record must be kept by the general practitioner working on the panel system of the case of every applicant and care, together with his illness. They occur in books which are made up in columns, and those records are inspected at fairly frequent intervals, and if they are not completely made up there are fines applied. I have seen the practitioner repeatedly, having the names kept in proper sequence, then fill in from memory the diagnoses which were absurd; and the statistics and reports from them were utterly erroneous.

Senator DONNELL. One concluding question, Doctor. Do you favor all in all S. 1606, or are you opposed to it?

Dr. KENNEDY. As a whole, or in part?

Senator DONNELL. As a whole. Well, I will put it entirely with respect to the compulsory health insurance feature of it set forth in title II.

Dr. KENNEDY. That particular portion of the bill, from my experience and beliefs, I do object to. There are parts of it referring to

better sanitation and better medical education and to the establishment of public hospitals for those unable to care for themselves and where the communities cannot do it; I am in sympathy with all those aims.

Senator DONNELL. But not the compulsory health insurance?

Dr. KENNEDY. The compulsory health insurance, with its necessary inevitable regimentation of medicine, I oppose.

The CHAIRMAN. But you would have no objection to the establishment of a voluntary system if it could be made to apply so extensively in the country as to bring down the costs of medical care so that everybody could get access to it?

Dr. KENNEDY. I am heartily in favor of it, and actively engaged and interested in the creation of a single facility for doing that.

The CHAIRMAN. A single facility?

Dr. KENNEDY. I am interested in one in Indiana.

The CHAIRMAN. I mean to say, would you be interested in some plan that the American Medical Association, with their vast power and influence, one voluntary system which would cover the whole country and give the people low insurance rates which would enable them to get everything we are seeking to get under this bill?

Dr. KENNEDY. I think that the needs of this vast country are such that it would be difficult to include within one scheme the needs of every section of the country, so I favor the State organizations, which may be fitted to their particular needs.

Senator DONNELL. Do you believe those State organizations could be so organized and operated on a voluntary prepayment basis as to solve these problems to the extent or better than the Government compulsory insurance would solve them?

Dr. KENNEDY. I do so think.

The CHAIRMAN. You think they could bring down the cost of medical care to such a degree that it would make it possible for everyone in the country to get adequate medical care at a very low cost?

Dr. KENNEDY. I believe so. I hope so, and am engaged in an effort to prove it.

The CHAIRMAN. Thank you, Doctor. We will meet tomorrow morning at room 104.

Dr. GOIN. May I add one statement to my statement?

The CHAIRMAN. Yes.

Dr. GOIN. The costs of voluntary insurance were mentioned in relation to the cost of Government insurance. I wanted to put in the record that the California Physicians' Service has undertaken to insure the California Grange, about 100,000 people, for \$62 per year for the family.

The CHAIRMAN. Complete medical care?

Dr. GOIN. With the restrictions I mentioned in my statement.

Senator DONNELL. 10 o'clock, Mr. Chairman?

The CHAIRMAN. 10 o'clock.

(Whereupon at 4:55 p. m., Wednesday, April 17, 1946, the committee adjourned to meet at 10 a. m., Thursday, April 18, 1946.)

NATIONAL HEALTH PROGRAM

THURSDAY, APRIL 18, 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, Pepper, Ellender, and Donnell.

The CHAIRMAN. The hearing will come to order.

The first witness this morning is Dr. Ernst P. Boas, chairman of the Physicians Forum, Inc. Dr. Boas, do you have a prepared statement?

Dr. BOAS. Yes, sir, Mr. Chairman; I have a statement I would like to present to the committee.

The CHAIRMAN. You may proceed.

STATEMENT OF DR. ERNST P. BOAS, CHAIRMAN OF THE PHYSICIANS FORUM

Dr. BOAS. I represent the Physicians Forum, a national organization of doctors who are interested in the improvement of medical care and in the dissemination of information on the subject among physicians and the public.

Our group, all doctors, counts among its members some of the country's most distinguished physicians, including a large number in private practice who have a first-hand knowledge of medical economics as it affects doctors and patients. Our membership also in private practice who have a first-hand knowledge of medical schools and are therefore familiar with the influence of these institutions on medical practice and the health of the public. All our members belong to the American Medical Association or to the National Medical Association. Therefore, I address you as a physician and on behalf of physicians.

ENDORSEMENT OF S. 1606

The Physicians Forum unequivocally supports the bill under consideration, S. 1606. As practicing physicians, we know better than any other group of fellow Americans the present deficiencies in medical care, the needless suffering and death constantly occurring throughout this land because of bad distribution and scarcity of doctors and hospitals in many communities. We know that many persons cannot afford to buy ordinary medical care, and that few can cope with the costs of catastrophic illness.

We know that many regions of this country cannot support the doctors and hospitals they need so badly. After searching inquiry we have reached the conclusion that national compulsory health insurance represents the only practical method to finance medical care and bring it within reach of all the people of the United States.

Ample factual evidence has been presented to this committee of the need for such a program. The availability of medical care depends today on how much the patient can pay, and in what part of the country he lives, not on his medical needs.

We believe that in a democracy adequate medical care is a right to which all citizens are entitled. This right is necessary for the enjoyment of all other rights and privileges, for sick people are not free people.

If we agree that medical care is a right to which all are entitled and that many cannot afford to buy it, it is clear that a large part of the money to pay for it must come from other sources. There is ample precedent to look to government to fill this gap, whether it be the local, State, or Federal Government. For years government has provided medical care for the indigent, and it has borne almost the total cost of the medical care of the mentally ill and of the tuberculous, because families are unable to bear the drain of such long-drawn-out chronic illnesses. Expenditures by government for public-health activities, for child and maternal health, and for veterans run into sizable figures. Today public agencies in the United States spend hundreds of millions of dollars of tax revenues for the support of medical facilities and services for the civilian population.

No one challenges the principle of the use of public funds for the prevention of disease. But the prevention of disease today involves much more than the old-line activities of the public health officer—sanitation and vaccination. Today the chronic, so-called degenerative diseases, such as the heart diseases, high blood pressure, diabetes, cancer, and chronic rheumatism, are the great hazards to life and health.

Their control and prevention involves the creation of complete facilities for early diagnosis and treatment, and making them freely available to all. People must be encouraged to consult a physician at the first intimation of a bodily disorder, and not wait, as unfortunately many do, until the disease has progressed to an advanced stage at which damage may be irreparable. The financial barrier that keeps patients from seeking medical advice must be eliminated.

Today we can no longer say, "This on one hand is preventive medicine, a proper function of Government; and this, on the other hand, is curative medicine, the function of the practitioner of medicine whose services must be bought in the open market." These two aspects of sickness control have become merged; preventive medicine begins with measures of personal hygiene and health examinations conducted by the medical practitioner. So it is a logical and natural step to turn to Government for funds to extend adequate medical care to all citizens of this country.

Because of the uneven distribution of wealth in the United States the Federal Government must assume responsibility. The increasing mobility of our population also makes it necessary that health plans be national in scope, so that the worker will not lose his benefits when he moves from one State to another.

Under the provisions of the bill, medical coverage would include upward of 90 percent of the entire population in one medical care program. This is as it should be, for the need for health insurance arises from the fact that the vast majority cannot afford to pay individually for adequate medical care.

It has been suggested by some that initially the coverage should be limited to a fraction of the population and that the benefits should be extended gradually as experience accumulates. Limitation of coverage to certain occupational groups or to geographic areas would be inequitable. Limitation by setting an income ceiling eligibility, say an income of \$3,500, would exclude only a small fraction of the population and would make administration of the act more difficult, not easier. The Physicians Forum approves the broad coverage proposed in this bill.

Much has been made, by opponents of this bill, of the point that this program adds over \$4,000,000,000 in taxes on a now overburdened taxpayer. This is not a true statement of the facts. Before the war, the Nation as a whole spent about \$4,000,000,000 a year on medical care, so that the cost of the proposed medical care program will not be significantly higher. It is not all new money that has to be raised over and above present expenditures.

The administrative and organizational features of the bill are well conceived. Quite properly the Surgeon General of the United States Public Health Service is the administrator. The opponents of this legislation have raised the cry that the Surgeon General would become the "medical dictator" of the Nation. Nothing could be further from the truth.

The bill provides that he is responsible to the Federal Security Administrator. Of equal importance is his responsibility to the National Advisory Medical Policy Council. This Advisory Council is not, as some have maintained, without power or responsibility. The bill specifically provides that in matters of policy, and in most important matters, the Surgeon General can act only after consultation with the Advisory Council, any four members of which may call a meeting.

Public airings of the opinions of the Council are assured by the provision that the Surgeon General in his regular reports to Congress must include a report of his consultations with the Council along with its recommendations. Thus the Council will have real responsibility and power to advise and make its views known. The cry of "dictator" is being supported by those of the medical profession whose dictatorial control of the medical policies of the country is being threatened.

It is also falsely charged that all details of medical care would be run from Washington by a horde of bureaucrats. Once more the provisions of the bill itself give the lie to this argument. Actually all that the Federal Government would do is what is necessary to the success of any national plan—collect the money and set up minimum standards to be followed by all doctors and hospitals. Decentralization of administration is assured by the instruction that the Surgeon General utilize as far as possible the services of State and local advisory and technical committees to advise in administration.

The bill does not affect the present set-up of medical practice. Doctors may refuse patients, patients may choose doctors. Unfortunately, even the fee-for-service system of payments to practitioners is allowed if practitioners so elect.

We say "unfortunately," because it is an accepted fact based on experience, that no health insurance plan has been able to function with fullest efficiency under the fee-for-service system. It creates a huge amount of paper work for physicians and the administration, and it leads to inevitable abuse by doctor and patient. We predict that physicians will be the first to repudiate this method of payment.

The section of the bill that provides a substantial appropriation for both research and professional education is laudable. Without the continuous leaven of research and education the practice of medicine quickly withers and becomes a mediocre routine. The best medicine today is practiced in our university hospitals where teaching and research go hand in hand with the care of the sick.

EFFECT OF THE BILL ON DOCTORS

We are physicians and it is natural for us to ask the question: "How does compulsory national health insurance affect us? Granted the public has everything to gain from this measure, what about us?"

The physician today is a spilt personality. He is a combination of a professional man and a small businessman. These dual activities often conflict with one another, to the doctor's distress and patient's disadvantage.

All too often the physician is prevented from giving his patient the benefit of the full resources of medicine because the patient cannot afford the expense of the procedures involved. The doctor is unable to practice medicine in the way he wishes and in the way it should be practiced. At present, all doctors are very busy and very prosperous. They forget that only a few years ago 60,000 doctors who are now being released from the armed services were competing with them for patients, and that a large number of these patients had no money. In 1936 the median net income of physicians was \$3,234; in 1938, \$3,027, and in 1940, \$3,245. Compulsory health insurance will stabilize the income of doctors over the years, and in fact will increase the incomes of the majority. It has been estimated that general practitioners under the plan will earn about \$8,000 a year gross and specialists about twice as much from the insurance practice aside from private practice.

Most physicians enter and remain in the field of the practice of medicine because they derive a sense of satisfaction from the prevention and alleviation of sickness. Under this bill the physician will find his relationship with his patients unimpeded by economic barriers. No longer will the problem be whether the patient can afford the treatment the physician thinks is necessary. No longer need the physician hesitate to call for the complete working up of any case, regardless of cost. No longer need the patient wait until the disease becomes acute before consulting the physician. For the first time, preventative and curative medicine can come into its own on the largest possible scale.

The Physicians Forum is gratified by the provisions in the bill authorizing cooperative groups of physicians to give services under the plan. The application of the national compulsory health insurance principle will solve the economic problem involved in the provision of medical care to all, but it would be a grave mistake to believe

that all problems of medical care will be solved when the economic basis alone is assured. Professional and technical medical considerations determine the adequacy of medical care, whether paid for by an insurance fund, by governmental, philanthropic or private enterprise. The record of the various compulsory health insurance schemes in Europe demonstrates that an economic solution alone is not the whole answer. A health insurance scheme must be based consequently on the principle of cooperative group practice.

Group practice offers many advantages to doctors and patient. It cuts down overhead expense—rent, secretarial and nursing help—it eliminates duplication of expensive laboratory equipment, and makes it possible to use such equipment to capacity. This saving can be passed on to the patient who can thus obtain the best diagnostic and therapeutic services for at least 30 percent less than if he had to visit many individual doctors' offices, each one fully equipped but utilized only part of the day.

But there is a much greater merit to the plan. When a group of doctors work together, examine the same patients, and discuss the many problems that arise in the daily practice of medicine, they are constantly teaching and stimulating one another. Each physician is learning something daily from his colleagues, and is ever stimulated to his best performance. If such group practice is made available by means of a prepayment plan, whereby the patient is entitled to all of the facilities of the clinic that are needed in his particular case, without having to pay separately for each item, it makes possible much better medicine.

The bill permits the Surgeon General to make contracts with hospitals for complete medical services, and so enables the present excellent university and voluntary hospitals to serve the insured public. Funds designated to pay for physician's services, however, are not earmarked. It is important that the amounts allocated for hospital care and for professional services be separated; else it might lead to exploitation of the physicians by the hospitals.

Additional provisions are needed in the bill to safeguard the physicians' rights and privileges. There should be some specific provision assuring that the income of physicians will conform on the average to levels at present current in more prosperous communities of the United States, with due consideration to the fact that income levels should actually be somewhat higher than they are today, because the physician will be paid for much of the work he today does without compensation. There should be provisions enabling the physician to pursue postgraduate study, and to take appropriate vacations without loss of income.

To bring good medical care to the country at large, to make group practice possible, and to provide for the needed extension of public health and preventive services, fully equipped health centers, smaller general hospitals, and large general hospitals must be established throughout the country. It would be impossible to make intelligent plans for a Nation-wide medical care program, as provided for in this bill, without making provision for needed hospital facilities. These, of course, we know are being planned for in the Hill-Burton bill which is now before the Congress.

SHORTCOMINGS OF VOLUNTARY PLAN

Many have cherished the hope that voluntary sickness insurance plans might fill the need. Even the conservative organized medical profession has accepted the principle of voluntary health insurance, provided the organization furnishing such protection is governed and controlled by physicians.

These plans are essentially medical expense indemnity insurance, much like accident and sickness insurance one can buy from a commercial insurance company. They are schemes to reimburse the patient for the costs of medical care provided through physicians. They give the patient a certain protection against the cost of catastrophic illnesses, but do not assure him adequate medical care. They guarantee the physician payment of certain of his bills, but do not make it much easier for him to provide the best medical service to his patients.

The cash indemnity plans strike at only one of the several weaknesses in the current medico-economic set-up, the unpredictability of heavy medical expense. Experience has shown that medical insurance, to be practical and to provide adequate medical service, must cover all elements of medical care, and must be of a service rather than of an indemnity character. It must be a prepayment plan for medical services. The patient pays a certain sum annually, and for this receives complete medical coverage, for general practitioner, specialist, laboratory, hospital and preventive services.

But even when doctors are paid by salary or by a capitation scheme, i. e. a certain sum annually for each patient on their panel, voluntary insurance against sickness is not cheap; the charges must be from \$25 to \$30 per person per year. For a family of four, this amounts to about \$120 a year. For low-income families, for those with incomes below \$2500, this is far too expensive. The other necessities of life at these income levels are too demanding; prepayment for illness is put off in the hope that illness will not strike. Even the American Medical Association has published an analysis in which it has stated that families with family incomes of \$3,000 or less, are unable to purchase complete medical care.

For all of these reasons the protection offered by voluntary sickness insurance in this country is minute in comparison to the need. A mere handful have complete medical coverage, and, even if one adds thereto those with partial insurance of an indemnity nature, hardly 5 percent of the population of the country are covered. In this the experience of the United States reflects the experience of other countries more advanced in the organization for the distribution of medical care; voluntary plans fall far short of meeting the needs of the country.

We approve of the section of the bill which provides increased grants to States for public health services. The present system of grants-in-aid and cooperation between the United States Public Health Service and the States in the promotion of public health services has been very successful, but limited in scope. Under the provisions of the bill it will be possible to expand these programs rapidly, and in particular to help those States that are in greatest need.

The section providing increased grants to States for maternal and child health services is admirable and the Forum approves an expansion of these services. However, if we are to have a national health insurance program, as called for in title II of this bill, care should

be taken to prevent any overlapping of services. As President Truman pointed out in his message to Congress:

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.

Maternal and child health services should be limited to community-wide services on the basis of filling any need not covered by National Health Insurance, and the program should be carefully integrated with the overall plans for health and medical services. Despite the Children's Bureau's enviable record of solid achievement in its present maternal and child health program, it would nevertheless seem desirable to coordinate this program with the general health services under the direction of the Federal Security Agency, or of a Cabinet official.

We endorse the provision for medical care of needy persons. However, the Forum strongly disapproves of the use of Federal grants-in-aid for direct payments to patients for medical care—a method too easily abused, perhaps by failure of the patient to use the payment for medical purposes. The only sound method of supplying medical care to relief cases is by grants the proceeds of which are used to insure such people under the National Health Insurance Fund.

The essence of the arguments presented by the opponents of this bill is that it would bring about a system of State medicine or socialized medicine. What is this great bugaboo we have been taught to fear? The terms as used today have an emotional, not a factual connotation; they are catchwords employed to arouse emotional resistance to plans to improve or change the methods of distributing medical care.

ATTITUDE OF THE AMERICAN MEDICAL ASSOCIATION

Chief among those opposed to national compulsory health insurance is the American Medical Association and its satellite the National Committee of Physicians. The American Medical Association has always opposed public action in any field of medical care, except in the case of the indigent. It is common knowledge that it opposed the establishment of workmen's compensation insurance, of the Blue Cross hospital insurance plans, and until recently it relentlessly fought plans for voluntary medical care insurance. It is instructive to review the minority report prepared by representatives of the American Medical Association who were on the committee on the costs of medical care. They wrote:

The minority recommends that government competition in the practice of medicine be discontinued * * * The minority recommends that government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden.

They then go on to say:

Nothing has been made clearer than the fact that voluntary insurance schemes have everywhere failed. It seems clear, then, that if we must adopt in this country either of the methods tried out in Europe, the sensible and logical plan would be to adopt the method to which European countries have come through experience, that is, a compulsory plan under governmental control.

Senator DONNELL. That is a minority report, is it not, Doctor?

Dr. BOAS. Yes, there was a large group of representatives of the American Medical Association on the committee on the costs of medical care, and they disapproved of the majority report and presented their own minority report, and this is an extract from that.

The CHAIRMAN. Was that minority report subsequently brought to the house of delegates of the American Medical Association?

Dr. BOAS. I do not know that, Mr. Chairman.

In the light of these historic facts, the present tactics of the American Medical Association in opposing national compulsory health insurance and in advocating voluntary plans under its own management seem somewhat disingenuous. It has already been shown that there is no basis for its chief claims that the practice of medicine will be regimented, that the personal relationships between doctor and patient will be destroyed, that there will be no free choice of physician, that the quality of medical care will deteriorate.

The American Medical Association is in fact serving as a guild battling to retain the economic privileges of the medical profession. In this campaign it has allied itself with businesses that are purveyors of commercial aspects of medical care—with pharmaceutical houses, makers of surgical instruments and appliances, and certain insurance companies—and through the agency of the National Physicians Committee has obtained substantial funds from these sources to carry on its propaganda.

While the American Medical Association accepts and encourages the business transformation that the modern industrial era has brought about in the practice of medicine, the Physicians Forum recognizes the evils that this change has entailed, their destructiveness to the medical profession, and their harm to the patients whom it serves. Through such a national health program as is proposed in S. 1606 most of the financial handicaps that have prevented the extension of good medical care to all citizens will be lifted, and physicians will be free to rededicate themselves fully to the prevention of disease and the treatment of the sick.

We urge favorable action on this bill. America now has its greatest opportunity before it—the opportunity to safeguard and improve the national health. As a nation we have learned the importance of good health of all our citizens, and are realizing that we cannot afford to leave the health of our people to the chance that they may have sufficient income to command modern medical care; or to expose them to the disadvantages that their race, their color, their occupation, or their residence in a less favored economic community may bring about.

Doctors must be given the opportunity to employ the complete resources of modern scientific medicine and place them at the service of all our people.

The CHAIRMAN. Doctor, you have mentioned the National Physicians Committee. Will you tell us what the National Physicians Committee is, and how it was set up?

THE NATIONAL PHYSICIANS COMMITTEE

Dr. BOAS. The National Physicians Committee is an outgrowth of Mr. Gannett's Committee on Constitutional Government. Originally, I have forgotten when, I think in 1939, he called together a large number of physicians and urged them to establish such a committee, to back his general policies. Out of this grew the National Physicians Committee.

The CHAIRMAN. Are these physicians members of the American Medical Association?

Dr. BOAS. Yes, most of them. I think all of the officers of the National Physicians Committee are prominent members of the American Medical Association. The house of delegates of the American Medical Association in repeated resolutions has approved of the activities of the National Physicians Committee.

The CHAIRMAN. They have approved it?

Dr. BOAS. Oh, yes.

The CHAIRMAN. Well, many member of the American Medical Association repudiate any connection with the Physicians Committee, they disclaim any knowledge of it in many instances, and claim that the American Medical Association has no connection whatever with it.

Dr. BOAS. They have no legal connection.

The CHAIRMAN. But prominent members of the American Medical Association who are opposed to this bill are also interested in the Physicians Committee, is that the connection?

Dr. BOAS. That is the connection, and I am quite certain that they work in sympathy and in harmony with one another. I am sorry I have not got the resolutions here with me, but very recently, the house of delegates passed a very laudatory resolution praising the work that the National Physicians Committee was doing.

The CHAIRMAN. Have you seen some of the literature that the National Physicians Committee has put out in this country?

Dr. BOAS. Yes, I have.

The CHAIRMAN. I notice that one pamphlet that they have circulated refers to S. 1606 in the following language:

It would entail the most vicious and dangerous aspects of socialized medicine.

What do you think of that charge?

Dr. BOAS. Well, I think that those are just words. I think that we must agree first of all what we mean by "socialized medicine." As I understand socialized medicine, it is a system whereby the Government operates all hospitals and all medical facilities, and employs all doctors and nurses and other health workers on a salary, and pays for this out of tax funds and that every citizen of the country has a right to free medical care. That is what I would call socialized medicine. Of course, nothing like that at all is proposed.

The CHAIRMAN. Do you find anything in this bill which is before the committee, S. 1606, which could be called vicious or dangerous?

Dr. BOAS. No.

The CHAIRMAN. The National Physicians Committee, also, in one of its pamphlets says that the bill reveals a remarkable mixture of unimportant verbiage intended to divert attention or deceive. What do you think of that statement in this pamphlet issued by the committee?

Dr. BOAS. I would interpret that as unimportant verbiage intended to deceive.

The CHAIRMAN. The National Physicians Committee states that the enactment of the bill, and I quote—

would destroy the practice of medicine in the United States, practically, it would make all expectant mothers, all mothers and children to the age of 21, wards of the State.

What do you think of that charge?

Dr. BOAS. I do not see any substance to it whatsoever.

The CHAIRMAN. You have seen some of these pamphlets that they have circulated, I assume you have, Doctor?

Dr. BOAS. I have.

The CHAIRMAN. Do you consider them as mere propaganda, intended to deceive the people of the country and the medical profession on the real purposes and intent of this legislation?

Dr. BOAS. That is what they undoubtedly are, and it may be interesting for you to know that many physicians who may not approve of the compulsory health insurance, nevertheless strongly disapprove of these pamphlets and the activities of the National Physicians Committee, because they recognize that they are not factual.

The CHAIRMAN. In another pamphlet that they have issued, entitled "Political Medicine," they had this to say:

The political distribution of medical care would entail making a public record of the characteristics of the most intimate and sacred personal relationships of each and every patient.

Do you agree with that statement?

Dr. BOAS. That is certainly a false statement. First of all, in every State there are State laws regarding the privileged communications between doctors and patients, and under National Health Insurance, these laws would not be waived. There is nothing in the bill that provides for any publicity of the records or for any inspection of the records, and certainly there will be no manner in which the sacred personal relationship between doctor and patient would be disturbed.

The CHAIRMAN. Doctor, you have examined many of the voluntary insurance plans that have been circulated around the country?

Dr. BOAS. I am acquainted with a fair number of them.

VOLUNTARY INSURANCE

The CHAIRMAN. What do you think of the possibility of ever developing voluntary insurance systems in this country which would meet the problem of enabling the average American citizen to get medical care at reasonable costs?

Dr. BOAS. As I pointed out in my testimony, I think the chances of voluntary insurance giving substantial coverage to our people is almost nonexistent. It is perfectly true that in certain limited areas and in certain industries voluntary plans have done pretty good jobs, but they have been very few.

Voluntary insurance plans, if they are to give complete coverage, such as is planned in bill 1606, are far too expensive for the average person. At present, only about 5 percent of our people are covered by voluntary insurance plans, and most of these are very partial coverage, only for surgical operations or obstetrical care or something of that sort. I think the experience has been of long enough duration, both in this country and other countries, to show that the voluntary plans do not fill the bill.

The CHAIRMAN. The experience in other countries has been that voluntary health insurance does not fill the bill?

Dr. BOAS. That is right.

The CHAIRMAN. Both the British Medical Association and the Canadian Medical Association have come to that view, is that true?

Dr. BOAS. That is correct, sir.

THE ADVISORY COUNCIL

The CHAIRMAN. What is your opinion of the provisions of this bill, in relation to the advisory council that it proposes to set up?

Dr. BOAS. Well, as I tried to point out, I think that the proposed plan of organization of the advisory council is a sound one. The Surgeon General is instructed to consult the council before taking action on most vital matters. The council can call meetings of its own at the request of four members, and the Surgeon General must report to the Congress what the recommendations of the council were and why he disagreed with any of them, if he did. I understand this particular technique is an accepted form in other branches of government and that it has worked well. So I think there is every reason to suppose that the advisory council as planned will be very useful.

The CHAIRMAN. You do not think, then, that under this bill the Surgeon General could set himself up as a dictator and interfere with the doctors of the country in their practice?

Dr. BOAS. I am certain that he could not, and I am sure, of course, that you gentlemen in Congress know much more about this than I, because after all, the Surgeon General has to come to you every 2 years for appropriations, and if he has conducted affairs in a high-handed manner, I think that he will find himself in trouble.

The CHAIRMAN. Do you know the present Surgeon General of the United States?

Dr. BOAS. Yes, sir.

The CHAIRMAN. What is your opinion of him, of his reputation as having been efficient and effective?

Dr. BOAS. He is widely known as an exceptionally able and high-minded and competent physician.

The CHAIRMAN. And he has the confidence and respect of the medical profession to a very high degree?

Dr. BOAS. He certainly has.

The CHAIRMAN. And you do not think that he could in any manner turn himself into a dictator if this bill was passed?

Dr. BOAS. He could not, and I do not think that he could even if he tried to.

The CHAIRMAN. Because under the provisions of the bill, his power and authority to interfere with the practice of medicine is pretty well protected?

Dr. BOAS. It is.

The CHAIRMAN. Thank you, Doctor.

Any questions, gentlemen?

Senator ELLENDER. Where do you practice?

Dr. BOAS. In New York City.

Senator ELLENDER. How long have you been practicing there?

Dr. BOAS. I was licensed in 1914, and after my hospital internship, I entered practice for a year and then entered the Army in the last year, and was in the service for 2 years, and then I entered practice again, and then I was director of a hospital for 8 years, and I have been in private practice of medicine again since 1929.

Senator ELLENDER. You were born in this country?

Dr. BOAS. I was.

Senator ELLENDER. You received your education in New York City?

Dr. BOAS. I got my education at the College of Physicians and Surgeons in Columbia University.

Senator ELLENDER. What is the membership of the Physicians Forum?

Dr. BOAS. Approximately 1,000.

Senator ELLENDER. I notice that you say that all of the members of that group belong to the American Medical Association or to the National Medical Association.

Dr. BOAS. That is right.

Senator ELLENDER. How many of that group belong to the American Medical Association?

Dr. BOAS. I cannot tell you for certain, but I imagine that we have only about 40 or so who belong to the National Medical Association.

Senator ELLENDER. To the National Medical Association?

Dr. BOAS. Yes, sir, that is the Medical Association of the Negroes. The reason we have that provision is that doctors can only join the American Medical Association only through their county societies. In the North, Negroes are admitted to county societies so they can join the AMA. In the South they cannot and so they are unable to join the American Medical Association. So that is why we have that provision.

Senator ELLENDER. So that of your entire membership, that is of the Physicians Forum, practically all of them belong to the American Medical Association?

Dr. BOAS. That is right.

Senator ELLENDER. When was that formed?

Dr. BOAS. In 1939.

Senator ELLENDER. For what purpose?

Dr. BOAS. It was formed for study. It was called the Physicians Forum for the Study of Medical Care. When the organization was formed, we had no preconceived notions as to the answers. We knew that we were very much dissatisfied with many aspects of medical care, and we met originally as a study group. It was only after a number of years of exploration and study that we finally came to the conclusion that national compulsory health insurance was the logical answer to these problems, and I think it was in 1943 at a membership meeting that the association voted to support that in principle, and also at that time, to support the first Wagner-Murray-Dingell bill.

Senator ELLENDER. That is what I was coming to. To what extent did your group help in perfecting the legislation we now have under consideration?

Dr. BOAS. Well, we presented analyses of the first Wagner-Murray-Dingell bill, criticizing various aspects of it, and sent them here to Washington to the Senators, and to the Social Security Board, and we had a number of subsequent conferences with them about certain details, and some of our recommendations were accepted and some were not. I have for the record a copy of an outline analysis of S. 1606 prepared by our group.

(The outline is as follows:)

[The Physicians Forum, Inc., 510 Madison Avenue, New York 22, N. Y.]

OUTLINE AND ANALYSIS OF THE WAGNER-MURRAY-DINGELL BILL, S. 1606, H. R. 4730

The Physicians Forum, after searching inquiry, reached the conclusion in 1943 that Federal health insurance represents the only present practical method

to finance medical care and bring it within reach of all the people of the United States. Accordingly it supported the health and medical features of the Wagner-Murray-Dingell bill of 1943. A detailed analysis of this part of the bill was made, and constructive criticisms for its improvement were offered to its sponsors. Many of the suggestions offered by the Physicians Forum and by other organizations that gave thoughtful consideration to the bill were incorporated in a subsequent draft.

A new bill, Senate bill 1606, has been introduced into the Senate by Senators Wagner and Murray, and into the House of Representative Dingell (H. R. 4730). The new bill is devoted to the establishment of a health insurance plan designed to supply nearly complete health and medical care to individuals and their families throughout the country. In addition, more funds are made available for public health services; for maternal and child health care, including services for crippled children; and for medical care of needy persons.

Several important features of the bill warrant emphasis because of the fallacious statements that have been made about it.

A very adequate system of checks and balances in administration has been established. The Surgeon General is advised by a National Advisory Council representing the professions rendering services and the public. The decisions of the Surgeon General are subject to the approval of the Federal Security Administrator.

Local autonomy and control is strongly emphasized and provided for in the bill. Only financing and over-all policy are formulated on a strictly national basis. It is definitely stated in the provisions for all of the health programs called for in both titles of the bill that national administrators are to have no authority over the selection, tenure of office, or compensation of local personnel employed on a merit basis according to established standards. Nor shall there be any national control over the administration, personnel or operations of participating hospitals and institutions.

The administrative costs as well as the total costs would be small considering the benefits. Experience with the social security system has demonstrated the efficiency of operation and low administrative cost of this branch of the Government. The total money to be utilized for medical services assured in the bill is approximately the same as the American people spend today for these same services.

All people will have free choice of physicians, and physicians under the plan can accept or reject patients and can practice outside the plan as well as under it if they so choose. As a matter of fact, private practice will be greatly increased because millions of people now attending public clinics will, through health insurance, become private patients.

The Wagner-Murray-Dingell bill provides the best method for protecting and preserving the health of our nation. The passage of these provisions is essential to the well-being of the United States in the coming years.

The bill has two titles:

Title I: A. Public health services; B. Maternal and child health services; C. Medical care for needy persons.

Title II: Prepaid personal health service benefits.

TITLE I

Increased grants to States for public health services

This part of the bill is an amendment of section 314 of the Public Health Service Act of July 1, 1944. The subsections concerned with grants for the venereal disease and for the tuberculosis programs are unchanged. Those dealing with general public health work provide Federal cooperation with the States and coordination of various health programs to achieve as rapidly and as economically as practicable the development of adequate public health services in all parts of the country. The present authorization of \$20,000,000 a year for grants to States is replaced by an authorization to appropriate a sum sufficient to carry out the purpose.

To receive Federal grants for public health services the States are required to develop their own plans and to submit these plans for approval. The proportion of grants to States is determined by an explicit formula, designed to give relatively more aid to the poorer States and less to the richer States. Federal grants range from 50 to 75 percent of the total expended under the approved State programs. Grants must be approved by the Surgeon General if they meet the requirements specified in the law. Programs must be State-wide in scope by 1949.

Comment

The present system of grants-in-aid and cooperation between the United States Public Health Service and the States in the promotion of public health services has been very successful, but limited in scope. Under the provisions of the bill it will be possible to expand these programs rapidly, and in particular to help those States that are in greatest need. We approve of this section.

Increased grants to States for maternal and child health services

This section makes more elastic and adequate provisions than the existing programs for each State to extend and improve services and facilities for maternal and child health and for crippled children. As in the case of grants for public health, States develop their own plans in accordance with their needs. These must conform to certain basic requirements to insure reasonable standards, systematic and efficient financing and administration, extension of the services to all parts of the States within 10 years and availability to all mothers and children in the State. Demonstration services and personnel training are to be developed under the State plan. The Chief of the Children's Bureau is the responsible administrator who must approve all plans. Federal grants would be on a variable basis, so as to give special aid to the poorer States. Federal grants would range from 50 to 75 percent of the total expended under the approved State programs. Wide latitude is left to the States as to the scope and content of the programs. No specific appropriations are made, but expenditures necessary to carry out the program are authorized.

In addition an appropriation of \$5,000,000 is made to the Children's Bureau during the first year to make special studies and investigations to promote efficiency in this program, to establish policies in consultation with advisory committees, to make and publish rules and regulations and to coordinate Children's Bureau activities with those of the Public Health Service and the Social Security Board. In subsequent years the appropriation is to be a sum sufficient for these purposes.

Comment

The purpose of this section of the bill is admirable, and the forum approves an expansion of services. However, if we are to have a national health insurance program, as called for in title II of this bill, care should be taken to prevent any overlapping of services. As President Truman pointed out in his message to Congress: "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." Maternal and child health services should be limited to community-wide services on the basis of filling any need not covered by national health insurance, and the program should be carefully integrated with the over-all plans for health and medical services. Despite the Children's Bureau's enviable record of solid achievement in its present maternal and child health program, it would nevertheless seem desirable to coordinate this program with the general health services under the direction of the Federal Security Agency.

Medical care of needy persons

This section provides Federal grants-in-aid to States for medical care of needy persons. The grants range from 50 to 75 percent of the total expended, depending on the State's per capita income. An appropriation of \$10,000,000 is made for the first year, and for each year thereafter a sum sufficient for the purposes. Federal grants are made after approval by the Social Security Board. State plans to be approved by the Board must be in effect in all parts of the State, must be efficiently administered by a single State public assistance agency and must include no citizenship or residence requirement.

Medical care may be provided through money payments to claimants or through payments to those furnishing the care or by direct provision of such care. The State may arrange with the Surgeon General to make equitable payments into the personal health services account and thus supply medical care to the needy under the national health insurance plan as set up under title II of this bill.

Comment

At present States receive no grants for medical aid for general relief cases. Federal grants of 50 percent of the State and local expenditures, up to a fixed maximum regardless of the financial capacity of the State and the locality, are at present provided in assistance for the needy aged, the needy blind, and dependent

children. More specifically, Federal grants are made only for amounts paid unconditionally to the relief recipient or his guardian. The requirement of a direct grant and a monthly maximum limit greatly the effective provision of medical services for indigent groups.

The new bill removes these limitations. It permits Federal grants for all indigent groups, it removes the maximum, it makes larger grants to States with per capita income below the national average, it provides grants for medical care whether it is paid for by cash grants to the recipient or directly to those furnishing these services. In fact, it allows the States and localities to contract with the insurance program to provide medical services to indigent individuals—who are not insured under the prepaid medical service plan—on the same basis as for the insured and their dependents. If the latter course is followed the invidious distinction of charity patients will be abolished, physicians will give the same care to all and will receive like compensation for all groups of patients from the insurance fund. The number of pay patients to be cared for by private physicians will thus be increased.

The forum strongly disapproves of the use of Federal grants-in-aid for direct payments to patients for medical care—a method too easily abused, perhaps by inadequate payments, perhaps by failure of the patient to use the payment for medical purposes. The only sound method of supplying medical care to relief cases is by grants the proceeds of which are used to insure such people under the national health insurance fund.

TITLE II—PREPAID PERSONAL HEALTH SERVICE BENEFITS—NATIONAL HEALTH INSURANCE

Coverage

All individuals are to be considered insured for medical care if they have been employed and have been paid not less than \$150 in the base year. Coverage is also extended to all legal dependents of such employed persons. All retired and survivor beneficiaries under the Social Security Act are entitled to receive personal health service benefits. Employed persons are to be considered insured irrespective of citizenship or residence. Coverage for medical care under this bill extends beyond the groups now benefiting from the Social Security Act. Included are all persons in industry and commerce, agricultural and domestic workers, seamen, employees of nonprofit institutions (except ministers and members of religious orders), and self-employed persons such as small businessmen, farmers and professional persons. Not included are those employed—and covered by existing pension systems—by the United States Government, by a State or in any service exempt from income tax. States may enter into contracts with the Surgeon General to make the medical care program available to the unemployed needy.

Comment

Under the provisions of the bill, medical coverage would include upward of 90 percent or more of the entire population in one medical care program. This is as it should be, for the need for health insurance arises from the fact that the vast majority cannot afford to pay individually for adequate medical care. American Medical Association figures show that 75 percent of all American families need financial assistance to pay for any serious illness.

It has been suggested by some that initially the coverage should be limited to a fraction of the population and that the benefits should be extended gradually as experience accumulates. Limitation of coverage to certain occupational groups or to geographic areas would be inequitable. Limitation by setting an income ceiling eligibility, say an income of \$3,500, would exclude only a small fraction of the population and would make administration of the act more difficult, not easier. The forum approves the broad coverage proposed in the bill.

Personal health services account

The bill calls for the creation, by the United States Treasury, of a personal health services account and authorizes appropriations to finance the medical care benefits. From the appropriations, the Secretary of the Treasury is to credit to the account the equivalent of 3 percent of all wages up to \$3,600 a year, as well as certain additional amounts spent for special health benefits and for administration. The bill does not state how these sums are to be raised, but leaves this decision up to Congress. Previous drafts of the bill, however, have

called for equal payments by employer and employee on a social-security basis, with supplementation from general tax funds.

Comment

Today the Nation as a whole spends \$4,000,000,000 a year on medical care. The total amount expended for compulsory health insurance will not be significantly higher than this aggregate amount. The advantage would be that persons would not be called upon as individuals to meet the heavy obligations imposed by the need for medical care, and they would feel free to seek medical services as soon as needed.

The forum believes that it would be sound policy for Congress to legislate a distribution of national health insurance costs between employer and employee, with supplementation from general tax funds, as called for in earlier drafts of this bill. With the worker and employer contributing directly to the cost of social insurance they would be more apt to take an interest in the proper administration of the whole program. Such direct payment by the persons benefiting would take medical care out of the realm of charity, with which public medicine has been stigmatized, and would make it a right. As in existing social security legislation the employer would contribute an equal amount. The benefits to the employer, derived from proper care for the health of his employee, are well recognized. If additional provision were made for appropriations by the Federal Government out of general tax funds, it would safeguard the program, give it a certain elasticity and allow for some experimentation.

Benefits

All insured persons and their dependents are entitled to the service of a general practitioner in home, office, or hospital; services of specialists and consultants; complete laboratory services including X-ray and physiotherapy; special medical appliances, including eyeglasses; hospitalization; general and special dental services, and home nursing.

Limitation on benefits.—The Surgeon General, after consultation with the National Advisory Medical Policy Council and with the approval of the Federal Security Administrator, may require that for any calendar year the patient pay the physician, dentist or nurse a fee for the first service or for each service in a period of sickness. Such decision shall be made only when it becomes necessary to prevent or reduce abuses, but the maximum size of such a fee shall not be so great as to interpose a substantial financial restraint on proper care. Such fees may be limited to home calls, to office visits or to both. Each such determination shall be withdrawn as rapidly as practical.

In the same manner, if personnel is inadequate the dental benefits may be restricted provided that after July 1, 1947 they shall include at least: (1) examination including X-ray and diagnosis; (2) prophylaxis; (3) extraction of teeth which may be injurious to the general health of the individual; (4) treatment of acute diseases of the teeth, their supporting structures and adjacent parts, including fractures of the teeth or jaws. Complete dental care may be provided to children under a specified age. Home-nursing benefits may be limited to part-time care, or by limitation of cases, or by limitation of maximum service per case as may be practicable and necessary. Similarly the laboratory benefits may be curtailed if funds become inadequate.

Comment

The provision that, if it should become necessary to prevent abuses, the patient may be required to pay a fee for the first service or for each service in a period of sickness is unfortunate. Should this ever be applied it would set up a financial barrier between the insured person and the doctor, a barrier which health insurance is supposed to remove. It would tend to delay early recognition and treatment of disease. It would offer financial inducement to the physician to increase the number of his visits. If abuses arise that threaten the integrity of the insurance fund, it is better that they be regulated by the operation of local committees on which physicians are fully represented. A possible limitation of laboratory, dental and nursing benefits is also unfortunate, but may become necessary until more administrative and actuarial experience has become accumulated and more professional personnel is available.

Administration of personal health benefits

The Surgeon General of the United States Public Health Service administers the technical and professional aspects of the program, under the supervision and direction of the Federal Security Administrator. He is required to consult

with the National Advisory Medical Policy Council as to questions of general policy and administration, and with the Social Security Board in regard to health legislation and methods of providing personal health service benefits most effectively.

The National Advisory Medical Policy Council consists of the Surgeon General as Chairman, and 16 members to be appointed by the Surgeon General with the approval of the Federal Security Administrator. The members shall be selected from panels of names submitted by 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 in the need for medical, dental, nursing, hospital, laboratory, or related services. It is to include medical and other professional representatives, and public representatives in fair proportions. Members are appointed for a term of 4 years and are arranged in four classes so that four members are appointed every year. Members receive compensation at the rate of not more than \$25 a day and travel and subsistence expenses for the time devoted to official business.

The advisory council shall meet at least twice a year and whenever at least four members request a meeting. It and its members shall be provided with adequate clerical and secretarial assistance. It shall advise the Surgeon General with reference to questions of general policy and administration including: (1) professional standards of quality; (2) designation of specialists and consultants; (3) methods to encourage the attainment of high standards through coordination of the services of physicians and dentists with those of educational and research institutions, hospitals and public health centers; (4) standards for hospitals, coordination among hospitals and the establishment of a list of participating hospitals; (5) suitable methods of paying for personal health service benefits; (6) studies of the quality and adequacy of personal health services; (7) grants-in-aid for professional education and research.

In regard to most questions of policy the bill directs that the Surgeon General must consult the advisory council before taking action. Also the Surgeon General, in his report to each session of the Congress, must include a report of consultations with the advisory council, recommendations of the council and his comments thereon. This assures that there will be public information as to whether the Surgeon General is or is not consulting and taking the council's advice and makes public what its recommendations are.

The advisory council may establish similar advisory and technical committees on regional and local levels.

Organization.—In the administration of the personal health benefits the Surgeon General shall, insofar as practicable, give priority and preference to utilizing the facilities and services of State and local governmental departments and agencies on the basis of mutual agreements. Local area committees, selected from panels submitted from the professional and other agencies for health services, shall be appointed to aid in administration. Such committees shall include representatives of insured persons and medical and other professional representatives. These committees shall be consulted frequently and shall be kept informed by Public Health Service officers with respect to policies and the availability of benefits. They are authorized to make annual and special reports with recommendations either to the local area officers or to the Surgeon General through the State or regional officers. Wherever the State is the local cooperating agency, the State shall appoint such committees.

Policies and methods for administration.—Any physician, dentist or nurse legally qualified by a State may furnish services under this bill. Specialists or consultants who are to be entitled to special rates of payment are, however, to be designated by the Surgeon General from among qualified practitioners. Such specialists or consultants shall be chosen in accordance with general standards prescribed after consultation with the advisory council, and after taking into account their profession experience and skill. A group of qualified physicians, dentists or nurses may furnish services.

Beneficiaries may freely choose their physicians and dentists, or groups of physicians and dentists, and they have the right to change their selection. Physicians have the right to refuse patients. The services of a specialist or consultant shall ordinarily be available only upon the advice of the general practitioner. They shall also be available when requested by the individual and approved by the medical administrative officer. Lists of qualified practitioners and groups of practitioners, and of specialists and consultants shall be published and made available to the beneficiaries by the Surgeon General. Doctors who

are under the plan are at complete liberty to practice outside the plan as well as within it if they so choose.

Methods of administration, including the methods of making payments to practitioners, shall be such as are designed: (1) to insure prompt and efficient medical care; (2) to promote personal relationships between physician and patient; (3) to provide incentives for the professional advancement of practitioners and for the encouragement of high standards in quality of services through adequacy of payment, through opportunities for postgraduate study and through coordination among all the services furnished by general practitioners, specialists and consultants; by laboratory and other auxiliary services; hospitals; public health centers; educational, research and other institutions, and between preventive and curative services; (4) to aid in the prevention of disease, disability and premature death, and (5) to insure adequate service with the greatest economy consistent with high standards of quality.

Payment of doctors.—Payments to practitioners may be made: (1) on the basis of fees for services rendered, according to a fee schedule; (2) on a per capita basis, the amount being according to the number of individuals 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. The majority of the general medical and dental practitioners in each local area who have agreed to participate in the program shall elect the method of payment. But the Surgeon General may also make payments by another method (from among those listed above) to those practitioners who do not elect the method of the majority, especially when such alternative method of making payments contributes to carrying out the beneficial administrative provisions outlined in the preceding paragraph. Any of these methods of making payments may be used, by approval of the Surgeon General, in making payments to groups of practitioners that contain designated specialists or consultants as well as general practitioners. The Surgeon General may negotiate agreements to utilize inclusive services of hospitals and their staffs, and of attending staffs, or for entering into contracts for such inclusive services.

Payments to specialists and consultants may also be made by salary, whole time or part time; per session, fee-for-service; per capita, or combinations of these bases, as the Surgeon General and the specialists and consultants may agree.

Rates of payment may be nationally uniform, or may take account of relevant local conditions and other factors. Payments shall be adequate, especially in terms of annual income, and by reference to annual income customarily received among physicians, dentists and nurses, with due regard to age, specialization and type of community. Payments shall be commensurate with skill, experience and responsibility involved in furnishing service.

To maintain high standards in quality of services, maximum limits may be set to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish general medical or dental services.

The provision of general medical or dental benefits in each local area shall be a collective responsibility of all participating general medical and dental practitioners respectively.

Home nursing shall ordinarily be available only upon the advice of the attending physician, but it shall be available when requested by an individual and approved by a medical officer.

Hospitals.—The Surgeon General shall designate participating hospitals and shall from time to time publish lists of such institutions. A participating hospital is 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 patients and to have procedures for the making of such reports as the Surgeon General may require, to assure that hospitalization benefits are provided only to those entitled to them. The Surgeon General may accredit a hospital for limited varieties of cases, such as the chronic sick. Any institution not included in the list of participating hospitals has the right to a hearing. The Surgeon General shall exercise no supervision or control over the administration, personnel or operation of a participating hospital unless it is one which is owned and operated or leased and operated by the United States.

A maximum number of 60 days of hospitalization is allowed an individual in any benefit year. But if the Surgeon General finds that the funds in the account permit, he may extend the maximum term of hospitalization to as much as 120 days for the following calendar year.

The range of hospital benefits is as follows:

	<i>Per day</i>
First 30 days-----	\$3-\$7
After 30 days-----	\$1.50-\$4.50
Chronic Sick-----	\$1.50-\$3.50

In place of these payments to insured persons, the Surgeon General may enter into contracts with participating hospitals for the payment of reasonable costs of hospital service at rates within the limits set above, such payments 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. Such payment may be included in a contract between the Surgeon General and a participating hospital, for inclusive services of the hospital and its staff. Participating hospitals have the right to require payments from patients for the additional cost of more expensive facilities furnished for lack of ward facilities, or occupied at the request of the patient or for services not included in the contract.

Comment.—The administrative and organizational features of the bill are well conceived. Quit properly the Surgeon General of the United States Public Health Service is the administrator, and he is responsible to the Federal Security Administrator. This offers one check on him. Of equal importance is his responsibility to the National Advisory Medical Policy Council. This Advisory Council is not, as some have maintained, without power or responsibility. The bill explicitly provides that in matters of policy, and in most important matters, the Surgeon General can act only after consultation with the advisory council. Four members of the council can call a meeting. Public airing of the opinions of the council is assured by the provision that the Surgeon General in his regular reports to Congress must include a report of his consultation with the council along with its recommendations. Thus the council will have real responsibility and power—not to administer—but to advise and to make its views known.

Decentralization of administration is assured by the instruction that the Surgeon General utilize as far as possible the services of State and local departments and agencies, and by the appointment of local advisory and technical committees to advise in administration.

Complete freedom of choice of physicians is explicitly provided for. Cooperative groups of physicians are authorized to give services under the plan.

Unfortunately the fee-for-service system of payments to practitioners is allowed if the practitioners so elect, although the capitation system and straight salary are also provided for. It is an accepted fact, based on experience, that no sickness-insurance plan has been able to function with fullest efficiency under the fee-for-service system. The fee-for-service plan creates a huge amount of paper work for the physician and the administration, and it leads to inevitable abuse by doctor and patient. Physicians should be the first to repudiate this method of payment.

Appeal bodies

The Surgeon General is instructed to establish necessary appeal bodies to hear complaints from beneficiaries, from practitioners and from hospitals. Hearing bodies shall in all cases contain competent and disinterested professional representation. If a complaint involves only matters of professional practice or conduct, the hearing body shall consist exclusively of such professional persons.

Grants-in-aid for medical education, research and prevention of disease and disability

The Surgeon General is directed, with the advice of the National Advisory Medical Policy Council, to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education. Such grants would be made for projects showing promise of making valuable contributions with respect to the cause, prevention or methods of diagnosis or treatment of disease or disability. For the first 5 years, preference and priority shall be given to educational projects and to aid returning servicemen seeking postgraduate education in medical and dental work, personal health administration, rehabilitation services and related fields.

The appropriation of such grants-in-aid would be \$10,000,000 in 1946, \$15,000,000 in 1947 and, in subsequent years, 2 percent of the amount spent for health insurance in each preceding year.

Comment

Without the continuous leaven of research and education the practice of medicine quickly withers and becomes a mediocre routine. The best medicine today is practiced in our university hospitals, where teaching and research go hand in hand with the care of the sick. It is highly commendable, therefore, that the bill provides a substantial appropriation for both research and professional education.

Report concerning dental, nursing and other benefits; care and prevention for chronic sickness and mental diseases

The Surgeon General and the Social Security Board are directed to make studies and to report to Congress on the scope and method of financing complete dental and nursing services and the provision of other services not included under the insurance plan. This report must be made within 2 years after the enactment of the bill. A similar study and report must be made, within 3 years, on the services and facilities needed for the care of the chronic sick and for persons afflicted with mental diseases.

HILL-BURTON HOSPITAL CONSTRUCTION BILL

Earlier drafts of the Wagner-Murray-Dingell bill set up an extensive program to build hospitals and health centers as needed, especially in rural communities, in economically depressed areas, and in regions where facilities were over-taxed. In view of the fact that the Hill-Burton bill, which covers these needs in very similar provisions, was subsequently introduced into Congress, this part of the program has been omitted from the new Wagner-Murray-Dingell bill. The Hill-Burton bill now acts as a supplement to this Wagner-Murray-Dingell bill and is an integral part of the over-all health insurance plan called for by President Truman in his message to Congress. It has already been passed by the Senate, with amendments, and its enactment into law by Congress is virtually assured as it does not arouse opposition as does the Wagner-Murray-Dingell bill.

The hospital construction bill provides for Federal grants ranging from 33 $\frac{1}{3}$ to 75 percent of total construction costs, with larger percentages granted to States having lower per capita incomes. A total of \$375,000,000 is authorized to be appropriated over a 5-year period for grants for hospital construction. This sum will meet only about one quarter of the known needs. More adequate would be the provisions of the original bill, which called for \$100,000,000 the first year and an amount in subsequent years to be determined by Congress according to the need. The program is to be administered by the Surgeon General of the Public Health Service, in consultation with a Federal hospital council composed of professionals and consumers. State hospital construction programs must conform to established regulations and provide minimum standards for maintenance and operation. However, an amendment added before passage by the Senate provides that if the Surgeon General refuses to accept a State program, appeal may be taken before the Federal hospital council, which may override the Surgeon General's decision. Such an administrative plan would remove the right of any appeal beyond the decision of the Federal hospital council—a totally independent agency accountable to nobody. It would break the direct line and continuity of authority between the President of the United States, the Federal Security Administrator and the Surgeon General, and it would make this independent agency subject to Federal supervision or direction only at the moment when the members are appointed by the Federal Security Administrator. Such a veto power over essential administrative duties for carrying out a program involving large Federal sums of money would open wide the possibilities of influence upon special interests. The Federal hospital council should be retained as an advisory body only, as provided in the original, unamended bill.

Each application shall give assurance acceptable to the Surgeon General that the hospital will be made available to the extent of its facilities to every person residing in the area served, without discrimination on account of race, creed or color; with the exception that where separate health facilities are provided for separate population groups, such groups shall have equitable provision on the basis of need for services and facilities of like quality.

Another unfortunate clause has been inserted by amendment to the original bill, providing that each hospital should supply a reasonable volume of hospital services to persons unable to pay therefore, if such a requirement is not financially impractical. Such a clause offers a loophole to hospitals to deny services

to the needy who need it the most. It could be particularly unfortunate in those institutions which offer separate facilities for different population groups for this clause could be used to exclude the needy of a single group, unless there is also an antidiscrimination clause to cover this specific provision of the bill.

The term "hospital" in this bill includes health centers, general hospitals, hospitals for tuberculosis and for mental and chronic diseases, and equipment and facilities related to these institutions such as laboratories, out-patient departments, nurses' homes and training facilities.

There is a serious omission, however, in the definition of "public health center" by the bill as amended and passed by the Senate. The original bill defined a public health center as providing public health services and medical care. The words "and medical care" have been omitted in the present version. This definition should be returned to its original wording, for otherwise the desirable function of health centers as group practice centers in an integrated medical plan would be eliminated.

Comment

We heartily approve the general principles of the Hill-Burton bill for hospital construction. Repeated surveys have demonstrated the great lack of hospital facilities in many communities, particularly in poorer sections of the country, which unaided by Federal funds are unable to create the needed institutions. Today, doctors no longer can give proper medical service unless they and their patients have free access to adequate hospital facilities. It would be impossible to make intelligent plans for a Nation-wide medical care program, as provided by the Wagner-Murray-Dingell bill, without making provision for needed hospital facilities.

On the other hand, it would be an absurdity to plan for hospital construction without assuring that communities will have the funds to maintain these hospitals. Under such a system these hospitals would be all too likely to become nothing but bricks and mortar. This is the weakness of the Hill-Burton bill, unless its passage is accompanied by passage of the Wagner-Murray-Dingell bill.

The bill in its present amended form, however, contains objectionable features which tend to lessen materially its effectiveness. They create such loopholes that the purpose of the bill, to assist the States to "afford the necessary physical facilities for furnishing adequate hospital, clinic and similar services to all their people," may be defeated. The bill must be restored to its original form.

For further information write to: The Physicians Forum, Inc., 510 Madison Avenue, New York 22, N. Y.

Senator ELLENDER. As among the doctors of the country the Physicians Forum has been the mainspring back of this legislation that we are now considering?

Dr. BOAS. Really, this was a committee of physicians, for the improvement of medical care. I think the Physicians Forum and the Committee of Physicians have been the two physicians' organizations supporting this.

Senator ELLENDER. Which is this other?

Dr. BOAS. The Committee of Physicians.

Senator ELLENDER. What is that?

Dr. BOAS. The Committee of Physicians for the Improvement of Medical Care was established—I cannot tell you the exact date.

Senator ELLENDER. Before or after the Physicians Forum was organized?

Dr. BOAS. It was before.

Senator ELLENDER. What is the membership, do you know?

Dr. BOAS. They have only a relatively small committee, but then they have a large number—

Senator ELLENDER. Of how many?

Dr. BOAS. About 25, and then they have a large number of physicians who subscribe to their principles and proposals.

Senator ELLENDER. They, of course, are also backing the legislation that we are now considering?

Dr. BOAS. Yes, sir.

Senator ELLENDER. To what extent did that committee aid in preparing or submitting data for the legislation we are now considering?

Dr. BOAS. They acted much as we did.

Senator ELLENDER. Where is your membership confined to, in what States?

Dr. BOAS. About two-thirds of them are in New York State, and the rest are scattered throughout the country, from Maine to California.

Senator ELLENDER. Two-thirds from New York State, so that there are about in the neighborhood of 300 from the rest of the country?

Dr. BOAS. Yes.

Senator ELLENDER. How many states are represented, do you know?

Dr. BOAS. I cannot tell you for certain, but I believe the majority of the states are represented.

FREE CHOICE OF DOCTOR

Senator ELLENDER. I noticed on page 6 of your statement where you state, and I quote you, "Doctors may refuse patients, and patients may choose doctors." Can you point out for the committee the language in the bill where such privileges are accorded to the doctors and the patients you refer to?

Dr. BOAS. Yes, it may take me a moment to find it, but it is very definitely in here.

Senator ELLENDER. Let me ask you this before you answer the question, when you say "Doctors may refuse patients," you mean all doctors that are qualified to practice in any State, or do you mean doctors who will submit or agree to the plans that will be prepared through the Surgeon General's office?

Dr. BOAS. What I meant in that statement specifically was that an individual doctor has the privilege of refusing an individual patient. In other words, if a man elects to serve under the insurance fund, and patient X says, "I want you," and the doctor does not like that, the doctor says, "I prefer not to take you on," but in addition to that, of course, no doctor is compelled to serve under the insurance scheme. That is quite voluntary.

Senator ELLENDER. I am glad that you admit that, Doctor, however.

Dr. BOAS. I think it is right in the bill.

Senator ELLENDER. So that if a doctor does not desire to join as it were, or submit to the rules and regulations that may be agreed upon at Washington, his services cannot be used by patients who pay in the fund and who are entitled to the service?

Dr. BOAS. A doctor who is not enrolled with the insurance fund cannot treat patients who are insured and received payment from the insurance fund.

Senator ELLENDER. So that in order for a doctor to be able to serve, he will have to submit to this plan; there is no alternative?

Dr. BOAS. In order to be able to serve the insured people?

Senator ELLENDER. Yes.

Dr. BOAS. Unless they choose him voluntarily.

Senator ELLENDER. And also unless they pay extra?

Dr. BOAS. Yes, sir.

Senator ELLENDER. So that patients would be paying into the fund a certain percentage of their salary, and if they desired to obtain the services of a doctor of their own choosing, who is not a member of the plan, or who has not joined this plan, they will have to pay two ways?

Dr. BOAS. That is right.

Senator ELLENDER. There is no question in your mind about that?

Dr. BOAS. That is a fact.

Senator ELLENDER. Now, what did you mean when you said, "Doctors may refuse patients and patients may choose doctors"? You limit that, evidently, to the doctors who submit to the plan and to the patients who, by virtue of paying out of their salaries so much, are entitled to services?

Dr. BOAS. I would say limited to the doctors who voluntarily enroll in the plan. But as a matter of fact, we know, I think, from experience that if this legislation were to go into effect, within a few years, between 80 and 90 percent of the doctors of this country would enroll.

Senator ELLENDER. They would be forced to, I grant you that. If Congress puts this plan over, if this bill is enacted into law as it is now written, I am sure what you assert will come to pass, but it will not be on a voluntary basis. It will be a question of necessity, they will have no other alternative, or else starve to death.

You say that the average income of doctors in 1939 was \$3,200 and \$4,500?

Dr. BOAS. Yes, sir.

Senator ELLENDER. Is that average taken of all doctors from the moment they graduate from college, or after a certain period when they are in practice?

Dr. BOAS. That is the average of all practitioners, of all ages.

Senator ELLENDER. And as among those practitioners, I assume that you have a large segment of them making many, many times more than the \$3,200 and \$4,500?

Dr. BOAS. Not a large segment, I think as I recall the figures, and I am not absolutely certain of the precise percentage, but that only about 10 percent of the doctors in those years had incomes of \$10,000 or over.

Senator ELLENDER. You mean of the one-hundred-and-some-odd-thousand doctors over the country, only 10 percent?

Dr. BOAS. That is right.

Senator ELLENDER. Now, how do you reach the figure, or how do you reach the conclusion that should this plan go into effect, the average returns of a doctor will be \$8,000? What is the basis for that?

Dr. BOAS. Well, a very rough calculation is that for the general practitioner, for instance, if on a capitation system he can take care of about 1,200 patients, and he gets—

Senator ELLENDER. 1,200 patients, is that right?

Dr. BOAS. That is 1,200 patients on his panel, that does not mean that they are all sick, but he is responsible for 1,200 people, and he gets \$7 a person a year for that, that would be about \$8,400, and I believe that the insurance fund supplies sufficient funds for that approximate level of payment.

Senator ELLENDER. In reaching this figure of \$8,000, you assume that all doctors will join the plan, or will submit to the plan?

Dr. BOAS. I do not think that that would affect the income of doctors, what percentage of them joined the plan.

Senator ELLENDER. Well, Dr. Boas, if two-thirds of the doctors of the country join the plan, does it not mean that two-thirds of the doctors of the country that do join are going to have the greater part of the work to do?

Dr. BOAS. No; they would have more work to do than they could handle.

Senator ELLENDER. They would be paid in proportion to the amount of work they do, and therefore their rate of income would necessarily increase, would it not?

Dr. BOAS. Under such circumstances, it would.

Senator ELLENDER. Do you not think that that is possible unless all join?

Dr. BOAS. Well, I am quite sure that the overwhelming majority of doctors would join.

Senator ELLENDER. So that all doctors, no matter what their qualifications are, no matter how apt they are in contrast to others, will virtually be placed under the same fee basis and will receive practically the same return per year. Will not that follow?

Dr. BOAS. The difference will be largely as it is today, in the number of patients that they have.

Senator ELLENDER. No. Under the plan, the Surgeon General could assign you so many patients and he could assign me so many patients, if I were a doctor, and do the same thing as to all doctors over the country who belong to or who join the plan.

Dr. BOAS. I do not think that that is quite accurate. As I recall the provision in the bill, it simply says that the Surgeon General may limit the number of patients that any one doctor can have.

Senator ELLENDER. That is right.

Dr. BOAS. The idea being that if one doctor, by some technique, could acquire three or four thousand patients, which we know one man cannot handle, he could not do a decent job, and that could be curtailed.

But the Surgeon General is not going to sit down and say, "You can have 400 patients, and you, 500, and you, 800."

Senator ELLENDER. Will he not be forced in a measure to allot to each doctor virtually the same number of patients, in the long run?

Dr. BOAS. I do not believe so.

Senator ELLENDER. You do not believe so?

Dr. BOAS. No.

Senator ELLENDER. Would it be fair under the terms of this bill to the doctor who gets far less patients than another; for instance, if you are assigned 800 patients, and I am assigned 400, do you not think that I would have a cause to complain?

Dr. BOAS. If they were assigned, yes; but patients are not assigned in this bill. Patients reach their doctors under this bill as they do today. Here is one group and here is a large volume of patients and here is a large group of doctors, and these patients will say, "I know doctor X; he is a nice fellow."

Senator ELLENDER. But doctor X must be a member of the plan?

Dr. BOAS. Yes, sir.

Senator ELLENDER. There is no doubt about that?

Dr. BOAS. Certainly.

Senator ELLENDER. That is all. I must leave to serve on another committee.

Senator DONNELL. You are the chairman of the Physicians Forum?

Dr. BOAS. That is right.

Senator DONNELL. Is that the chief executive officer of the forum, or is there a president, also?

Dr. BOAS. No; that is the chief executive officer of the forum.

Senator DONNELL. And you have been occupying that office for how long?

Dr. BOAS. Six years.

Senator DONNELL. Do you know the number of members approximately that the forum has, we will say in the central West, in Missouri, and Kansas, and Nebraska and States of that type?

Dr. BOAS. I do not think that we have very many. I think we just have a scattering in these particular State. We have a fair number in Illinois.

Senator DONNELL. Your members are largely in States having the largest cities; is that right?

Dr. BOAS. I suppose that that is correct; yes, sir.

Senator DONNELL. I believe you said about 600 of them are in New York State?

Dr. BOAS. Yes, sir.

Senator DONNELL. That would leave, as Senator Ellender pointed out, about 300 scattered over the rest of the country?

Dr. BOAS. Yes, sir.

Senator DONNELL. You are, also, a member of the American Medical Association, are you not?

Dr. BOAS. I am.

Senator DONNELL. In fact, I believe you stated in your testimony that all of the members of the Physicians Forum are members either of the American Medical Association or the National Medical Association?

Dr. BOAS. Yes, sir.

Senator DONNELL. And the National Medical Association is constituted of Negroes?

Dr. BOAS. That is correct.

Senator DONNELL. Now, Doctor, when the President issued his message of November 19, 1945, you sent him a telegram, did you not?

Dr. BOAS. Yes, sir.

Senator DONNELL. In which you said right at the outset:

Our membership, composed largely of practicing physicians throughout the country who belong to the American Medical Association, most warmly commend you for your able and comprehensive message to the Congress on the state of the Nation's health.

You were not in any sense criticizing the American Medical Association in that statement, were you?

Dr. BOAS. No.

Senator DONNELL. Were you using that sentence with respect to membership in the American Medical Association as indicating any hostility to the association or as indicating any feeling that the association was not an organization of high standing?

Dr. BOAS. No.

Senator DONNELL. It does consist, does it not, Doctor, of approximately 125,000 of the physicians and surgeons of the country?

Dr. BOAS. Certainly.

Senator DONNELL. And you have been a member of it and still are a member of it?

Dr. BOAS. I am.

THE AMERICAN MEDICAL ASSOCIATION

Senator DONNELL. Now, you say in your statement that the American Medical Association is in fact serving as a guild, battling to retain the economic privileges of the medical profession. Do you regard it as inconsistent at all that you should remain in that association if its purposes are to "serve as a guild, battling to retain the economic privileges of the profession"?

Dr. BOAS. The American Medical Association has a good many functions. Its educational and clinical functions have, on the whole, been very excellently carried out. My only point of disagreement with the American Medical Association is in the field of medical economics, and I see no reason to withdraw from it. As a matter of fact, one of the reasons why the forum was established was that many doctors were rather shocked by the public statements of the American Medical Association in this field, and felt it necessary that a group of doctors should be established who could have their own avenues for expressing radically different opinions.

Senator DONNELL. And yet it remains true, does it not, Doctor, to be a member of the American Medical Association is not regarded as a reproach against a physician, but rather as an indication of his interest and standing in the profession?

Dr. BOAS. That is certainly correct.

Senator DONNELL. And as you have said, along scientific and educational lines of medical nature, and surgical nature, you regard the work of the association as eminently helpful to the Nation, do you not?

Dr. BOAS. Absolutely.

Senator DONNELL. And you simply disagree with the Association on this particular policy with respect to compulsory health insurance and matters of that type?

Dr. BOAS. That is right.

Senator DONNELL. I observe in your statement that you mention at page 13, that in light of certain historic facts, to which you refer, do you have your copy before you now?

I would like to have you address yourself to that—you say:

In the light of these historic facts the present tactics of the American Medical Association in opposing national compulsory health insurance and in advocating voluntary plans under its own management seem somewhat disingenuous.

I am not sure that I just remember it accurately, the meaning of "disingenuous," but I think it implies a sense of lack of sincerity, does it not?

Dr. BOAS. It does.

Senator DONNELL. And that was the thought that you had in your mind in the use of that term; is that right?

Dr. BOAS. That is right.

Senator DONNELL. Now, I understand, however, that the historic facts to which you refer, if I am incorrect, please correct me, are

those that are set up in a minority report in the American Medical Association to which you had referred in the immediately preceding paragraph; is that right?

Dr. BOAS. No; I do not think that I made myself clear, Senator.

Senator DONNELL. What did you mean?

Dr. BOAS. The committee on the costs of medical care was an independent committee headed by Dr. Ray Lyman Wilbur, former Secretary of the Interior, and that consisted of public-health physicians, economists, publicists, and representatives of the American Medical Association, and this committee, after spending much time and money in analyzing the whole situation published that report which I believe you have in your hand, and the representatives of the American Medical Association disagreed with that report, and submitted their own minority report which is incorporated in that volume.

Senator DONNELL. So the minority report then represents the views at that time of the members of that committee from the American medical Association; is that right?

Dr. BOAS. That is right.

Senator DONNELL. What that report subsequently submitted to the American Medical Association's house of delegates?

Dr. BOAS. I do not know.

Senator DONNELL. You do not know what happened on that?

Dr. BOAS. No.

Senator DONNELL. Now, Doctor, let me ask you with respect to Dr. Wilbur, he is still active, is he not, in professional and public affairs?

Dr. BOAS. I believe so.

Senator DONNELL. And do you know the position which he has taken with respect to this matter of health insurance?

Dr. BOAS. I do not.

Senator DONNELL. You do not know that?

Dr. BOAS. I do not.

Senator DONNELL. Now, Doctor, in your statement which you have given to us here, you feel that the American Medical Association, as you say, is in fact, serving as a guild, battling to retain its economic privileges. What do you mean by "economic privileges" there?

Dr. BOAS. Well, today, the practice of medicine is a very highly individualistic activity. I guess doctors are more independent and more dictatorial within their own little spheres than any other people. This arises out of the nature of their work, and their relationship to patients. If a doctor is successful in developing a special practice and gaining recognition in one way or another, he can have a very substantial income, as we know, and it is these successful doctors who, to a large extent, are the ones who are governing the policies of the American Medical Association, and there is no doubt that although the lot of the average doctor would be improved by a bill such as this, the very large incomes of some surgeons and specialists would in the long run be deflated.

Senator DONNELL. Do you think, Doctor, that the average member of the American Medical Association with whom you have come in contact realizes that this bill, S. 1606, or a plan of that type, would improve the average economic welfare of the practitioners?

Dr. BOAS. No; he does not, because he is given no opportunity to learn. You see, the medical press is closed to any discussion of this bill. The American Medical Association and the State journals and

the county journals, with a very few exceptions, refuse to publish any opinions favoring this bill, and they only publish destructive attacks on the bill, many of which are very inaccurate. So that the average doctor has very little opportunity to know what it is all about.

Senator DONNELL. And do you think that the American Medical Association in this general policy of the restriction of the dissemination of information, is governed by a small group at the top of the association, the larger-income practitioners?

Dr. BOAS. Yes, sir.

Senator DONNELL. Is that your thought?

Dr. BOAS. Yes, sir.

Senator DONNELL. And yet, as a matter of fact, the American Medical Association does have a house of delegates, chosen from all over the United States and meets annually, does it not?

Dr. BOAS. It does.

Senator DONNELL. And sets forth the policies of the association, does it not?

Dr. BOAS. Yes, sir.

Senator DONNELL. It is not composed solely of these top-notch men, is it?

Dr. BOAS. I do not think solely, but the house of delegates is composed of leaders in the various States.

Senator DONNELL. It is also elected, is it not, by the physicians from the various States?

Dr. BOAS. No.

Senator DONNELL. Well, what is it?

Dr. BOAS. It is a very complicated business. To get into the house of delegates, first of all, the county societies elect delegates to the State societies.

Senator DONNELL. Pardon me just a moment, the county societies, they are not composed exclusively of the top-notch income doctors, are they?

Dr. BOAS. No; they are composed of the mass of physicians.

Senator DONNELL. And they elect delegates to the State bodies, is that right?

Dr. BOAS. That is right, and then this delegated State body in turn, elects delegates to the board of delegates of the American Medical Association.

Senator DONNELL. This State body is not composed exclusively of the top-notchers in the point of income?

Dr. BOAS. Not in point of income alone, no.

Senator DONNELL. It is the ordinary State Medical Association, composed of doctors of all types and descriptions, from all over the State, is it not?

Dr. BOAS. Yes; but as is the rule in most of these things, the more successful ones gravitate to the top of the medical organization, as well as in their practices.

Senator DONNELL. But, Doctor, the man who has the ordinary, average practice, out in the little town that I live in, or lived in, has just as much of a vote in the State organization as the man that is making \$10,000 or \$15,000 a year, has he?

Dr. BOAS. He certainly has.

Senator DONNELL. And the State organizations, they send on their delegates to the national house of delegates; that is right, is it not?

Dr. BOAS. That is right.

Senator DONNELL. And then the national house of delegates expresses the viewpoint of the association as an entirety, does it not, in its resolutions?

Dr. BOAS. Yes, sir.

Senator DONNELL. And you know the attitude so expressed by the house of delegates of the American Medical Association has been opposed to compulsory health insurance; is that right?

Dr. BOAS. That is correct.

Senator DONNELL. Now, Doctor, on the matter of what you have termed by the term "propaganda," I realize, as do you, that that is a term which may be applied by a man against a proposition to anyone in advocacy of it, and conversely; but we will leave out the word "propaganda." We will say that in the dissemination of views or information there are numerous organizations actively giving out information in favor of this bill, S. 1606, are there not?

Dr. BOAS. There are a number; yes.

Senator DONNELL. For instance, take your own organization, the Physicians' Forum, you have got out a printed digest here, Outline and Analysis of the Wagner-Murray-Dingell Bill, S. 1606.

Dr. BOAS. Yes.

Senator DONNELL. I have it in my hand. It consists of 8 pages, and at the bottom is:

For additional information write to the Physicians' Forum, Inc., 510 Madison Avenue, New York City.

How is the Physicians' Forum financed, Doctor?

Dr. BOAS. Voluntary contributions.

Senator DONNELL. Do you know what the annual budget is?

Dr. BOAS. It has varied from year to year according to our income.

Senator DONNELL. Yes.

Dr. BOAS. For many years we relied almost exclusively on contributions from the doctor members. In the past year we have been more successful in getting some large voluntary contributions.

Senator DONNELL. Do you recall approximately the total income of the Physicians' Forum in the year 1945?

Dr. BOAS. I should estimate it at approximately \$12,000.

Senator DONNELL. About \$12,000, and do you know what it has run so far this year, 1946?

Dr. BOAS. Well, we just had an affair at which we raised money, and which I imagine will have to carry us through most of the year.

Senator DONNELL. How much did you raise at that affair?

Dr. BOAS. \$6,000.

Senator DONNELL. \$6,000.

Dr. BOAS. And otherwise we have got in maybe two or three thousand.

Senator DONNELL. Is the affair to which you refer a Physicians' Forum dinner at the Hotel Waldorf Astoria held on April 11?

Dr. BOAS. Yes.

Senator DONNELL. There was an invitation sent out to that by you to the general effect as follows:

The Forum is holding a dinner at the Waldorf Astoria on Thursday, April 11, to honor Senator Wagner, Senator Murray, and Representative Dingell. Tickets, \$7.50.

Your formal invitation, with the names of other distinguished guests, will reach you in a few days. Meanwhile, please file this note in your diary.

That went out to a list of gentlemen, did it not?

Dr. BOAS. It did.

Senator DONNELL. And you presided over that meeting?

Dr. BOAS. Yes.

Senator DONNELL. And at that meeting these funds were raised to which you refer. Now, Doctor, in addition to your own organization there are numerous others giving expression of views favorable to S. 1606, as, for illustration, the Committee on Medical Care. Do you know that organization? I believe Mr. Michael M. Davis is chairman. Do you know that organization?

Dr. BOAS. I think you have the title incorrect.

Senator DONNELL. Possibly I do.

Dr. BOAS. There is the Committee on the Nation's Health, in which Doctor Davis was active.

Senator DONNELL. There is also the Committee on Research and Medical Economics, that committee, for which Mr. Michael M. Davis signs in some capacity on its letterhead. You are familiar with that organization?

Dr. BOAS. As far as I know they are a research group. They have not done any propaganda or public education at all.

Senator DONNELL. This particular group, the Committee on Research and Medical Economics, is located at 1790 Broadway, New York, and Mr. Michael M. Davis is the chairman?

Dr. BOAS. Either that or the executive secretary.

Senator DONNELL. And you are on the board yourself?

Dr. BOAS. Yes.

Senator DONNELL. And there is an editorial board of the Quarterly Journal, and you are on that board?

Dr. BOAS. Yes; but that Quarterly Journal is a suspended publication.

Senator DONNELL. And I ask you, Doctor, if this committee issued a booklet consisting of some 34 pages which I hold in my hand entitled, "Principles of a Nationwide Health Program." Did it issue that booklet?

Dr. BOAS. Yes.

Senator DONNELL. Your name appears on the outside?

Dr. BOAS. As one of the participants.

Senator DONNELL. And among the others are Mr. I. S. Falk, Mr. Basil C. McLean, Mr. Michael M. Davis, and Dr. John P. Peters. Was Dr. Peters on that committee?

Dr. BOAS. This was a temporary group to study these principles.

Senator DONNELL. But it did issue this report, and it is stated:

This report, with its 29 sponsors, is published with the cooperation of the committee on research and medical economics.

Dr. BOAS. That is true.

Senator DONNELL. The expenses of the conference and this publication were met by gifts, contributions for this purpose, is that true?

Dr. BOAS. Yes.

Senator DONNELL. Do you know of a so-called organization called the Group Health Organization?

The CHAIRMAN. Senator, before you leave that, I would like to have the witness furnish the committee with a copy of this report that the Senator has been examining for our records.

Dr. BOAS. Yes, sir. I am sure we can.

(The document referred to has been filed with the committee.)

Senator DONNELL. Do you recall, Doctor, who made the major gifts referred to in this foreword of the health program committee conference?

Dr. BOAS. I do not know. I had nothing to do with the financial end.

Senator DONNELL. I will ask you if you know also of an organization which had a telegram—sent in here yesterday—addressed to the Committee for the Nation's Health. Do you know that organization?

Dr. BOAS. Yes.

Senator DONNELL. Are you a member of that, also?

Dr. BOAS. I am.

Senator DONNELL. And Dr. Peters is also in that organization, is he not?

Dr. BOAS. I believe so.

Senator DONNELL. Doctor, I cite these as illustrative of the fact that not all of the information being given out with respect to this bill is coming from opponents. There is likewise a very active campaign being made by numerous people who believe in the bill, too. That is right, is it not?

Dr. BOAS. That is right.

Senator DONNELL. And I observe in your statement of the Physicians' Forum, that right on the front page you mention:

All people will have free choice of physicians, and physicians under the plan can accept or reject patients and can practice outside the plan as well as under it if they so choose. As a matter of fact, private practice will be greatly increased because millions of people now attending public clinics will, through health insurance, become private patients.

You believe that to be true?

Dr. BOAS. I do.

Senator DONNELL. There is also mentioned further down in the bill, and I do not see it right now, but something with respect to the freedom of choice. You believe along the lines you testified to here this morning; you believe it exists under S. 1606?

Dr. BOAS. Yes.

Senator DONNELL. You do say this:

The bill in its present amended form, however, contains objectionable features which tend to lessen materially its effectiveness. They create such loopholes that the purpose of the bill, to assist the States to "afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people" may be defeated. The bill must be restored to its original form.

That is on your original statement?

Dr. BOAS. That refers to the Hill-Burton bill.

Senator DONNELL. That refers to the Hill-Burton bill?

Dr. BOAS. Yes.

Senator DONNELL. You are not talking about this one, then?

Dr. BOAS. No.

Senator DONNELL. I see. I beg your pardon. I thought you were talking about this bill here.

The CHAIRMAN. The document itself shows clearly that it refers to the Hill-Burton bill.

Senator DONNELL. I think the doctor is correct in that.

The CHAIRMAN. I would like to ask, also, if we could have a copy of that for our records.

(The document referred to has been filed with the committee.)

The CHAIRMAN. I would like to ask, also, Doctor, if in either of these documents you have misrepresented or distorted the provisions of this bill in any respect?

Dr. BOAS. I certainly have not done so consciously, sir.

The CHAIRMAN. You think everything you have stated is true and correct?

Dr. BOAS. I do.

Senator DONNELL. Doctor, referring further to your testimony this morning, you say on page 4 that—

under the provisions of the bill, medical coverage would include upward of 90 percent of the entire population in one medical-care program.

Do you think it is wise to have that limitation of 90 percent, or should it be 100 percent?

Dr. BOAS. I think ideally it should be 100 percent.

Senator DONNELL. Why do you think 90 percent would be approvable at this time?

Dr. BOAS. Apparently it has the highest coverage they could get at the moment. The people not working are not included. And then I believe, if I remember right, that the railroad workers are not included, and I think also Federal employees and State employees. But I think that as soon as it becomes technically possible to include all of them it would be all the better.

Senator DONNELL. Doctor, in your testimony you refer to the argument that the opponents of the legislation have raised, as you stated, that the Surgeon General would become the medical dictator of the Nation, and you state:

Nothing could be further from the truth.

And then you say:

The bill provides that he is responsible to the Federal Security Administrator.

Do you mean to imply by that that if there is any dictatorship it does not vest in the Surgeon General, but rather in the Federal Security Administrator? Is that what you mean?

Dr. BOAS. No. My meaning was that that was one safeguard and the Advisory Council was a further safeguard, as well as the general set-up of the bill.

Senator DONNELL. Now, as a matter of fact, Doctor, even the appointment of the members of the Advisory Council is confined to persons who meet the approval of the Federal Security Administrator, is it not?

Dr. BOAS. It is.

Senator DONNELL. I read specifically on that point this sentence from section 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.

So no man can be appointed to the Advisory Council unless that man or woman, as the case may be, meets the approval of the one man, the head of the Federal Security Administration. That is right, is it not?

Dr. BOAS. That is right.

HEALTH INSURANCE IN EUROPE

Senator DONNELL. Yes, sir. Now, Doctor, you make mention also of one of the things in your testimony that I am not clear on as to your meaning:

The record of the various compulsory health insurance schemes in Europe demonstrate that an economic solution alone is not the whole answer.

Just what do you mean by that sentence?

Dr. BOAS. I mean by that that the compulsory insurance plans in Europe, while they have brought about many improvements in medical care over what existed in those countries before they were introduced, by no means are perfect, and that one reason why they are not perfect is that not enough attention has been paid to the quality of medical care given.

Senator DONNELL. What is your observation as to the quality of medical care that has been given in Europe under compulsory health insurance?

Dr. BOAS. Well, in Scandanavia, as we all know, it is excellent. In England it is much better than it was before the health insurance scheme went into effect, but of course the coverage there is very limited to certain low-income classes and only to the workingman and not his family, and allows only general practitioner care, so the coverage is very incomplete.

Senator DONNELL. Would you say, Doctor, that the quality of medical care that has been given, generally speaking, under the English compulsory insurance has been of as high a type as American physicians generally give to their patients?

Dr. BOAS. Probably not.

Senator DONNELL. Doctor, have you read Barron's National Business and Financial Weekly for April 8, 1946?

Dr. BOAS. No.

Senator DONNELL. Are you acquainted with a lady by the name of Elizabeth W. Wilson?

Dr. BOAS. No.

Senator DONNELL. Who has written an article entitled "Hazards of Compulsory Health Insurance. Enormous Prospective Costs of Political Medicine Not Well Understood." Have you read that?

Dr. BOAS. I think I glanced through it the other day.

Senator DONNELL. Was Miss Wilson at one time with the Social Security Administration here in Washington?

Dr. BOAS. I have no idea.

Senator DONNELL. I shall read you the closing four sentences of that, and ask you to state whether or not you are informed as to the correctness or incorrectness of the facts alleged therein. She says:

It is not surprising that the workers distrusted this type of medicine. In 1936, about 600,000 British workers distrusted this type of medicine. In 1936, about 600,000 British workers renounced their right to medical care under the insurance system by failing to register on the panel. In the same year, one-third of the French workers who were eligible for insurance did not qualify for it. These facts underscore the question as to the medical success of health insurance.

Doctor, I am not asking you to state whether you agree with the conclusion, but are her historical facts with respect to British and French workers as set forth in this excerpt of it correct or not?

Dr. BOAS. I have no idea on that.

FREE CHOICE OF DOCTOR

Senator DONNELL. You have no idea on that. Doctor, you also mentioned that in your opinion this bill does not constitute socialized medicine. I agree again with you, Doctor, that it is very easy for terms to be confused in order to use them for propaganda purposes, and I shall try not to use the term "socialized medicine," but let me ask you this:

There is under the bill a certain restriction in the right of people to select their own doctors; that is true, is it not?

Dr. BOAS. Only insofar as they must select doctors registered with the fund if they want the fund to pay for it.

Senator DONNELL. Is there not a further point on that? Let me illustrate it this way: suppose, for instance, in a small community consisting of 10,000 people there are 10 doctors, and that 1,000 people are assigned to each of those doctors. A panel is made up and issued and they are allowed that 1,000 persons. There will be, will there not, quite a natural tendency for the public to get on the list of the doctors generally considered to be the best in the community?

Dr. BOAS. That is true.

Senator DONNELL. When that panel is filled up, the people that come up later on are not going to be able to get on the panel of those particular doctors?

Dr. BOAS. First of all, even in a town of 10,000 there is not such unanimity of opinion as to the value of various doctors, and I think the distribution would be fairly good. The only limitation would be when one man suddenly became swamped and got 2,000 of the patients.

Senator DONNELL. Regardless of whether or not there is equal or unequal distribution on the point of merit, let us take the hypothesis of a community of 10,000 and 10 doctors, and each doctor allowed 1,000 on his panel, just to make it easy mathematically. If Dr. John Jones' panel is filled, and if there are 100 other people that want to get on his panel, there is no provision under this law by which those other 100 people can get on it; is that right?

Dr. BOAS. No, they cannot.

Senator DONNELL. So to that extent there is a restriction on the right and power of the people to get on that panel; that is true, is it not?

Dr. BOAS. Yes. But there is virtue in that restriction, because the only reason for that restriction is that we know if a doctor sees too many patients—and we have doctors who see 50 or 60 patients a day—they practice very sloppy medicine. Whether they do it under any system, it is not good for the patient.

Senator DONNELL. But the thought I was driving at is, there is a restriction, regardless of whether it is meritorious or justified, there is a restriction?

Dr. BOAS. There is a restriction.

The CHAIRMAN. And that situation exists today. That is to say, that a doctor who becomes quite famous cannot take everybody. He cannot take the practice of the entire community even though he is sought by the entire community.

Dr. BOAS. What actually happens, Senator Murray, is that when a doctor becomes so successful that he has more patients than he can handle, he jacks up his fees and therefore he eliminates the free choice of physician, because the poorer people cannot come to him.

The CHAIRMAN. We cannot adopt that system in this bill, so we adopt the other device of protecting the patients and giving them good service by this method?

Dr. BOAS. Yes.

Senator DONNELL. Now, regardless of the merit or demerit of the suggestion in the bill, Doctor, the fact remains, does it not, that today without this bill being in effect if you or I get sick and go to Dr. Jones, if Dr. Jones in his judgment thinks he can take us, there is no legal restriction against his doing so?

Dr. BOAS. There is not.

Senator DONNELL. There is no legal restriction against us trying to get on his list.

Dr. BOAS. That is true.

Senator DONNELL. It is true that he may find that he cannot take us, which, after all, is his judgment rather than the Surgeon General's action, or his Deputy, to say whether he does or does not take a patient?

Dr. BOAS. Yes.

Senator DONNELL. Whereas under the bill S. 1606 there is a restriction to the extent I have indicated; that is correct, is it not?

Dr. BOAS. That is correct.

Senator DONNELL. So your statement, from which I quoted, "All people will have free choice of physicians," et cetera, will have to be interpreted with that exception I have mentioned, at least, would it not?

Dr. BOAS. Yes.

Senator DONNELL. Now, Doctor, I would like to also ask you this: you also mention in your pamphlet that physicians can accept or reject patients. You say that on page 1 of the pamphlet.

I call your attention, Doctor, to the provisions of the bill, section 205 (c), in which the Surgeon General, as I understand it, has a right to designate services which shall be deemed to be specialist or consultant services, and the practitioners from those included in subsection (a) of the section who shall be qualified as specialists or consultants and entitled to special rates of compensation provided for specialists and consultants.

He does have that power, does he not?

Dr. BOAS. Yes.

Senator DONNELL. I assume that you think that is beneficial?

Dr. BOAS. That is right.

Senator DONNELL. But the Surgeon General does have that power we have indicated under the bill; that is true, is it not?

Dr. BOAS. Yes.

Senator DONNELL. I want to inquire about something which I am free to say I do not know, and I am asking for enlightenment. I want to ask you whether or not you think that a person under this bill would have the right to select an osteopath to perform services for him, or are osteopaths included within the term "physician" as mentioned in the bill?

I might amplify that by asking you to tell us whether or not you think services in osteopathy would be included under the term, "personal health service benefits," inasmuch as that is defined in section 214 as—

includes general medical benefit, special medical benefit, general dental benefit, special dental benefit, home-nursing benefit, laboratory benefit, and hospitalization benefit.

So that my question, which is entirely too long, resolves itself into two questions: First, whether or not osteopaths are included, in your opinion, within the term "physician"; and in the second place, whether or not the services they render are "personal health service benefits" to which persons are entitled under this bill?

Dr. BOAS. I do not know that I can answer that categorically. I believe they would be covered by the individual State laws, as I recall the section, and I cannot find it immediately.

The CHAIRMAN. Is that section 205 (a)? Page 45.

Dr. BOAS. There is a statement that—

any physician, dentist, or nurse legally qualified by a State to furnish any services included as personal health service benefits under this bill shall be qualified to furnish such services as benefits.

Senator DONNELL. May I interpolate this at that point, so that you may have the thought in my mind before you. I observe that language:

Any physician, dentist, or nurse legally qualified by a State—

That raises the question, is an osteopath a "physician"? I assume that he is.

Any physician, dentist, or nurse legally qualified by a State to furnish any services included as personal health service benefits—

The term, "personal health service benefits," is defined, as I indicated, to include—

general medical benefit, special medical benefit, general dental benefit, special dental benefit, home-nursing benefit, laboratory benefit, and hospitalization benefit.

The query in my mind is, even though a physician qualified by a State is within this bill, inasmuch as there is a further qualification that it is only those physicians who are qualified to furnish general medical benefits, or special medical benefits, whether or not osteopaths are included in the term "physician" in view of those remarks on the meaning of the term, "personal health service benefits." That is the thought in my mind.

Dr. BOAS. All I can say is I hope not.

Senator DONNELL. You hope they are not. Your thought would be if they are included that the bill should be amended to exclude osteopaths, is that right?

Dr. BOAS. I think that would be preferable.

Senator DONNELL. Do you have any idea how many osteopaths there are, or how many persons are patients?

Dr. BOAS. I do not know, sir.

Senator DONNELL. I take it it runs into the millions, probably, of persons who are patients of osteopaths.

Dr. BOAS. I really do not know.

Senator DONNELL. We will leave aside the number. There are certainly quite a considerable number of people who believe in osteopathy and go to osteopaths?

Dr. BOAS. Yes.

Senator DONNELL. Doctor, may I ask you what you think of the fairness or unfairness of a bill which would require every person, whether he believes in not going to medical doctors, but in going to osteopaths, that requires him to contribute to a fund here which could only be used, according to your hopes, in the payment of medical doctors as distinguished from osteopaths? Do you think it fair, if you and I believe in osteopathy, and want to go to an osteopath, that we will have to pay into this fund and then go and spend our money separately for osteopathy?

Dr. BOAS. I think two answers can be given to that. First of all, you can make the analogy between education and recognize the fact that everybody believes in school taxes, although they may send their children to private schools or parochial schools, and nobody contests the justice of that.

I believe health is of just as fundamental interest to the Nation and life as education, and that therefore universal support of the health facilities is a justified general tax.

Now, the trouble with the rest of the argument, if you accept osteopaths you might accept chiropractors and naturopaths and all that.

Medicine and the practice of medicine is a scientific proposition; it is not a matter of belief. It is a matter of fact. Anybody who has given scientific and objective study to the matter knows that these other systems of medicine are not based on fact but on fancy.

As a matter of fact, the few osteopathic schools remaining are adopting more and more of a general medical curriculum, and it is just a matter of time before they will be absorbed in medicine.

Every osteopath I have spoken to regrets that he is not an M. D.

I do not think the exclusion of these special cults is objectionable at all.

Senator DONNELL. You feel that insofar as payment for professional services of doctors is concerned, that the moneys which will be collected under this plan should be used to pay medical doctors and surgeons, likewise to the exclusion of such groups as osteopaths?

Dr. BOAS. I believe that from the point of view of wanting to see that good medical care is made available to all.

Senator DONNELL. May I ask one further question, and this is with respect to the Physicians' Forum.

Does it have anyone who has gone over this act in detail and has looked over it section by section as to the detail? Has someone done that?

Dr. BOAS. A group of us have.

Senator DONNELL. Physicians or lawyers or both?

Dr. BOAS. Physicians.

Senator DONNELL. Have any lawyers gone over the bill for legal phases of it on behalf of the Physicians' Forum?

Dr. BOAS. Not on behalf of them. We have consulted with representatives of the National Lawyers' Guild, but they have not gone over it for us. We have had no lawyers go over it for us.

Senator DONNELL. Did you consult with Mr. Linder, who testified here?

Dr. BOAS. Mr. Linder, and Mr. Wagner.

Senator DONNELL. Have you consulted with any members of the American Bar Association? That is, representing the American Bar Association, in their conferences with you?

Dr. BOAS. No.

Senator DONNELL. Yes, sir. That is all, Mr. Chairman, I think.

The CHAIRMAN. Doctor, from your studies you feel that the need for a national bill of this kind exists in this country?

Dr. BOAS. Absolutely.

The CHAIRMAN. And you feel that that need could not be met by voluntary systems, which you have studied?

Dr. BOAS. That is right.

The CHAIRMAN. What are the reasons why voluntary systems cannot cure the situation?

Dr. BOAS. First of all, they are too expensive for the average family. That is, if they are to give complete coverage. The existing plans give only very partial coverage, give only practically indemnity insurance for major illnesses. They are expensive to administer and expensive to sell, and the benefits are relatively small.

The CHAIRMAN. The membership is restricted in all of them, is that not true? Not everybody can come in and join?

Dr. BOAS. They usually recruit them by groups, industry and the like.

The CHAIRMAN. And you say the costs are so high that it would exclude the people in the lower income brackets?

Dr. BOAS. Yes. They are even high for the people in the lower white-collar brackets. And they just have not worked. They have been trying, for a generation, and the coverage is minimum.

The CHAIRMAN. And they fluctuate up and down? People are in for a while and then drop out?

Dr. BOAS. That is right.

The CHAIRMAN. And the result is they are always in a chaotic state?

Dr. BOAS. And when times get bad everybody drops out.

The CHAIRMAN. And that is when they need the service the most?

Dr. BOAS. That is.

The CHAIRMAN. As in the late depression?

Dr. BOAS. Yes, sir.

The CHAIRMAN. When the WPA had to take over the situation and pay the doctors in many sections of the country for rendering medical aid to the people?

Dr. BOAS. Yes.

The CHAIRMAN. The doctors did not object to that situation at that time, did they?

Dr. BOAS. Well, they did not relish the amount of money they were getting.

The CHAIRMAN. But it carried them through the depression?

Dr. BOAS. It helped carry them through the depression.

The CHAIRMAN. And they were all anxious to get on the panels at that time so as to save themselves financially, because if they did not get on, in some industrial communities, they would go broke?

Dr. BOAS. It is very astonishing, but I have yet to see any panel insurance scheme, large scheme, salaried clinic job, for which there were not always hundreds of applicants from doctors; and that is why I am sure if this bill goes into effect practically all doctors will join it. I have never known a doctor to turn down some security, because their incomes are so insecure.

The CHAIRMAN. As a matter of fact, in most communities there is a spirited contest among the members of the profession to get on programs of that kind, for instance, to be the physician for a certain big organization?

Dr. BOAS. That is right.

The CHAIRMAN. These fraternal organizations like the Elks, and different organizations of that kind?

Dr. BOAS. Yes.

The CHAIRMAN. Which pay them an annual salary or a fee system which enables them to make considerable income?

Dr. BOAS. That is right.

The CHAIRMAN. And none of them has ever criticised that system, and, as you say, there is great competition to secure those appointments?

Dr. BOAS. Great competition.

The CHAIRMAN. I guess that is all, Doctor.

Senator DONNELL. Mr. Chairman, I ask leave, please, to have incorporated in the record a copy of the article by Elizabeth W. Wilson, which I hand to the reporter.

The CHAIRMAN. Yes.

Senator DONNELL. Appearing in Barron's National Business and Financial Weekly, April 8, 1946, entitled "Hazards of Compulsory Health Insurance. Enormous Prospective Costs of Political Medicine Not Well Understood."

(The article referred to is as follows:)

[Barron's National Business and Financial Weekly, April 8, 1946]

HAZARDS OF COMPULSORY HEALTH INSURANCE

ENORMOUS PROSPECTIVE COSTS OF POLITICAL MEDICINE NOT WELL UNDERSTOOD

(By Elizabeth W. Wilson)

Proponents of compulsory health insurance in the United States, through design or mere good luck, have contrived to keep the debate on the level of humanitarianism, where it isn't too difficult to prove that some Americans who get no medical attention these days would get some under their scheme.

Thus opposition to the Wagner-Murray-Dingell bill has been left largely to the medical profession, which argues, chiefly, that it can do the job better and cheaper by itself than with big government at its elbow.

This is the shirking of a plain duty by the business community. Business and industry, in the long run, must provide a rising standard of living for the

country. Business and industry should examine compulsory health insurance not alone for the desirability of its professed goals—no one quarrels with those—but also as to the ultimate cost and the braking effect that cost will have on every activity of the nation.

The Wagner-Murray-Dingell bill, if passed, will make this country the forty-second to promise workers and their dependents medical care and cash indemnities for wage losses due to illness. Experience in these other countries offers us some clues as to whether the Nation's pay rolls can bear this load in addition to payments for old age benefits and unemployment compensation.

The size of the burden of compulsory health insurance costs and its relation to kindred burdens already being borne are consistently underestimated by the Wagner-Murray-Dingell bill's proponents.

President Truman has said that from the outset the medical benefits of the bill will cost about \$3,250,000,000 a year, or 4 percent of pay rolls. Experts say this is overoptimistic: that the initial cost will be nearer \$4,000,000,000 a year than \$3,000,000,000.

On top of that 4 percent, cash benefits will start out by costing almost 2 percent of the national pay roll. That's also on top of the 2 percent now going into old age and survivorship benefits, and the 1.8 percent on an average that is paid for unemployment compensation.

Many competent observers say that even this 9.8 percent-of-pay roll figure is too small to start with, and there's no room for doubt that it will soon be far above this total.

First, medical costs will increase. Adequate medical treatment is becoming a more and more expansive and expensive term. Laboratory analyses, X-rays and the services of specialists are costly. More and more expensive drugs are prescribed oftener and oftener.

Proponents of health insurance contend that employers will be reimbursed for their increased tax payments by a rise in productivity of their presumably healthier employes. The fact is that the claim rate continues to rise every year. Assuming that a certain rise in early years would be due to the fact that sick persons, who nowadays continue to work because they have to bear the whole burden of laying off, would feel they could afford to quit work and take treatments, the load should flatten out after awhile.

If it doesn't—and it hasn't in any other country—either national health isn't improving as promised, or else malingering isn't being dealt with firmly enough.

Cash benefit costs will increase with medical costs. In England, the claim rate for wage-loss benefits increased 50 percent in 6 years. In Germany it trebled between 1885 and 1930. In England a survey in 1938 showed that 15 percent of those receiving cash benefits were not unable to work.

Malingering will be worse in this country than in England, because here it is planned to operate the whole scheme by a federalized bureaucracy, whereas the approved societies, which are co-operative groups of workers, manage the British benefits. Workers are obviously better placed to combat malingering than are agents of a democratic government.

In the light of these considerations, it appears probable that health insurance would cost more than 8 percent—some say 10 percent—of the pay roll of insured workers during the next 10 or 15 years. That would be a load of \$7,000,000,000 by 1960. This estimate is reinforced by the 300 percent rise in per capita costs of health insurance in Germany from 1914 to 1929, and the 250 percent increase in Britain in the same period. Worse yet, actuaries estimate that the increase in costs won't flatten out for 50 years.

Unemployment compensation costs can be expected to rise, too. The current 1.8 percent rate applies in a period of high employment. Considering the constant pressure for more liberal benefits, and the probable level of peacetime unemployment, it's highly optimistic to set the future annual level premium cost of unemployment insurance at as little as 2 percent after the reserves accumulated during the war are paid out.

Old age and survivorship benefits have cost less than was expected during the war. Many old people returned to work; they will retire again and draw their benefits. Moreover, there is a move afoot to liberalize the benefits. Actuaries estimate that under all reasonable assumptions old age and survivorship benefits will cost at least 4 percent of the pay roll some time before 1960.

Although there is a reserve for this type of insurance, it is much smaller than was originally contemplated, because Congress continues to defer the increase in taxes which would build the reserve to its projected size. This means that

in a few years the whole social security bill will have to be paid on a current-cost basis.

In short, during the next 10 or 15 years, the total annual cost of social insurance will be somewhere between one-seventh and one-sixth of the pay roll, or 10 to 12 billion dollars. It is almost certain that before the costs are stabilized, they will equal or exceed those of the British system which are estimated at 24 percent of the wage bill.

It would be inexpedient to have the worker and employer bear this whole cost. The May 1945, edition of the Wagner-Murray-Dingell bill provided that the employer and employee should each be taxed 4 percent of the pay roll. Thus from the outset a large and increasing sum would have to be defrayed by the general taxpayer. Already he has to meet the costs of the Federal and State governments, as well as interest on the public debt, a burden which will probably not fall below \$30,000,000,000 a year for many years to come.

Besides supporting the various governments and paying their debts, the general taxpayer—either as an individual or a corporation—is the source of funds on which business draws for expansion and research necessary for increased productivity. The crux of the economic problem of health insurance is this:

"Can business expand and become more productive if the funds of the general taxpayer are curtailed by taxes to meet an increasingly heavy social security burden on top of his other commitments?"

Political dangers in the health insurance program offered this country are just as real as the economic ones, although less obtrusive. The bureaucracy necessary to administer the Wagner-Murray-Dingell bill might comprise 500,000 persons or more. These government agents would be strategically placed in every village and in every district of every sizable city.

We may credit American voters with enough political maturity that the danger of such a machine being seized by a demagogue, as Hitler seized its corresponding facilities in Germany and turned them to his own uses, is remote. But we have seen our farm aid machinery, in its limited field, turned to producing majorities in referenda on farm-control policies that Hitler might have regarded with envy.

There is no guaranty that the health insurance bureaucracy wouldn't groom a class of benefit-receivers as compact and as single-minded for their own interests as the farmers are for theirs.

Aside from the tremendous cost and the grave political dangers, there is the major consideration that the health insurance probably won't even have the beneficial effects claimed for it.

This doubt is not based only on the fact, heretofore mentioned, that the rate of claims never levels off, as it should if public health were really growing better. Sir Henry Brackenbury, one of the most distinguished British advocates of health insurance has admitted that any betterment in the health of the people may be due "to education, public health measures and increase in medical knowledge," and not to the health insurance system itself.

Indubitably, there are some places where public health has improved, and there are some where it has deteriorated. An English publication, *Labor-Management*, admits that the medical services under health insurance, have developed "with patches of brilliancy, and patches of gross inefficiency." It is not primarily the fault of the insurance doctors; they are overworked. One writer estimates that even before the war, the average consultation with a panel doctor lasted only 4 minutes.

It is not surprising that the workers distrusted this type of medicine. In 1936, about 600,000 British workers distrusted this type of medicine. In 1936, about 600,000 British workers renounced their right to medical care under the insurance system by failing to register on the panel. In the same year, one-third of the French workers who were eligible for insurance did not qualify for it. These facts underscore the question as to the medical success of health insurance.

Dr. BOAS. Senator Murray, I have a bit more detailed report which I should like to submit in addition to my testimony.

The CHAIRMAN. Yes; you may do that.

(The statement referred to is as follows:)

TESTIMONY ON S. 1606 BEFORE THE SENATE COMMITTEE ON EDUCATION AND LABOR, APRIL 18, 1946, BY DR. ERNST P. BOAS, CHAIRMAN, THE PHYSICIANS FORUM

I represent the Physicians Forum, a national organization of doctors who are interested in the improvement of medical care and in the dissemination of infor-

mation on the subject among physicians and the public. We are concerned first with the quality of medical care; second, with the widest possible distribution of the highest quality of medical care; and third, with the practical attainment of these ideals through a system of prepayment.

Our group, all doctors, counts among its members some of the country's most distinguished physicians, including a large number in private practice who have a first-hand knowledge of medical economics as it affects doctors and patients. Our membership also includes physicians who are connected with hospitals and medical schools and are therefore familiar with the influence of these institutions on medical practice and the health of the public. All our members belong to the American Medical Association or to the National Medical Association. Therefore, I address you as a physician and on behalf of physicians.

The Physicians Forum unequivocally supports the bill under consideration, S. 1606. As practicing physicians we know better than any other group of fellow Americans the present deficiencies in medical care, the needless suffering and death constantly occurring throughout this land because of bad distribution and scarcity of doctors and hospitals in many communities. We know that many persons cannot afford to buy ordinary medical care, and that few can cope with the costs of catastrophic illness. We know that many regions of this country cannot support the doctors and hospitals they need so badly. After searching inquiry we have reached the conclusion that national compulsory health insurance represents the only practical method to finance medical care and bring it within reach of all the people of the United States.

Ample factual evidence has been presented to this committee of the need for such a program. The availability of medical care depends today on how much the patient can pay, and in what part of the country he lives, not on his medical needs.

The past decades have been years of tremendous medical discovery and progress. Good medical care today is better than it has ever been, but it is also more expensive, so costly, in fact, that the majority of patients cannot afford to benefit from the present available medical knowledge. No longer is the solitary medical practitioner able to give adequate service to his patients. The constant development of new laboratory techniques, the increasing tempo of specialization, with the complex and difficult technical procedures which this involves, have brought it about that frequently many doctors must cooperate to reach a diagnosis and carry out treatment for a single patient. He pays a separate fee for each service rendered, and the doctor is compelled to send him from one specialist or one laboratory to another in order to obtain the data that he needs to reach a diagnosis or carry out treatment. The costs rapidly mount, so that often needed special examinations are postponed or omitted because the patient cannot afford to pay for them. A survey by the National Opinion Research Center of the University of Denver revealed that 31 percent of the people questioned had put off seeing a doctor because of the cost, and 23 percent had to borrow money to pay doctor or hospital bills.

We believe that in a democracy adequate medical care is a right to which all citizens are entitled. This right is necessary for the enjoyment of all other rights and privileges, for sick people are not free people. The most articulate expression of this viewpoint is found in the late Franklin D. Roosevelt's new bill of rights. In January 1944 he said:

"We have accepted, and so to speak, a second bill of rights, under which a new basis of security and prosperity can be established for all—regardless of station, race, or creed." Among these he said is: "The right to adequate medical care and the opportunity to achieve and enjoy good health; the right to adequate protection from the economic fears of old age, sickness, accident, and unemployment."

This principle was reaffirmed by President Truman. In his message to Congress on November 19, 1945, the President 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. * * * 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."

If we agree that medical care is a right to which all are entitled, and that many cannot afford to buy it it is clear that a large part of the money to pay for it must come from other sources. There is ample precedent for government to fill this gap, whether it be the local, State, or Federal Government. For years government has provided medical care for the indigent, and it has borne almost

the total cost of the medical care of the mentally ill and of the tuberculous, because families are unable to bear the drain of such long drawn out chronic illnesses. Expenditures by government for public-health activities, for child and maternal health, and for veterans run into sizable figures. Today public agencies in the United States spend hundreds of millions of dollars of tax revenues for the support of medical facilities and services for the civilian population.

No one challenges the principle of the use of public funds for the prevention of disease. But the prevention of disease today involves much more than the old-line activities of the public health officer—sanitation and vaccination. Today the chronic, so-called degenerative diseases, such as the heart diseases, high-blood pressure, diabetes, cancer, and chronic rheumatism, are the great hazards to life and health. Their control and prevention involves the creation of complete facilities for early diagnosis and treatment, and making them freely available to all. People must be encouraged to consult a physician at the first intimation of a bodily disorder, and not wait, as unfortunately many do, until the disease has progressed to an advanced stage at which damage may be irreparable. The financial barrier that keeps patients from seeking medical advice must be eliminated.

Today we can no longer say, "This is preventive medicine, a proper function of government; and this, on the other hand, is curative medicine, the function of the practitioner of medicine whose services must be bought in the open market." These two aspects of sickness control are inseparable; preventive medicine begins with measures of personal hygiene and health examinations conducted by the medical practitioner. So it is a logical and natural step in the prevention of disease today to turn to government for funds to provide adequate medical care facilities for all citizens of this country.

Because of the uneven distribution of wealth in the United States the Federal Government must assume responsibility. A State such as New York could finance its own system of medical care, but there are many States that are unable to do so. North Carolina, for instance, has an average net per capita income of \$317 compared to \$573 for the country as a whole; it has only two-thirds as many doctors and two-thirds as many hospital beds per unit of population as the country at large. Similar parallels between income and medical resources can be traced throughout the country. The increasing mobility of our population also makes it necessary that health plans be national in scope, so that the worker will not lose his benefits when he moves from one State to another.

The proposals for improvement of medical care have concerned themselves principally with the application of the insurance principle to the payment of medical care. Insurance applies the sound principle of pooling risks to reduce individual hardships. It spreads the cost of illness and makes it possible to meet the extraordinary cost of major illnesses out of a common fund to which all contribute. Insurance furnishes a practical method of overcoming the financial limitations to the purchase of adequate medical care. People can budget and make regular payments when they are well to pay for medical services when they are ill. Providing medical care for the people of our Nation by the insurance method is not foreign to our system of government. It is no more "foreign" than is the system of old-age security and unemployment insurance.

The Physicians Forum supports Senate bill 1606 because the bill recognizes, as we do, that sickness is a problem which concerns the whole community, and promotes the aims we consider essential for a system of national health insurance.

Under the provisions of the bill, medical coverage would include upward of 90 percent of the entire population in one medical-care program. This is as it should be, for the need for health insurance arises from the fact that the vast majority cannot afford to pay individually for adequate medical care.

It has been suggested by some that initially the coverage should be limited to a fraction of the population and that the benefits should be extended gradually as experience accumulates. Limitation of coverage to certain occupational groups or to geographic areas would be inequitable. Limitation by setting an income ceiling eligibility, say an income of \$3,500, would exclude only a small fraction of the population and would make administration of the act more difficult, not easier. The Physicians Forum approves the broad coverage proposed in this bill.

Much has been made, by opponents of this bill, of the point that this program adds over \$4,000,000,000 in taxes on a now overburdened taxpayer. This is not a true statement of the facts. Before the war the people of this Nation as a

whole spent about \$4,000,000,000 a year on medical care, so that the cost of the proposed medical-care program will not be significantly higher. It is not all new money that has to be raised over and above present expenditures. The advantage will be that persons would not be called upon as individuals to meet the heavy obligations imposed by the need for medical care and they would be free to seek medical services as soon as needed.

The bill does not state how these funds are to be raised, but leaves this decision up to Congress. The forum believes that it would be sound policy for Congress to legislate a distribution of national health insurance costs between employer and employee on a social-security basis, with supplementation from general tax funds, as called for in earlier drafts of this bill. There are definite advantages in financing a national health program by contributory insurance payments through pay-roll deductions. With the worker and employer contributing directly to the cost, they would be more apt to take an interest in the proper administration of the whole program, for they have a stake in it. It is just and psychologically sound for the worker to contribute to the costs of his own medical care. Knowing that he has paid for medical service, he will regard this service as a right, he will demand that it be adequate; and every stigma of charity, that in the past has been associated with medical services provided by government, will be eliminated. The benefits to the employer, derived from proper care for the health of his employee, are well recognized.

The provision in the bill, that if it should become necessary to prevent abuses, the patient may be required to pay a fee for the first service or for each service in a period of sickness, is unfortunate. Should this ever be applied, it would set up a financial barrier between the insured person and the physician, a barrier which health insurance is supposed to remove. It would tend to delay early recognition and treatment of disease. It would offer financial inducement to the physician to increase the number of his visits. If abuses arise that threaten the integrity of the insurance fund, it is better that they be regulated by the operation of local committees on which physicians are fully represented. A possible limitation of laboratory, dental, and nursing benefits is also unfortunate, but may become necessary, we recognize, until more administrative and actuarial experience has become accumulated and more professional personnel is available.

The administrative and organizational features of the bill are well conceived. Quite properly the Surgeon General of the United States Public Health Service is the administrator. The opponents of this legislation have raised the cry that the Surgeon General would become the "medical dictator" of the Nation. Nothing could be further from the truth. The bill provides that he is responsible to the Federal Security Administrator. Of equal importance is his responsibility to the National Advisory Medical Policy Council. This Advisory Council is not, as some have maintained, without power or responsibility. The bill specifically provides that in matters of policy, and in most important matters, the Surgeon General can act only after consultation with the Advisory Council, any four members of which may call a meeting. Public airings of the opinions of the Council are assured by the provision that the Surgeon General in his regular reports to Congress must include a report of his consultations with the Council along with its recommendations. Thus the Council will have real responsibility and power to advise and make its views known. The cry of "dictator" is being supported by those of the medical profession whose dictatorial control of the medical policies of the country is being threatened.

It is also falsely charged that all details of medical care would be run from Washington by a horde of bureaucrats. Once more the provisions of the bill itself give the lie to this argument. Actually all that the Federal Government would do is what is necessary to the success of any national plan—collect the money and set up minimum standards to be followed by all doctors and hospitals. Decentralization of administration is assured by the instruction that the Surgeon General utilize as far as possible the services of State and local advisory and technical committees to advise in administration.

The bill does not affect the present set-up of medical practice. Doctors may refuse patients, patients may choose doctors. Unfortunately, even the fee-for-service system of payments to practitioners is allowed if practitioners so elect. We say "unfortunately," because it is an accepted fact based on experience, that no health-insurance plan has been able to function with fullest efficiency under the fee-for-service system. It creates a huge amount of paper work for physicians and the administration, and it leads to inevitable abuse by doctor and patient. We predict that physicians will be the first to repudiate this method of payment.

The section of the bill that provides a substantial appropriation for both research and professional education is laudable. Without the continuous leaven of research and education the practice of medicine quickly withers and becomes a mediocre routine. The best medicine today is practiced in our university hospitals where teaching and research go hand in hand with the care of the sick.

We are physicians and it is natural for us to ask the question: "How does compulsory national health insurance affect us? Granted the public has everything to gain from this measure, what about us?" The physician today is a split personality. He is a combination of a professional man and a small businessman. These dual activities often conflict with one another, to the doctor's distress and patient's disadvantage. All too often, the physician is prevented from giving his patient the benefit of the full resources of medicine because the patient cannot afford the expense of the procedures involved. The doctor is unable to practice medicine in the way he wishes to and in the way it should be practiced. At present, all doctors are very busy and very prosperous. They forget that only a few years ago 60,000 doctors who are now being released from the armed services were competing with them for patients, and that a large number of these patients had no money. In 1936 the median net income of physicians was \$3,234; in 1938, \$3,027, and in 1940, \$3,245. Compulsory health insurance will stabilize the income of doctors over the years and, in fact, will increase the incomes of the majority. It has been estimated that general practitioners under the plan will earn about \$8,000 a year gross, and specialists about twice as much from insurance practice aside from private practice.

Because there will be no such thing as free services, we should no longer hear, as we did, in the recent past, that physicians are contributing a million dollars' worth of free medical service per day. Dispensary services in their present form, where doctors receive no pay whatsoever, would disappear. All medical service would be paid.

Moreover, doctors would no longer be compelled to choose their locale on the basis of whether the community could afford a physician. They would not be forced, as they are now, to crowd the urban areas and enter into harsh competition with one another for the restricted number of middle-class patients from whom they derive the bulk of their income today. There would be less inducement for them to indulge in the dishonest practices of fee splitting and the kick-back.

Economic pressure on the young doctor entering practice would also be relieved to a considerable degree. Smaller communities would be in a position to attract the younger man who nowadays shuns them for economic reasons. Moreover, the young physician could always enter into contract with the insurance fund on a salary basis, full or part time, and thus bridge the first years of practice during which economic insecurity is greatest.

Most physicians enter and remain in the field of the practice of medicine because they derive a sense of satisfaction from the prevention and alleviation of sickness. Under this bill the physician will find his relationship with his patients unimpeded by economic barriers. No longer will the problem be whether the patient can afford the treatment the physician thinks is necessary. No longer need the physician hesitate to call for the complete working up of any case, regardless of cost. No longer need the patient wait until the disease becomes acute before consulting the physician. For the first time preventive and curative medicine can come into its own on the largest possible scale.

The Physicians Forum is gratified by the provision in the bill authorizing cooperative groups of physicians to give services under the plan. The application of the national compulsory health insurance principle will solve the economic problem involved in the provision of medical care to all, but it would be a grave mistake to believe that all problems of medical care will be solved when the economic basis alone is assured. Professional and technical medical considerations determine the adequacy of medical care, whether paid for by an insurance fund, by governmental, philanthropic, or private enterprise. The record of the various compulsory health insurance schemes in Europe demonstrates that an economic solution alone is not the whole answer.

We must adopt a fresh approach to the technical and professional aspects of medical care, just as we have for the economic aspects. The old answer was to supply a family physician for all. This would give each patient the services of a general practitioner and assure the doctor's income. It does not allow for all of the components of medical care that today are accepted as essential; it does not recognize the preventive services, the services of specialists and con-

sultants, the provision of the more complex diagnostic and therapeutic facilities, and hospitalization. Medical machinery must be geared to carry to each patient the full benefits of the whole art and science of medicine. What is needed is a better coordination and organization of medical facilities. A health insurance scheme must be based on the principle of cooperative group practice.

Group practice offers many advantages to doctors and patient. It cuts down overhead expenses—rent, secretarial and nursing help—it eliminates duplication of expensive laboratory equipment, and makes it possible to use such equipment to capacity. This saving can be passed on to the patient, who can thus obtain the best diagnostic and therapeutic services for at least 30 percent less than if he had to visit many individual doctor's offices, each one fully equipped but utilized only part of the day. But there is a much greater merit to the plan. When a group of doctors work together, examine the same patients, and discuss the many problems that arise in the daily practice of medicine, they are constantly teaching and stimulating one another. Each physician is learning something daily from his colleagues, and is ever stimulated to his best performance. Group practice made available by means of a prepayment plan, whereby the patient is entitled to all of the facilities of the clinic that are needed in his particular case, without paying separately for each item, assures much better medicine.

The bill permits the Surgeon General to make contracts with hospitals for complete medical services, and so enables the present excellent university and voluntary hospitals to serve the insured public. Funds designated to pay for physicians' services, however, are not earmarked. It is important that the amounts allocated for hospital care and for professional services be separated, else it might lead to exploitation of the physicians by the hospitals.

Additional provisions are needed in the bill to safeguard the physicians' rights and privileges. There should be some specific provision assuring that the income of physicians will conform to the average to levels at present current in more prosperous communities of the United States, with due consideration to the fact that income levels should actually be somewhat higher than they are today, because the physician will be paid for much of the work he today does without compensation. There should be provisions enabling the physician to pursue postgraduate study, and to take appropriate vacations without loss of income.

To bring good medical care to the country at large, to make group practice possible and to provide for the needed extension of public health and preventive services, fully equipped health centers, smaller general hospitals and large general hospitals must be established throughout the country. It would be impossible to make intelligent plans for a Nation-wide medical-care program, as provided for in this bill, without making provision for needed hospital facilities. Health centers will be the units in which the preventive medicine of the local community will be established. They should be large enough to include facilities for offices for physicians of that area, who with proper equipment and working as a group can take care of many of the local needs. These health centers should be integrated with county or district hospitals, and these hospitals in turn should be related to larger hospitals in the urban centers where the most difficult cases and those requiring the most specialized treatment will be taken care of. Very many communities have not the financial resources to establish such institutions, and Federal funds will have to be made available for their construction. With such a set-up doctors will be attracted to the smaller communities and will be able to practice good medicine.

Many have cherished the hope that voluntary sickness insurance might fill the need. Even the conservative organized medical profession has accepted the principle of voluntary health insurance, provided the organization furnishing such protection is governed and controlled by physicians.

During the past decade an increasing number of voluntary health insurance plans have been launched. Broadly speaking they may be divided into two great classes: one which operates on a fee-for-service basis; i. e. the doctor is paid out of the insurance fund for every individual visit or service rendered; a second which is a per capita prepayment or service plan where the physician receives a certain sum annually, for which he renders complete general practitioner service to the patient. Organized medicine has insisted on the fee-for-service method of paying doctors, and has supported a number of plans developed on this principle throughout the country. In most of these benefits are restricted to all or part of the doctor's fee for a surgical operation, or for obstetrical services.

These plans are essentially medical expense indemnity insurance, much like accident and sickness insurance one can buy from a commercial insurance com-

pany. They are schemes to reimburse the patient for the costs of medical care provided through physicians. They give the patient a certain protection against the cost of catastrophic illnesses, but do not assure him adequate medical care. They guarantee the physician payment of certain of his bills, but do not make it much easier for him to provide the best medical service to his patients.

The cash indemnity plans strike at only one of the several weaknesses in the current medico-economic set-up, the unpredictability of heavy medical expense. Experience has demonstrated that medical insurance, to be practical and to provide adequate medical service, must cover all elements of medical care, and must be of a service rather than of an indemnity character. It must be a prepayment plan for medical services. The patient pays a certain sum annually, and for this receives complete medical coverage, for general practitioner, specialist, laboratory, hospital and preventive services.

A few such voluntary health insurance plans are in successful operation. They can exist only under special favored circumstances, among employees of one large industry, and as a rule with a subsidy from the employer. Usually they cover the worker, but not his family. They succeed in times of plenty, but with curtailment of employment, at a time when they need it most, many workers lose their insurance.

In all such plans that are functioning efficiently—plans such as those of the Endicott-Johnson Shoe Co., of the Stanacola Co., of the Henry Kaiser Permanente Foundation, and of the Ross-Loos Clinic—the physicians are salaried. They do not operate on a fee-for-service system. Experience has shown that a certain small percentage of both patients and doctors take advantage of the insurance fund if payment is made for each service rendered, instead of by straight salary, and run up unnecessary bills. So in order to protect the insurance funds, plans employing the fee-for-service method of payment compel the patient to pay for the first few calls of any illness, and set up a complicated and expensive system of checks to detect cheating. Such safeguards discourage the patient from calling the doctor at the first signs of illness, and impede preventive services, but are essential to protecting the insurance fund from bankruptcy. A number of insurance plans initiated by medical societies suffered such financial losses, were compelled to give up complete medical coverage and now sell only indemnity insurance for surgical operation. Insurance guaranteeing complete medical coverage cannot be set up, except at a prohibitive cost, if the fee-for-service principle is retained.

But even when doctors are paid by salary or by a capitation scheme, i. e., a certain sum annually for each patient on their panel, voluntary insurance against sickness is not cheap; the charges must be from \$25 to \$30 per person per year. For a family of four this amounts to \$120 a year. For low income families, for those with incomes below \$2,500, this is far too expensive. The other necessities of life at these income levels are too demanding; prepayment for illness is put off in the hope that illness will not strike.

Skimping of charges to make the insurance plan available to persons with lesser incomes leads to poor medical service and to exploitation of the physicians. Many voluntary insurance plans have this defect, particularly those set up by labor or fraternal organizations. The reason lies in the simple fact that the clients have incomes too low to allow payment for complete satisfactory medical services.

For all of these reasons the protection offered by voluntary sickness insurance in this country is minute in comparison to the need. A mere handful have complete medical coverage, and even if one adds thereto those with partial insurance of an indemnity nature, hardly 5 percent of the population of the country are covered. In this the experience of the United States reflects the experience of other countries more advanced in the organization for the distribution of medical care—voluntary plans fall far short of meeting the needs of the country.

The essence of the arguments presented by the opponents of this bill is that it would bring about a system of "State medicine" or "socialized medicine." What is this great bugaboo we have been taught to fear? The terms as used today have an emotional, not a factual, connotation; they are catchwords employed to arouse emotional resistance to plans to improve or change the methods of distributing medical care. As President Truman stated in his message to Congress recommending the enactment of national health legislation:

"They (i. e. the American people) 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."

Yet we have a good deal of State medicine in the country. Those who cry that this bill destroys the private practice of medicine in the United States ignore completely that a large part of the expenditures for doctors and hospitals in 1942 were either tax-supported or otherwise without cost to the patient. We have public systems for the care of the mentally ill, the tuberculous, the merchant seamen, and the veteran.

We have advisedly devoted most of our remarks to title II of this bill. It is the most important section and at the same time it bears the brunt of the attack by the opponents of the bill. Yet, title I is an important part of the program for a healthier nation and it receives the support of the physicians forum.

We approve of the section which provides increased grants to States for public health services. The present system of grants-in-aid and cooperation between the United States Public Health Service and the States in the promotion of public health services has been very successful, but limited in scope. Under the provisions of the bill it will be possible to expand these programs rapidly, and in particular to help those States that are in greatest need.

The section providing increased grants to States for maternal and child health services is admirable and the forum approves an expansion of these services. However, if we are to have a national health insurance program, as called for in title II of this bill, care should be taken to prevent any overlapping of services. As President Truman pointed out in his message to Congress: "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." Maternal and child health services should be limited to community-wide services on the basis of filling any need not covered by national health insurance, and the program should be carefully integrated with the over-all plans for health and medical services. Despite the Children's Bureau's enviable record of solid achievement in its present maternal and child health program, it would nevertheless seem desirable to coordinate this program with the general health services under the direction of the Federal Security Agency or of a Cabinet official.

We endorse the provision for medical care of needy persons. At present States receive no grants for medical aid for general relief cases. Federal grants of 50 percent of the State and local expenditures, up to a fixed maximum regardless of the financial capacity of the State and the locality, are at present provided in assistance for the needy aged, the needy blind and dependent children. More specifically, Federal grants are made only for amounts paid unconditionally to the relief recipient or his guardian. The requirement of a direct grant and a monthly maximum limit greatly the effective provision of medical service for indigent groups.

The new bill removes these limitations. It permits Federal grants for all indigent groups, it removes the maximum, it makes larger grants to States with per capita income below the national average, it provides grants for medical care whether it is paid for by cash grants to the recipient or directly to those furnishing these services. In fact, it allows the States and localities to contract with the insurance program to provide medical services to indigent individuals—who are not insured under the prepaid medical service plan—on the same basis as for the insured and their dependents. If the latter course is followed the invidious distinction of charity patients will be abolished, physicians will give the same care to all and will receive like compensation for all groups of patients from the insurance fund. The number of pay patients to be cared for by private physicians will thus be increased.

The forum strongly disapproves of the use of Federal grant-in-aid for direct payments to patients for medical care—a method too easily abused, perhaps by inadequate payments, perhaps by failure of the patient to use the payment for medical purposes. The only sound method of supplying medical care to relief cases is by grants, the proceeds of which are used to insure such people under the national health insurance fund.

Chief among those opposed to national compulsory health insurance is the American Medical Association and its satellite, the National Committee of Physicians. The American Medical Association has always opposed public action in any field of medical care, except in the case of the indigent. It is common knowledge that it opposed the establishment of workmen's compensation insurance, of the Blue Cross hospital insurance plans, and until recently it relentlessly fought plans for voluntary medical-care insurance. It is instructive to review the minority report prepared by representatives of the American Medical Association who were on the Committee on the Costs of Medical Care. They wrote: "The minority recommends that Government competition in the practice of medicine be discontinued. * * * The minority recommends that Government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden." They then go on to say: "Nothing has been made clearer than the fact that voluntary insurance schemes have everywhere failed. * * * It seems clear, then, that if we must adopt in this country either of the methods tried out in Europe, the sensible and logical plan would be to adopt the method to which European countries have come through experience, that is, a compulsory plan under Government control."

In the light of these historic facts the present tactics of the American Medical Association in opposing national compulsory health insurance and in advocating voluntary plans under its own management seem somewhat disingenuous. It has already been shown that there is no basis for its chief claims that the practice of medicine will be regimented, that the personal relationships between doctor and patient will be destroyed, that there will be no free choice of physician, that the quality of medical care will deteriorate.

The American Medical Association is in fact serving as a guild battling to retain the economic privileges of the medical profession. In this campaign it has allied itself with businesses that are purveyors of commercial aspects of medical care—with pharmaceutical houses, makers of surgical instruments and appliances, and certain insurance companies—and through the agency of the National Physicians Committee has obtained substantial funds from these sources to carry on its propaganda. While the American Medical Association accepts and encourages the business transformation that the modern industrial era has brought about in the practise of medicine, the physicians forum recognizes the evils that this change has entailed, their destructiveness to the medical profession, and their harm to the patients whom it serves. Through such a national health program as is proposed in S. 1606 most of the financial handicaps that have prevented the extension of good medical care to all citizens will be lifted, and physicians will be free to rededicate themselves fully to the prevention of disease and the treatment of the sick.

We urge favorable action of this bill. America now has its greatest opportunity before it—the opportunity to safeguard and improve the national health. As a nation we have learned the importance of good health of all our citizens, and are realizing that we cannot afford to leave the health of our people to the chance that they may have sufficient income to command modern medical care; or to expose them to the disadvantages that their race, their color, their occupation or their residence in a less favored economic community may bring about. Doctors must be given the opportunity to employ the complete resources of modern scientific medicine for the benefit of all our people.

Senator ELLENDER. At this point, Mr. Chairman, I would like to insert into the record a statement from the Louisiana State Medical Society on this matter.

The CHAIRMAN. That may be done.

(The document referred to is as follows:)

LOUISIANA STATE MEDICAL SOCIETY,
New Orleans 13, La., April 15, 1946.

COMMITTEE ON EDUCATION AND LABOR,
United States Senate, Washington, D. C.

GENTLEMEN: The Louisiana State Medical Society, through a special committee, on directive of the executive committee, offers the attached brief in reference to Senate bill 1606 and House bill 4730. This represents the objections of the medical profession of the State of Louisiana to the various provisions of these bills.

It is our understanding that oral testimony by the individual State medical societies will not be permitted. We therefore respectfully ask that this brief be accepted and printed as a part of the hearings of the committee just as though an appearance had been made by our group.

Yours very respectfully,

P. T. TALBOT M. D.,
Secretary-Treasurer.

**VIEWS OF THE LOUISIANA STATE MEDICAL SOCIETY IN REFERENCE TO SENATE BILL 1606
AND HOUSE BILL 4730**

We realize that there is some attempt made by these bills to expand and provide for needed medical services; a feature which is universally approved by the entire medical profession and something which we have been constantly improving for many years. The best medical minds in the world have been and are busy working on a continuation of this effort. Even through the most destructive war we have ever had and with the small number of men remaining at home, there has been no let-up in this activity during this period of time. The revolutionary plans as provided for in the bills, which should be regarded as socialization of medicine, are typical of postwar periods and such plans after being tried usually revert back to the methods of the past.

Following is a review of S. 1606.

The bill is basically in error in presuming that with the increase in medical care there will be a reduction in the incidence of disability and illness in childhood, because, for such a reduction all students of health realize the basic needs are improvement of environments, especially of rural families, essential clothing, food, personal and community hygiene, housing, sanitation, and raising the standards of literacy.

The bills will not supply more adequate medical care as claimed by the proponents, which is the motivating influence claimed for such legislation. The results to the contrary, will produce inferior and politicalized medicine and thus delude the American people in this erroneous impression.

The implications in these bills are un-American and alien to ideologies, typical of totalitarianism and communism which wear the dominating rule in Germany, Italy, and Russia. This is socialized medicine more sweeping and even more far reaching than any ever attempted in any country, with the possible exception of Russia.

It should be conceded by well supported data that the medical profession of this great country, on past performance and their potentialities, would be the right and proper group to turn to and depend upon for any remedial changes, if needed, in order to render adequate medical care, therapeutic medicine, and research.

Any form of compulsion, implied or stated, is contrary to our democratic concepts and robs our country of the stability and strength so strongly manifested by free enterprise, so elemental to our social economy. This freedom of medical opportunities has contributed more to the strength, health, and happiness of this great Nation than any other factor, which has resulted in making our Nation the greatest and strongest in the world.

The United States Public Health Service should never be restricted or hampered in the functions assigned to them of preventive medicine by added burdens of therapeutic medicine for which they are not prepared by practice to perform, comparable to our regular physicians. Their fields of preventive medicine offer many opportunities which have been so ignominiously neglected to their discredit and reaction on the health of the Nation.

In regard to title I, section A, we would refer to our statement above.

Concerning title I, section B, we object to the Federal Government encroaching on the practice of medicine in any of its branches. We feel that the care of pregnancy and the care of infants and crippled children are specialized branches of medicine and should be left to the medical profession to provide for medical care in the same manner as they do for all other diseases of the human body. In regard to treatment of crippled children, we feel that this field of medicine is very thoroughly taken care of in our State by the organized profession and allied groups and that the provisions for taking care of these children are adequately provided for on a State basis.

We do not understand why provisions for the above services should be included in this bill as all are provided for now by the Federal Government.

If larger appropriations are needed for the conduct and expansion of any of this work there is no doubt that Congress now has the power to grant same.

In reference to title I, section C, "Grants to States for care of needy persons," we approve grants-in-aid to supplement funds of State and local agencies to provide full medical care and hospitalization for the needy; same should be provided only to persons whom the payment for such services would be a hardship, and same should be done with State control and local administrative authority as now being done in our State; supplying medical care and hospitalization both free of charge.

We object to title II in its entirety for the following reasons:

The Surgeon General would be authorized and directed to arrange for the availability of benefits; he would have full control of the expenditure of unestimated billions of dollars without outside interference, setting up a one-man dictatorship.

The patient would not have the free choice of a physician, but would have a choice only of a physician who is a member of the panel; i. e., a physician who has agreed to work under the plan and on condition that the Surgeon General has not so limited that physician's practice as to preclude the acceptance of more patients. Should the patient's family physician not be a member of the panel said individual would be required to pay his family physician's fee for medical service, after having already had a tax for medical services deducted from his earnings. The fundamental rights and democratic privileges of freedom, to select one's own physician, and the great comfort enjoyed in the maintenance of the patient-physician relationship is destroyed by these bills.

In every instance where the Government has interfered in the distribution in the quality of medical care, it has destroyed the initiative and the incentives of the individual doctor and it has robbed the medical profession of its independence and its self-respect.

The States would be forced to accept the provisions of the bills whether they approved this legislation or not; this would be unconstitutional because it does away with state rights. (Following the close of Civil War the medical profession had incorporated in the constitution of Louisiana provisions whereby all State activities carried on in charitable institutions, grants to hospitals and individuals should be a State responsibility).

The present expansion of voluntary prepayment medical insurance, both from a National and State viewpoint, the great increase in industrial medicine and the enlargement of contracts for medical and surgical services through commercial insurance groups, all at a lower cost than will be required under these bills, should preclude the necessity for governmental supervision of medical care. The American Medical Association, which is in a better position to know the medical needs of the country, has recently adopted a constructive program for the improvement of medical care. (Refer to the attached clipping from the March 9, 1946, journal of the AMA.) The objectionable features contained in the bills introduced by Messrs. Wagner, Murray and Dingell have been entirely eliminated in the national program of the American Medical Association, sponsored by physicians on a voluntary prepayment basis substituting a process of evolution rather than revolution.

We are in favor of seeing that everyone is provided with proper medical care but are opposed to further taxation on an already overburdened public and particularly to the inequitable payment of such taxation. The low-income individual, who is now eligible for medical services free of charge in city and State institutions in Louisiana would be compelled to pay for such service.

Unemployed individuals over 65 years of age would not be eligible for participation, leaving them to the mercy of the public and their friends even though they may have participated in the plan for a number of years.

It would require at least 300,000 bureaucrats to administer this program.

Federal funds would be provided to subsidize medical education and medical research. We are opposed to this provision of the bills because the Surgeon General would be authorized and directed to administer grants-in-aid to nonprofit institutions and agencies engaging in research or undergraduate or postgraduate professional education, and he would have some \$80,000,000 annually at his disposal. Such a program would lower the standards of opportunity in this field and would probably inhibit the dissemination of such results as might accrue to those who are most deeply interested in such discoveries. Most of the great discoveries and improvements in medicine since the foundation of our country have been done by private initiative by our medical schools and by grants and loans from philanthropic sources and associated medical groups, such as pharmaceutical

houses, and instrument houses which have aided the medical profession in keeping the high standards of medical practice which it now enjoys. Therefore, at the present the American medical profession stands head and shoulders above the medical profession in any other country in the world. We feel that the American public is better protected than the people of any other country in the world. We feel that the American public has a right to this continued medical service and that it should not be dissipated by such revolutionary measures as proposed in the Wagner-Murray-Dingell bills.

NATIONAL HEALTH PROGRAM OF THE AMERICAN MEDICAL ASSOCIATION

ADOPTED BY THE BOARD OF TRUSTEES AND THE COUNCIL ON MEDICAL SERVICE,
FEBRUARY 14, 1946

1. The American Medical Association urges a minimum standard of nutrition, housing, clothing, and recreation as fundamental to good health and as an objective to be achieved in any suitable health program. The responsibility for attainment of this standard should be placed as far as possible on the individual, but the application of community effort, compatible with the maintenance of free enterprise, should be encouraged with governmental aid where needed.

2. The provision of preventive medical services through professionally competent health departments with sufficient staff and equipment to meet community needs is recognized as essential in a health program. The principle of Federal aid through provision of funds or personnel is recognized with the understanding that local areas shall control their own agencies as has been established in the field of education. Health departments should not assume the care of the sick as a function, since administration of medical care under such auspices tends to a deterioration in the quality of the service rendered. Medical care to those unable to provide for themselves is best administered by local and private agencies with the aid of public funds when needed. This program for national health should include the administration of medical care, including hospitalization to all those needing it but unable to pay, such medical care to be provided preferably by a physician of the patient's choice with funds provided by local agencies with the assistance of Federal funds when necessary.

3. The procedures established by modern medicine for advice to the prospective mother and for adequate care in childbirth should be made available to all at a price that they can afford to pay. When local funds are lacking for the care of those unable to pay, Federal aid should be supplied with the funds administered through local or State agencies.

4. The child should have throughout infancy proper attention, including scientific nutrition, immunization against preventable disease and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child care and infant welfare stations administered under local auspices with support by tax funds whenever the need can be shown.

5. The provision 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. Where such facilities are unavailable and cannot be supplied through local or State agencies, the Federal Government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established (Hill-Burton bill).

6. A program for medical care within the American system of individual initiative and freedom of enterprise includes the establishment of voluntary non-profit prepayment plans for the costs of hospitalization (such as the Blue Cross plans) and voluntary nonprofit prepayment plans for medical care (such as those developed by many State and county medical societies). The principles of such insurance contracts should be acceptable to the council on medical service of the American Medical Association and to the authoritative bodies of State medical associations. The evolution of voluntary prepayment insurance against the costs of sickness admits also the utilization of private sickness insurance plans which comply with State regulatory statutes and meet the standards of the council on medical service of the American Medical Association.

7. A program for national health should include the administration of medical care, including hospitalization, to all veterans, such medical care to be provided

preferably by a physician of the veteran's choice, with payment by the Veterans' Administration through a plan mutually agreed on between the State medical association and the Veterans' Administration.

8. Research for the advancement of medical science is fundamental in any national health program. The inclusion of medical research in a National Science Foundation, such as proposed in pending Federal legislation, is endorsed.

9. The services rendered by volunteer philanthropic health agencies such as the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Inc., and by philanthropic agencies such as the Commonwealth Fund and the Rockefeller Foundation and similar bodies have been of vast benefit to the American people and are a natural outgrowth of the system of free enterprise and democracy that prevail in the United States. Their participation in a national health program should be encouraged, and the growth of such agencies when properly administered should be commended.

10. Fundamental to the promotion of the public health and alleviation of illness are widespread education in the field of health and the widest possible dissemination of information regarding the prevention of disease and its treatment by authoritative agencies. Health education should be considered a necessary function of all departments of public health, medical associations and school authorities.

The CHAIRMAN. Thank you very much, Doctor.

Dr. Robinson will be the next witness.

Dr. ROBINSON. May I bring Dr. Cornelli with me?

The CHAIRMAN. Yes, you may.

STATEMENT OF DR. E. I. ROBINSON, PRESIDENT, NATIONAL MEDICAL ASSOCIATION, ACCOMPANIED BY DR. PAUL B. CORNELLI

The CHAIRMAN. Doctor, you may state your name, and the organization you represent.

Dr. ROBINSON. I am Dr. E. I. Robinson, representing the National Medical Association.

The CHAIRMAN. Doctor, you are licensed to practice medicine in what State?

Dr. ROBINSON. I am a licensed physician practicing in the State of California.

The CHAIRMAN. How long have you been a practicing physician?

Dr. ROBINSON. I have been a practicing physician for 27 years.

The CHAIRMAN. And you are still practicing medicine in that State?

Dr. ROBINSON. Still practicing in California.

The CHAIRMAN. Doctor, do you have a prepared statement which you wish to follow in your appearance here this morning?

Dr. ROBINSON. I do.

The CHAIRMAN. You may proceed.

ENDORSEMENT OF THE BILL

Dr. ROBINSON. The National Medical Association, which is composed of approximately two-thirds of the approximately 4,000 Negro physicians in this country and which is separate and distinct from the American Medical Association, is in favor and supports the S. 1606 known as the Wagner-Murray-Dingell bill. It bases its support primarily on the fact that this bill is an expression of the democratic principle that an attempt will be made to give the most to the greatest number of individuals, and because it is in conformity with the general welfare clause in our Constitution whereby the Federal Government assumes the responsibility to see to it that the welfare of every individual in the Nation will be adequately safeguarded.

The National Medical Association is firm in its belief that the various sections of the bill, if put into operation, would help to improve the health of the Nation as a whole, and particularly the health of individuals in the low socioeconomic level which includes a large section of the Negro population. Because the National Medical Association is an organization composed of Negro physicians, it is particularly interested in the welfare of Negro people.

HEALTH PROBLEMS OF THE NEGRO

At present, the Negro has a number of health problems which would certainly be ameliorated by the passage of this bill. Some of these problems may be briefly enumerated since they are well known to people interested in health and welfare.

1. The death rate of the Negro is approximately 30 to 40 percent higher than that of the white population and his average expectation of life is 10 to 12 years shorter than that of his white neighbor.

2. A number of diseases such as tuberculosis, venereal diseases, pneumonia, influenza, and heart diseases have a much higher rate of mortality in the Negro than in the white population.

3. Negro mothers and babies die proportionately in higher numbers than white mothers and babies. For the United States as a whole, approximately two and one-half times as many Negro mothers die as white mothers, and about twice as many Negro infants die under 1 year as white babies.

4. There is a lack of hospital facilities of all types for Negroes. In most communities the number of general-hospital beds is anywhere from one-tenth to one-half the ratio of beds per population allocated to the white population. It is true that this bill has no provisions for the building of hospitals, since this is the responsibility of the Hill-Burton bill or S. 191, but it should be stated here that the building of hospitals will be of no value unless the means for their operation are made available. This is the reason why the passage of S. 1606 is of particular importance in supplementing S. 191.

In the South, approximately 10,000 to 11,000 Negroes die of tuberculosis yearly and yet there are less than 6,000 beds for the care of these individuals. The American Public Health Association has stated that there should be at least two beds for every death from tuberculosis in order to care adequately for this disease. Thus there is need in the South for about 20,000 to 25,000 beds for the care of Negro tuberculosis patients. The dearth of convalescent-care facilities and of hospitals for the mentally ill as far as Negroes are concerned is very well known by most of the public health authorities.

5. There is need for trained professional personnel in the Negro population. There are only approximately 4,000 Negro physicians in this country or 1 Negro physician for about every 3,500 Negroes. In some States the number of Negro physicians is insufficient to take care of the needs of the population. A study in North Carolina has shown that there is need for 800 Negro physicians in that State alone yet at present there are only 170. In the State of Mississippi with a million or so Negroes, the number of Negro physicians is about 50. There are only about 1,700 Negro dentists in this country to care for a population of 13,000,000 Negroes. There are other professional

deficiencies, such as public-health nurses, medical social workers, and laboratory technicians.

6. The economic situation of the Negro may well be considered part of the health picture and is particularly pertinent in connection with the discussion in support of this bill. The health problems of the Negro are inextricably tied up with his economic situation rather than with any inherent racial factor. Simply stated, it may be said that he is not healthy because he cannot purchase health. The per capita income of Negroes in the South is low and the bulk of Negroes live in the South. This is indirectly shown by the fact that in the 1940 census the median per capita income in the State of Georgia was \$461 and in Mississippi \$389.

On the basis of these few facts, the National Medical Association believes that the passage of this bill would help to eradicate some of those disparities and improve the level of the health of this section of the population.

PROPOSED AMENDMENTS

However the National Medical Association is of the opinion that there are certain safeguards which should be established so that the operation of the bill will be effective and will not provide opportunities for abuse. Therefore this society wishes to list certain suggestions which may be helpful in this direction.

1. In title I of the bill, which concerns the grants-in-aid to be administered by the United States Public Health Service and the United States Children's Bureau, the National Medical Association wishes to urge that these two agencies make every effort to see to it that services are developed for the Negro population in terms of their needs, rather than on the basis of any arbitrary ratio. This is particularly applicable to southern communities where all too often there has been a tendency to neglect the Negro in the equitable expenditure of funds either for health or for education.

2. In the provision of the bill dealing with medical care of needy persons, the National Medical Association strongly disapproves of the use of grants-in-aid for direct payments to patients for medical care. It is hoped that this method will not be put into operation since it would be preferable to supply medical care to relief cases by grants the proceeds of which would be used to insure such people under the national health insurance fund.

3. In title II of the bill which is concerned with prepaid personal health service benefits, it is hoped that if the bill is passed, the United States Public Health Service in the administration of the section of this bill will see to it that there will be Negro representation on the national advisory medical policy council and also in the State and local committees which will be established for purposes of advice and guidance.

4. The National Medical Association strongly disapproves the provision which necessitates that the patient be required to pay a fee for the first service or for each service in a period of sickness. This would lend itself to a great deal of abuse, since it would offer financial inducement to the physician to increase the number of his visits.

5. Lastly, it is hoped that in the payment of physicians under a national health insurance plan the fee-for-service system would be eliminated. It has been the experience in other countries where health

insurance has been in practice for a number of years that the fee-for-service plan creates a great deal of paper work and leads to abuse by doctor and patient.

Summarily, the National Medical Association wishes to express its commendation to the men who have been responsible in formulating this bill since it believes that only through the establishment of a sound national health program can the health of the nation be definitely improved.

The CHAIRMAN. Thank you, Doctor. Any questions, gentlemen?

Senator DONNELL. I would like to ask a few, Mr. Chairman.

Doctor, early in your testimony you state that the National Medical Association, and I quote:

bases its support primarily on the fact that this bill is an expression of the democratic principle that an attempt will be made to give the most to the greatest number of individuals and—

It is what is after "and" I call your attention to particularly—

because it is in conformity with the general-welfare clause in our Constitution whereby the Federal Government assumes the responsibility to see to it that the welfare of every individual in the Nation will be adequately safeguarded.

Dr. ROBINSON. I will ask Dr. Cornelli to answer that for you.

Senator DONNELL. Let me ask a few questions before he answers, please. What is your name, please?

Dr. CORNELLI. Paul B. Cornelli.

Senator DONNELL. Paul B. Cornelli. What is your profession?

Dr. CORNELLI. I am a physician.

Senator DONNELL. Are you a lawyer?

Dr. CORNELLI. No, sir.

Senator DONNELL. Dr. Robinson, may I ask you who is responsible for the insertion in your statement of that language which I have quoted, namely:

it is in conformity with the general-welfare clause in our Constitution whereby the Federal Government assumes the responsibility to see to it that the welfare of every individual in the Nation will be adequately safeguarded.

Dr. ROBINSON. I am.

Senator DONNELL. Then why, may I inquire, is it that you prefer not to answer the question?

Dr. ROBINSON. I have a little throat trouble. I have read the statement; and Dr. Cornelli has been here before as our representative in congressional legislation.

Senator DONNELL. It is because of your throat?

Dr. ROBINSON. Yes, sir.

Senator DONNELL. Dr. Cornelli, have you studied this question as to the effect of the general-welfare clause of the Constitution?

Dr. CORNELLI. I would say, Mr. Senator, that it is an accepted fact. I believe that many of the services which have been developed in this country through the United States Public Health Service have been developed on the basis of the general-welfare clause. If you will let me follow this through—

Senator DONNELL. Surely.

Dr. CORNELLI. Namely, that the Government can use tax funds for the improvement of the health and welfare of the Nation. For instance, the venereal-disease law, which was passed in 1938, and the

Cancer Act, 1937 or 1938, allocated millions of dollars on the basis that it could do this to improve the general welfare and health of the Nation. I think that is an accepted fact.

Senator DONNELL. Doctor, the specific question I had in mind was, and I think I put it to you: as to whether or not you have examined into the question as to whether or not the statement in our Constitution is one whereby—

the Federal Government assumes the responsibility to see to it that the welfare of every individual in the Nation will be adequately safeguarded—

is a sound construction of the so-called general-welfare clause of the Constitution? Have you looked into that?

Dr. CORNELLI. I did maybe about 15 years or so ago, when I was working for my doctorate in public health. I have not checked the meticulousness of the statement as expressed in the memorandum here, but I believe that that expression is the attitude or feeling in this country in terms of the general-welfare clause.

Senator DONNELL. To what clause in the Constitution do you refer to as the "general-welfare clause"?

Dr. CORNELLI. I do not have the Constitution here.

Senator DONNELL. Is it section 8 of article I, which reads:

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.

Dr. CORNELLI. That is the statement which we used in the formation of this memorandum.

Senator PEPPER. Senator, maybe he would also wish to call attention to the fact that in the preamble to the Constitution, as one of the objectives in the formation of the Government there is reference to the general welfare.

Senator DONNELL. I have no objection to mentioning that. However, the distinguished Senator well knows that the Supreme Court of the United States stated distinctly that the preamble confers no legislative power whatsoever. That is the distinct holding of the Supreme Court.

Senator PEPPER. I was just wondering whether you wished to pursue this technical inquiry, because obviously these men are not the profound students of the Constitution that you are, and if you do not doubt the power of Congress to pass this bill, their opinion, I dare say, on the question of the constitutionality and effect on the general-welfare clause in the Constitution would not be particularly pertinent to this inquiry.

Senator DONNELL. Senator, the only reason I asked the question is that Dr. Robinson has come before us as the head of a great national medical association making a statement that this bill is in conformity with the general-welfare clause in the Constitution, and defines that as one whereby—

the Federal Government assumes the responsibility to see to it that the welfare of every individual in the Nation will be adequately safeguarded.

Senator PEPPER. Maybe the doctor intended to say, as, for example, "I believe that the Government should do that."

Dr. ROBINSON. Yes.

Senator PEPPER. It seems to me, since it has not done it so far, maybe he meant to assume the passage of this bill, in which case the Government would to a large extent do that.

Senator DONNELL. I wanted to find, Mr. Chairman and gentlemen of the committee, the basis for this construction of the general-welfare clause as being one under which the—

Federal Government assumes the responsibility to see to it that the welfare of every individual in the Nation will be adequately safeguarded.

I shall not pursue the inquiry with these two gentlemen, save only in compliance with the Senator's mention of the preamble, to read the preamble. I think it is only fair that it be read.

Dr. CORNELLI. I would like to direct a question to the Senator.

Senator DONNELL. Surely.

Dr. CORNELLI. Do you not believe that in our Nation the Federal Government, in most of the legislation which has had to do with the health and welfare and security of the Nation, in terms of individuals, that legislators by and large have assumed that the Federal Government has this responsibility? They may not have construed it in the specific sense I have stated, but I believe in back of the minds of all well-thinking legislators that is the true attitude of mind.

Senator DONNELL. Since you ask the question, I will answer it itematically, that by the general-welfare clause or a combination of clauses, that—

the Federal Government assumes the responsibility to see to it that the welfare of every individual in the Nation will be adequately safeguarded.

And since he has asked the question I would like to say three things.

First, that the preamble reads as follows:

We the People of the United States, in order to form a more perfect Union, establish justice, insure domestic tranquility, provide for the common defence, 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.

Second, that in the case of *Dore v. U. S.* (195 U. S. 140), and *Jackson v. Massachusetts* (197 U. S. 22), it is held that no power is derived from the preamble of the Constitution save only the source of taxation.

Senator PEPPER. What was the date of that case, Senator?

Senator DONNELL. The Jackson case was 1905, Jackson against Massachusetts. The Dore case, 1904. Neither of those cases have been overruled or modified so far as I am informed.

Senator PEPPER. Have you followed those cases down through Shephard's Citations?

Senator DONNELL. No, sir; I have not. I think it is well understood, Senator Pepper, and I think the Senator will not challenge this statement, that it is well understood among lawyers that this is a correct statement of law, and that no power to enact any statute is derived from the preamble to the Constitution.

Senator PEPPER. Would you check that in Shephard's Citations?

Senator DONNELL. I would be glad to do it, and put into the record whatever I find, and I undertake to state here what is the law.

Senator PEPPER. There has been a good deal of change in the Constitution since 1905.

Senator DONNELL. I might add, Mr. Chairman, that the book from which I read of the Constitution of the United States of America is

put out by the United States Government Printing Office, in 1936, pursuant to Senate Concurrent Resolution No. 35, adopted May 14, 1936, which is 31 years after 1905; and I make the statement without qualification or restriction that the law is, in my best judgment, as is stated, and that we shall find it so. But I shall be glad to check it and put into the record what I find.

The CHAIRMAN. Gentlemen, it seems to me that this is a highly technical point and I do not think it would be fair to ask laymen to pass on these technical matters. I assume that we will have sessions of our committee, at which time we will go into these constitutional problems very extensively.

Senator DONNELL. I think so, Mr. Chairman.

The CHAIRMAN. I have great respect for the learning and ability of the Senator, and I am sure he will be very helpful to us at that time in working it out, but I do not believe we should question laymen on it.

I remember an experience of mine, years ago in a trial, a very able lawyer for the Defense involved one of my witnesses in a technical discussion of mineralogy. My witness, just an ordinary miner, but as a result of the cross examination the miner was induced to qualify as a sort of expert and the lawyer made him appear at a disadvantage.

I do not think it is fair to bring up a technical discussion on a constitutional question with a layman. I think it could be regarded as something irrelevant to the general statement.

Senator DONNELL. Mr. Chairman, in response I may say that I should not have pursued this further, but Dr. Cornelli himself requested permission to ask me a question, which I attempted to answer.

In the second place, I present also this fact: That when a witness presents himself to this committee, as the doctor has, very courteously and interestingly, and states in his testimony on behalf of the National Medical Association that this bill is—

in conformity with the general welfare clause in our Constitution whereby the Federal Government assumes the responsibility to see to it that the welfare of every individual in the Nation will be adequately safeguarded.

I think it is highly appropriate at least to note in the record the contrary view.

I shall be very brief with respect to the third matter to which I call your attention, and that is this: That the following is quoted from a portion of a paragraph appearing at 127 of this book, published in 1936 by the United States Printing Office:

The phrase, "to provide for the general welfare"—This portion is quoted from the case of the *United States v. Butler*, 297 U. S., at page 64 or thereabouts, issued in 1936. The opinion was:

"The view that the clause grants power to provide for the general welfare, independently of the taxing power, has never been authoritatively answered." Mr. Justice Story points out that if it were adopted, "it is obvious that under color of the generality of the words, to 'provide for the common defence and general welfare,' the Government of the United States is, in reality, a government of general and unlimited powers, notwithstanding the subsequent enumeration of specific powers. The true construction undoubtedly is that the only thing granted is the power to tax for the purpose of providing funds for payment of the Nation's debts and making provision for the general welfare."

I simply want to challenge the statement, Mr. Chairman, that under the general welfare clause the Federal Government assumes the responsibility to see to it that the welfare of every individual in the Nation

will be adequately safeguarded; and I close by calling specific attention to the provisions of amendment 10 of the Constitution, which reads:

The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

The CHAIRMAN. Senator, my understanding is that Public Law 410, which provides the Public Health Service, has been upheld by the Supreme Court. Particularly titles 2 and 3 were upheld by the Supreme Court on the right to levy taxes and expend them for the public welfare.

Senator DONNELL. Well, I think you are familiar with the point raised on the floor of the Senate with respect to S. 191, and later with the school-lunch bill.

The CHAIRMAN. Yes.

Senator DONNELL. In which I am not attacking the power given, but I think there is a limitation on the power to tax, and there is no decision of the Supreme Court of the United States, so far as I know, which says that the Federal Government assumes the responsibility to see to it that the welfare of every individual in the Nation will be adequately safeguarded. I do not think it is the law, and I think it should be challenged clearly and distinctly in the record at this time.

The CHAIRMAN. We will take that matter up later on.

Senator DONNELL. That is all I desire to say, sir.

The CHAIRMAN. The next witness will be Dr. Harold T. Low.

STATEMENT OF DR. HAROLD T. LOW, PRESIDENT, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

The CHAIRMAN. Dr. Low, will you state your full name, and the association which you represent?

Dr. Low. My name is Dr. Harold T. Low, of Pueblo, Colo.

The CHAIRMAN. You are president of the Association of American Physicians and Surgeons?

Dr. Low. Yes, sir.

The CHAIRMAN. Will you explain what that association is, when it was created, and give us its membership?

Dr. Low. If I may say, sir; the first paragraph or two of our prepared statement will take care of that.

The CHAIRMAN. You may proceed, then.

Dr. Low. In addition, may I say that I have practiced medicine for 36 years and am still actively engaged therein.

I am president-elect of the south central branch of the American Neurological Society.

Mr. Chairman, I want to thank you for the invitation which you extended the association to appear here and to give our view on this legislation.

The CHAIRMAN. We are glad to have you here.

THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

The Association of American Physicians and Surgeons was organized a little more than 2 years ago. In this short time, it has gained far-reaching and rapid acceptance, having members in every State of the

Union and in 851 county medical societies. Its purpose is to represent physicians in the fields of medical economics, public relations, and legislation. It is financed entirely by membership fees and accepts no donations or other financial aid outside of its membership.

The association is democratic and sensitive to "grass roots" trends in the profession, and endeavors to translate them promptly into action. Inasmuch as its membership is found in practically every national medical group, it is thus afforded an excellent listening post by which it is capable of coordinating and interpreting the thinking and trends of the profession. It is believed its principles and objectives represent the convictions of at least 75 percent of American physicians. It has been endorsed by more than 98 percent of the local medical groups to which its plan has been submitted.

The purpose or purposes for which the association is formed are as follows:

To supplement the work of existing scientific medical societies by uniting physicians and surgeons so that they may act effectively in the public interest to improve the quality of medical care; to achieve the universal distribution of medical and surgical care under conditions that will both improve the quality of the services and remove economic barriers to its delivery; to establish general public understanding of, and cooperation with the profession in the objectives and purposes of individual and organized activities, and to promote ideal relations between the profession and the public; and to protect and improve the welfare and interests of its members in order that the profession may improve its service through the maintenance of professional and ethical standards that will attract the best of men and women to the study and practice of the art and science of medicine, and to that end will stress moral character and ethical attitudes of applicants for matriculation as being of equal importance with scholastic attainments. It is committed to policies which give to the individual physician as well as the patient his freedom of action, so that the traditional relation of physician and patient shall be maintained inviolate. The ultimate test of all of its actions shall always be the public interest.

OPPOSITION TO S. 1606

The Association of American Physicians and Surgeons is essentially in accord with the objectives of the proposed Wagner-Murray-Dingell bill, S. 1606. It is in almost complete disagreement with the methods proposed to attain these objectives.

The association agrees that health care and medical care should be always of national concern in order to stimulate positive action to achieve constant improvement; and goals for prevention and control of disease should be maintained at lofty levels. Since the matter of life and death is involved, the ultimate goal of attainment—the perfect goal—should be 100-percent elimination of disease. No group, professional, lay, or political has any higher goals for health care and medical care than the American medical profession. Look at the record of American medicine and you will find that its position of pre-eminence in furnishing this country with the finest medical care the world has ever known supports this fact.

The association is not reactionary. It does not believe that every worth-while plan for improving health and medical care must of

necessity be initiated by its membership. It extends a cooperative hand and will join willingly with any group, professional, lay, or political to work toward the solution of all health problems, as long as proposed methods for operating such plans do not destroy present physician-patient relationship of free choice. Further, there must be no regimentation or compulsion, which experience shows leads to disintegration of the quality of medical care administered.

Under title I, the bill provides grants-in-aid to States for the treatment and control of venereal diseases and tuberculosis, and the extension of the public health services; grants-in-aid to the States for the extension of maternal and child health services; grants-in-aid to the States to cover medical care of the needy. The association of American Physicians and Surgeons feels that these provisions should be embodied in a separate bill. Since grants-in-aid, under proper conditions and in principle, are not objectionable, there is the danger that title I could be used for the purposes of diverting attention and making more acceptable the provisions offered in title II, which are objectionable. Therefore the association believes it inadvisable to testify further on title I.

Title II proposes benefits, which, if provided under the American trustworthy system of freedom of enterprise, would merit the approbation and support of all Americans.

Here again, the association is in complete disagreement with the proposed methods for furnishing these benefits.

Under title II of this act the medical care is defined as personal health service benefits, and includes general medical benefits, special medical benefits, general dental benefits, home nursing benefits, laboratory benefits, and hospitalization benefits. Thus, it is readily seen that a complete, all-comprehensive system of medical and dental care is offered from the most transient, trivial illness to sickness of the most severe character.

It is proposed to extend these all-embracing benefits to all social-security beneficiaries and their dependents, which may include many others who are members of the immediate family. These benefits may be extended to other persons not now covered under provisions of the Social Security Act, if there is reasonable assurance that payment will be provided for such benefits. Thus, it is apparent, that by further amendment to the Social Security Act, practically the entire population of the United States would in time be eligible for personal health benefits.

ENDORSEMENT OF VOLUNTARY INSURANCE

The association firmly believes that these services can be provided satisfactorily through proper, voluntary plans of prepayment sickness insurance. These voluntary plans keep faith with the democratic principles of our American form of government as well as preserving the American system of the private practice of medicine, which is essential to the welfare of patients—the American public.

The Association of American Physicians' and Surgeons' proposal for providing these benefits is included in the association's recommended plan for national health, which is part of this statement and later will be presented in detail.

The association is opposed to title II of S. 1606 for many reasons, which in our considered opinion, are sound.

S. 1606 WOULD INVOLVE REGIMENTATION

In the first place, the bill as now written, proposes compulsory health insurance. Since funds are to be appropriated for all necessary expenses to provide the benefits, it means that the American citizens will be compelled to pay a tax for a service whether they elect to use that service or not. It is compulsion and regimentation, both of which are contrary to the democratic principles of the form of government which has made this Nation the leader of the world in all fields, including health. Further, we do not believe that good health can be compelled or legislated. The Nation's health can be improved by making available voluntary plans of sickness insurance, education of the public to use them, and education in good living and preventive medical services.

In this part of the bill it is proposed that the Government collects the funds available, manages the services, distributes the payments. This is State medicine. Since all physicians, dentists, and nurses are to be hired by the Government and their services rendered under rules and regulations established by the Surgeon General, and these services to be paid for by the Federal Government, the proposed scheme is socialization of medicine.

FREE CHOICE IS LIMITED BY S. 1606

The association is opposed to this part of the plan because it does not guarantee that important factor in the art of healing, of free choice of physician and free choice of patient. Proponents of this bill have made the statement that free choice is provided in the measure. This is not true. It is limited free choice with all of the destructive eventualities this limitation could impose.

It is free choice only of the doctors who are willing to serve under this system. We do not believe that a majority of American physicians would serve under this scheme, which in their opinion, would result in the deterioration of the quality of medical care administered, since their first responsibility as physicians is to the welfare of their patients.

It is not free choice because the bill provides that the Surgeon General can limit the number of patients that a physician may see, and he is permitted to provide other physicians when, in his opinion, too many patients select the same physician.

Further, it is not free choice unless the physician is willing to work under a plan for payment of services, which plan and amount of remuneration are set up by the Government.

S. 1606 MAKES THE SURGEON GENERAL A DICTATOR

The proposed bill makes the Surgeon General the dictator of medicine, since he is only obliged to "consult" with council members of his own choosing. The Surgeon General is authorized to prescribe the rules and regulations, to hire and fire physicians, dentists, and nurses; establish professional standards; designate specialists and consultants—consultants' services are available only to patients on recommendation of the general practitioners; establish standards to

apply to participating hospitals and designate individuals and institutions who are to receive grants-in-aid for professional education and research projects. In the opinion of the members of this association this unprecedented vesting of authority in one man and his chosen group of advisers is dangerous and un-American. It would mean eventual enslavement of physicians and patients, with resulting disintegration of the quality of medical care received by patients, which always follows in the wake of such change to compulsory, socialistic medicine. Germany, England, and Australia are some of the unfortunate nations which adopted socialistic plans of compulsory insurance and state medicine with subsequent break-down of the kind of medical care administered.

S. 1606 WOULD BE TOO EXPENSIVE

Administration of this compulsory health insurance and socialized medicine plan would be exorbitantly expensive and a back-breaking tax burden for already overburdened American taxpayers. Elizabeth W. Wilson, a writer and economist (*Christian Science Monitor*, March 20, 1946), who has spent 15 years studying the actual working of compulsory health insurance in various countries of the world, says by her finding that—

Operation of this bill would cost the individual participant approximately 6 percent of his income.

Miss Wilson says further—

That is almost half again as much as he now pays on the average for medical attention, and there is no guaranty that the cost would continue to be only about 6 percent of the individual's income.

Miss Wilson points out that in Germany the per capita cost increased sixfold in 45 years. In England it almost trebled from 1921 to 1927. She estimates, conservatively, that the cost of socialized medicine and compulsory health insurance in the United States, say 2000 A. D., would be two or three times as large as that of 1950.

Quentin Pope, a journalist who has been making a study of the system of state medical care in New Zealand, says that this socialistic system has resulted in greatly increased costs, overcrowded hospitals, a demoralized medical profession, and a general lowering of the standards of medical care.

During the 6 years of operation of this New Zealand plan, the number of civilian persons admitted to hospitals has more than doubled, although the population has increased very little. Mr. Pope says the national bill for these state medicine services has quintupled from an original \$5,000,000 a year budgeted for all physicians' services, to a present budget of \$25,000,000 a year.

The association strongly believes that this Nation can continue its customary record of health improvement and increasingly wider distribution of better medical care through the use of voluntary plans of prepayment sickness insurance for considerably less money than the costs of socialistic systems with their excessively expensive administration.

If we admitted the need of a government-managed health insurance program—and we do not admit it, because we believe that everyone

of the proposed objectives can be accomplished by means of voluntary plans, without compulsion and regimentation, and for considerably less money—it is well to know whether or not compulsory insurance schemes would achieve the objectives for which they are intended. Compulsory health insurance plans have been in effect in various parts of the world for considerable periods of time. Therefore, it is possible to determine the effect that such plans have upon public health by examination of the morbidity and mortality tables of these countries “enjoying” the so-called benefits of compulsory health insurance.

Dr. Lowell S. Goin (Los Angeles, Calif.), a past president of the California State Medical Association, in a recent article said:

Germany and England are countries which may reasonably be compared to our own, being, as they are, highly industrialized nations with large populations. Compulsory health insurance has been in existence in Germany for nearly 60 years and in England for nearly 45 years. Since so much has been made of the rejections for the armed services it will be interesting to compare these rejections with those in England.

Mr. Chairman, at this point Dr. Goin testified yesterday, and the first hand information he gave you will perhaps be better than quoting him here. With your permission, I will not read that paragraph.

The CHAIRMAN. That is very satisfactory, Doctor.

HEALTH INSURANCE IN ENGLAND

I might ask at this point, have you compared the compulsory system in England with the compulsory system proposed in this bill?

Dr. Low. During my visit to England, I had experience in comparing the present set-up in England. Of course, it is not as inclusive, or comprehensive as the proposed benefits under this bill.

The CHAIRMAN. And it was criticized very severely by the physicians there, and they have been seeking to have it improved, is that not true?

Dr. Low. Senator, there are two factions of physicians in England. One of them is comparable to the Physicians' Forum, and the other one is comparable to the American Medical Association, and they take opposite stands on that.

The CHAIRMAN. On both sides of the controversy they are reputable, distinguished members of the profession?

Dr. Low. Certainly.

The CHAIRMAN. So you do not intend any reflection on the character, ability, or patriotism of the men that belong to the Physicians' Forum or any other association?

Dr. Low. No, sir.

The CHAIRMAN. There is a vast difference between the compulsory health system in England that has been in operation and the system which we propose here.

Dr. Low. Yes. Up to the present time I think, practically, the Beveridge plan for complete medical care will compare almost identically with the provisions in this bill.

The CHAIRMAN. I will not interrupt you further, Doctor. Perhaps you would like to continue your statement.

Dr. Low. Thank you.

Dr. Nathan Sinai, author of a book called the Way of Health Insurance, is a proponent of compulsory health insurance. However, he says this:

Contrary to all predictions, the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness.

Dr. Sinai continues:

Various studies in the United States seem to show that the average recorded sickness per individual is from 7 to 9 days per year. It is nearly twice that amount among the insured populations of Great Britain and Germany, and has practically doubled in both countries since the installation of insurance.

And he concludes:

It seems to be a safe conclusion that insurance has certainly not reduced the amount of sickness.

The Association of American Physicians and Surgeons believes that the need for compulsory insurance and State medicine, as proposed by Senate bill 1606, is poorly established, since the experience of those countries having this type of system does not indicate an improvement in health or medical care, but rather a deterioration of both.

The CHAIRMAN. I would like to stop there. What countries in Europe have precisely the type which we have proposed here?

Dr. Low. None that I know of.

The CHAIRMAN. I beg your pardon?

Dr. Low. None that I know of.

The CHAIRMAN. You may proceed.

Dr. Low. The association holds to the belief that no actual need can be shown or sound arguments advanced for socialization of medicine. Therefore, we are concerned with why apparently sincere and intelligent people continue to agitate for its adoption. It is the answer to this question in our opinion, that contains the sinister implications of a plan not only to socialize medicine but all industry as well.

If proponents of S. 1606, which we claim constitutes socialized medicine, are sincere in their desire to provide better medical care with wider distribution of this service, and since experience of other countries shows that Federal compulsory systems do not accomplish this objective, then perhaps socialization is starting on the wrong end. For a number of years we have heard that one-third of American people are ill-housed, ill-clad, ill-fed, and ill-cared for, and yet Government sources were maintaining that we enjoyed the best health of any nation in the world. Analysis of these four postulates shows them to be purely economic. If ill health is due to poor food or lack of sufficient food it would seem that socialization should begin with the butcher and the grocer, for certainly the problem of feeding the people should not be laid on the doorstep of the American medical profession.

The association is fearful that the scheme for the Federal Government to establish political control of physicians and their patients is an entering wedge for the accomplishment of a completely socialized economy for this Nation. We believe that the proponents of political medicine, a few knowingly, and a majority unwittingly, are using this plan as a stepping stone to a socialistic state.

In the November 1945 issue of *Medical Economics* appeared an authenticated article entitled "Labor's Program To Socialize Medicine Internationally." This article is important because it explains the master plan of the International Labor Organization for socializing medicine in all countries of the world. In this article it is flatly stated that the Wagner-Murray-Dingell bill, Senate bill 1050, which is very similar to the present bill, was written largely by International Labor Organization leaders and that those same leaders are a powerful element in the current campaign for its passage.

Information on which the article was based was secured by and under the direction of a special investigator who has conducted inquiries for many congressional committees and has had extensive experience with medical-care issues. The editor of *Medical Economics* says that every fact contained in the article was checked and authenticated.

Here is a quotation from the story that appeared in *Medical Economics*:

It is commonly believed that certain Senators and Representatives have sensed a public demand for the socialization of medicine and have drafted legislation to provide it. This is at best a half-truth. The majority of American people have made no such demand. Those behind it are leaders in the labor movement in this country and abroad. A good many people associate legislation to socialize medicine with the advent of the New Deal. But in this sphere, Franklin D. Roosevelt was no innovator; he was a follower. Plans for socializing medicine throughout the world—one nation at a time—had been drawn up by the International Labor Organization years before.

The *Medical Economics* article states that the International Labor Office is staffed by experts drawn from many different countries. For medical care planning, Arthur J. Altmeyer, Chairman of the Social Security Board; Isadore S. Falk, Director of the Social Security Board's Bureau of Research and Statistics; and Wilbur Cohen, assistant, served as experts. None of them are physicians.

The *Medical Economics* article continues:

Thus has organized labor been striving for the past several decades to foist socialized medicine on the American public. Other countries have succumbed. Will the United States? Current proposals for the extension of the Social Security Act and for the creation of a system of Federal medicine are evidences of the current strategy. In the meantime, the American public, generally, is quite unaware that a planned economic revolution is taking place with socialized medicine an important factor.

In one of the writer's concluding statements he says;

The plan of the socializers has differed from the Communist ideal in only one aspect. Under communism the State owns everything and is the employer of the worker, be he doctor, nurse, or patient. Under socialism, the state finances, regulates, and administers the program.

The AAPS believes that the story *Labor's Program to Socialized Medicine Internationally* is important because the facts contained therein should be weighed when considering proposed legislation to place physicians and their patients under the control of a Federal system. Therefore, a copy of the complete article is attached to and becomes a part of the association's statement.

(The document referred to was filed with the committee.)

Dr. Low. The Association of American Physicians and Surgeons is not cognizant of any impartial survey that proves the need or desire of the majority of American citizens for the complete medical care

envisioned in this act. The proposed benefits are utopian, idealistic, but impossible of accomplishment. Such a comprehensive, compulsory system, if only partially effected, would result in imposing such a mass of work on the participating doctors, that their eventual inability to render the proposed services would bring disaster to the system.

Never in the history of the world, with the possible exclusion of Russia, and just recently England, has such an all-comprehensive system of medical care been contemplated. Germany, in its heyday, never insured more than 45 percent of its population; England only 38 percent. S. 1606 proposes to compel every man, woman, and child in America to become the medical wards of the Government, thus subscribing to the theory that what the Social Security Board decides is for the good of the people has to be good, whether the people want it or not.

The Federal Security Administrator, together with the Surgeon General of the Public Health Service, would become the absolute dictators of the prenatal, adolescent, and the adult medical life of all the people of the United States.

Doctors agreeing to participate in this compulsory, socialized medical system would be subject to the dictates, rules, regulations, and red tape imposed upon them by bureaucratic control. They would be constantly at the mercy of lay control, political appointees, subject to the complaints of disgruntled patients as well as persistent demands from malingerers seeking certification of illness. Doctors, like all people, are human, mortal and frail; and under the continued high pressure of patients, who would want their tax money's worth whether sick or not, and the depressing influence of directives, they would lose all initiative, and with the incentive lacking, become mere cogs in the system of socialized medicine. Deterioration of medical care would be the inevitable result.

Proof of this contention is a matter of historical fact and record. It was revealed in the complete break-down of medical care for veterans in the previous war, which almost resulted in a national scandal. Next to Russia the Veterans' Administration has the largest system of socialized medicine in the world. It is to be hoped that the house cleaning in the Veterans' Administration will accomplish better medical care for the veterans.

Compulsory health insurance will encourage public dependence, increase bureaucracy, and the burdens of taxation. It will lower the standards of medical practice, hinder medical progress, and result in regimentation of physicians and patients. Physicians are fighting this bill, not for financial preservation, but because they conscientiously believe it is not in the public interest, but on the contrary, will result in a serious impairment of the Nation's health.

VOLUNTARY INSURANCE CAN MEET THE NEED

We repeat, voluntary plans of prepayment medical care and hospitalization insurance will meet satisfactorily the health needs of the Nation. Insurance records for recent years show an increasingly greater acceptance of these plans by the American public.

The February issue of Nation's Business quoted the following statistics, which were recently released by the insurance industry:

Forty million persons already are covered by voluntary health and accident policies—a fivefold increase over 1939. In addition more than 5,000,000 persons are insured in prepaid medical-care programs, covering hospital and surgical bills.

The insurance report continued—

Consolidating all these voluntary protection measures, it is revealed that at least half of the population insures itself against medical costs; another 40 percent handle these emergencies on pay-as-you-go basis without hardship.

We urge that the Federal Government give support and encouragement to these voluntary plans, which if given time, and not in the too dim, distant future, as the records indicate, will furnish the objectives of this bill without jeopardizing the system of medical care, which has made this Nation foremost in health, and without compulsion and regimentation.

A PLAN FOR NATIONAL HEALTH

We believe the association's plan for national health, if executed, will achieve health goals satisfactory to the most idealistic. Therefore, we submit, for the consideration of the committee, the plan in these words:

The plan consists of five paragraphs:

The association proposes and recommends that medical care and hospitalization prepayment insurance be made available to the public by establishing voluntary plans of nonprofit insurances in all States. For all those unable to pay, and if they so elect, the association proposes and recommends that the Federal Government share equally with the States in providing funds to purchase insurance for this group under a plan to be administered by State and local agencies of the respective States. The selection of the voluntary plan to provide insurance for those unable to pay should be made by the State medical associations of the respective States, subject to agreement with the appropriate State agency, and determined on a basis of securing the most comprehensive and economical coverage.

Recognizing that this nation desires and is obliged to furnish the best medical care and hospitalization for veterans, the association recommends that such medical care be provided by a physician of the veteran's choice and hospitalization be given as near to the veteran's home as possible, whenever it is feasible to do so. It is recommended that payment for these services be made by the Veterans' Administration through a plan acceptable to the respective State medical associations and the Veterans' Administration.

Modern hospitals, health and diagnostic centers, properly distributed in relation to need, are essential to the provision of adequate medical care. Therefore, the association recommends that where such facilities are not available and cannot be furnished by local agencies, the Federal Government give aid to the respective States for the purpose of providing additional hospitals, health and diagnostic centers in those communities in which a need is shown and there is evidence of the communities' ability to maintain them. The administration of

the plan of Federal aid to hospitals, health and diagnostic centers should be under the jurisdiction of the respective states and their local agencies.

The association recommends the improvement of existing Federal health agencies with increased facilities and personnel, where need is shown, and emphasis placed on control by the local areas where the public health services are established. Health departments should not administer medical care and should approve the policy of medical care being provided by the physician of the patient's choice.

Higher standards of nutrition, housing, clothing, and recreation should be achieved through education, individual initiative, community effort, and Federal aid where needed.

The association recommends that a Nation-wide campaign of health education should be conducted under the cooperating sponsorships of national medical associations, State medical associations, county medical societies, and State and Federal agencies. Emphasis should be placed on health education in the schools and enlistment of the aid of all local civic groups and agencies. The educational campaign should stress the desirability for all individuals to participate in the voluntary plans of insurance.

The CHAIRMAN. Does that complete your statement, Doctor?

Dr. Low. That completes the prepared statement; yes, sir.

The CHAIRMAN. Do you desire to submit any further statement?

Dr. Low. With your permission, sir.

The suggestion was made to this committee by William Green that a thorough investigation be made of the lobbying activities of certain medical organizations, including the American Medical Association, and that the sources of their funds be made public. May I respectfully suggest to the chairman of this committee that an equally thorough investigation be made of the groups lobbying for the Wagner-Murray-Dingell bills—S. 1050 and S. 1606? The American public has a right to know whether their legislation has been drafted in response to popular demand or whether it is being sponsored by Government officials who have a vested interest in perpetuating and expanding their own jobs. On April 4, Arthur J. Altmeyer, Chairman of the Social Security Board, testified that Isadore S. Falk had written the major portion of S. 1606 with the aid of the U. S. Public Health Service. I think it is of great importance to everyone in this country to know about the professional competence and background of those who have essayed to write health and medical legislation that would affect 85 to 90 percent of the population. Who is Isadore Falk? What is his professional record? Who have been associated with him? What medical men have aided him? What part has Michael M. Davis played in lobbying for this legislation? Who finances Mr. Davis? What has been his past connection with the Rosenwald Fund? With what committees is he now connected for the purpose of pushing enactment of this legislation? How many Federal civil servants are assisting Mr. Davis despite the provisions of title 18, section 201 of the U. S. Code. These pertinent matters, I believe, should be investigated by your committee.

The CHAIRMAN. Thank you very much, Doctor. I am sure it would be a great help if all these organizations would voluntarily submit to us statements of their organizations, how they are financed, and what money they have spent for or against this legislation.

Some of the witnesses who have appeared here already who are sponsoring this bill have presented that, some organizations which favor the bill.

Dr. Boas, who explained the set-up of his committee, stated further the funds that they have accumulated and how they have spent it.

It would be helpful if all organizations on both sides would give us information such as Dr. Boas gave us here this morning.

Of course, it would be a terrible task for this committee right now to launch into an investigation of these organizations. We simply could not. This hearing will take maybe another month before we are through, and therefore it could not be expected that we could stop now and launch into an investigation of these organizations who are for or against this legislation.

Dr. Low. Might I ask the chairman, we would like to have incorporated in the record pages 143 to 147 in the 1943 Department of Labor Federal Security Agency appropriation bill for 1946.

The CHAIRMAN. It is a printed record?

Dr. Low. It is a printed record.

The CHAIRMAN. It may be submitted for the record without having to be necessarily printed, then.

Dr. Low. Submitted for the record; yes.

The CHAIRMAN. Yes. Doctor, we appreciate your appearance here this morning. We will, of course, try to get both sides of this controversy.

You, in the early part of your statement, said your organization "extends a cooperative hand and will join willingly with any group—professional, lay, or political—to work toward the solution of all health problems."

What voluntary organizations have you worked with, Doctor?

Dr. Low. We have not worked with any voluntary organizations. After all, we are only 2 years old.

The CHAIRMAN. I see. Prior to your connection with this organization have you advocated a method whereby the American people could be placed in a position where they could more easily receive modern medical care, especially those who at present seem to be denied full and complete modern medical care at reasonable rates?

Dr. Low. We would be willing to study that and have studied it to the extent that we have failed to find many people in this country who are unable to get medical care if they know how to get it.

The CHAIRMAN. I see. You feel that there are not very many people in this country denied access to modern medical care if they know how to get it?

Dr. Low. I feel there are certain low income groups that perhaps are; yes, sir.

The CHAIRMAN. But you think there are few, and it can be easily remedied?

Dr. Low. It can be remedied by grants-in-aid to the States which would take care of the needy.

The CHAIRMAN. How would it take care of those people in the very low income groups? In what manner would it make it possible for them to secure the best modern medical care and hospitalization?

Dr. Low. By the rules and regulations which the authority who had the regulation of the system would set up, a minimum wage under which a man would be entitled to these benefits as set up under the

voluntary plans by the Government paying that premium in a voluntary plan of insurance.

The CHAIRMAN. That plan has never been put into operation. You are merely studying that?

Dr. Low. We are advising it to the various States, to put that in.

The CHAIRMAN. Well, for the last 25 years in this country this problem has persisted, and no effort has been made by the American Medical Association to provide a remedy for it, and it has become necessary for outside groups to undertake to provide some plan or other benefit that may help to get this aid and medical care. Is that not true?

Dr. Low. Well, yes, sir; I think that is true.

The CHAIRMAN. In other words, the American Medical Association have closed their eyes to this situation in the country. They have opposed the voluntary systems that were first suggested in the country?

Dr. Low. Who opposed them?

The CHAIRMAN. The American Medical Association.

Dr. Low. I am not testifying for the American Medical Association.

The CHAIRMAN. Well, the American Medical Association is the important medical organization in the United States? It represents 90 percent of the American practitioners; and you do not want to belittle such an important organization as that, do you?

Dr. Low. No, sir.

The CHAIRMAN. You recognize, then, that they are the most important group of medical men in our country?

Dr. Low. They are.

The CHAIRMAN. And it would be natural for the people in this country to look to such an important organization as that to assist in bringing about some modification of the system of practice in this country which would make it possible for ordinary people to get modern medical care at reasonable cost?

Dr. Low. Senator Murray, in the recent past that has just gone by, during this war emergency, the astounding thing of that very class of people you are talking about was that they came into the doctor's office and paid their bill and did not object one little bit about the charge or fee which they were charged. They were glad to pay it.

The CHAIRMAN. That is not answering my question. I did not say anything about what the people are willing to do under the conditions which prevailed during the war, when everybody was employed and making a good income. I am talking about the immediate past and about the failure of the American medical profession; neither the American Medical Association nor any other association of medical men in the country undertook to solve the problem, is that not true?

Dr. Low. Not on the basis of a Federal insurance system, or national insurance system.

The CHAIRMAN. Well, that is the only way it could be remedied if doctors insisted on the present fee system. It is very costly for the ordinary citizen to get this modern medical care. The only way it could be provided would be by some system, either a voluntary system which would reach the problem, or a compulsory system.

Dr. Low. Senator, may I ask a question?

The CHAIRMAN. Or else it would have to be charity.

Dr. Low. There are places for charity, and the people did not hesitate to take the WPA when they were up against it.

The CHAIRMAN. You believe in charity in the United States? You think that is a very sound principle in our country, that people should be charitable to fellow human beings in distress, and that we could take care of everyone under a system of charity properly organized, and all of these problems that we have, such as lack of food, lack of clothing, lack of medical care, they could all be taken care of if we were all charitable?

Dr. Low. No, Senator. But I do say that the people that were taken care of for medical disease and for trouble and sickness under charity—and that includes the group of people in the low-income group—it has been said time and again that they receive the best medical care. Only the poor and the rich get medical care. The American medical profession will continue wherever necessary to take care of anyone that is sick.

The CHAIRMAN. Do you not think it would be better if we could place the American people on a footing whereby they could come in with their heads erect and get medical care without having to classify themselves as paupers or unable to pay and willing to accept charity?

Dr. Low. If that were so. Now, this bill interpreted by you and some other gentlemen who are interested in seeing its passage is not so bad in some respects, but when it becomes a law and the Surgeon General proposes to administer it, then there will be certain rules and regulations and directives put out that will have the effect of law that were not intended in the original bill.

The CHAIRMAN. I think you are unduly apprehensive about that, Doctor, because the Surgeon General acts under an advisory board, which has on it members of the medical profession, and he has to make periodical reports to the Congress of his activities and of the consultations he has had with this Board, so that Congress would always be able to see what he is doing and how he is carrying out the program. I do not think you should be so fearful and apprehensive about the activities of the Surgeon General, who has had a splendid record in this country. Ever since we have had the Public Health Service the organization has looked to that man as a man of great propriety, and honesty, and integrity. The present Surgeon General has the confidence of every doctor in the United States.

Dr. Low. That is true, but in the preventive part of medicine and not the curative part.

The CHAIRMAN. Do you think he would fail, then, to be fair and honest in respect to the medical care part of it?

Dr. Low. I do not think he would intentionally do so, but there has been some criticism in the past of other directives of other agencies that had the effect of law.

The CHAIRMAN. Yes, but they can always be checked up on. The Congress is in session almost constantly, and evils that develop of that kind can be taken up in Congress and acted upon. It seems to me that with the splendid record we have had in this country with our system of Public Health Service with the Surgeon General at the head of it, that we should not be so fearful and suspicious of this man who is going to sit with an advisory board which has physicians,

practitioners on it, to assist him in working out the program. It does seem to me that it is unreasonable to have such suspicion of him.

Dr. Low. Well, experience is a great teacher, Senator, and we have been through some of this in other agencies. When I was surgeon general of the Veterans of Foreign Wars it was my position to inspect some of the veterans' facilities. And we saw what effect directives from the Surgeon General had, in the Veterans' Administration.

The CHAIRMAN. Well, the Surgeon General has nothing to do with that.

Dr. Low. It did, on the morale and incentive and ambition of the physicians, and the fact is that the physicians were working there without authority at all. It was the lay people, even down to the wardman, that had the authority. It was not the doctors.

The CHAIRMAN. Well, in this system we have the National Advisory Board, and we have local advisory committees set up, and the local physicians have the right to determine the manner in which they are to be paid for their services, and can make recommendations as to how the thing is to be carried out. It seems to me that the bill is entirely democratic in every respect and gives recognition to the medical profession at every step.

Now, I wish you would tell us what particular work you have done in trying to bring about a cure of this problem of failure to get adequate medical care in the country for certain sections of our people?

Dr. Low. I have only been able to do work in my State.

The CHAIRMAN. Yes, sir. What is your State?

Dr. Low. Colorado, sir, very close to yours.

The CHAIRMAN. Yes, sir.

Dr. Low. We have set up the Colorado service plan, which has not yet been put into operation because we are attempting to study ways and means with experience of the other nonprofit voluntary plans to make it more comprehensive if it is at all possible.

The CHAIRMAN. Well, you have made a splendid statement. It is a very comprehensive and very eloquent statement, but it seems to me that you have not shown that you have taken much interest in this very important problem of national health care prior to very recent weeks since this agitation has developed over this plan.

Dr. Low. Personally or as the president of this association? From its inception we have attempted to put out publicity that the State should put out these plans and make them as comprehensive as was possible.

The CHAIRMAN. Would that not be State medicine that you would be proposing? It would be asking the State to do this.

Dr. Low. I mean the State medical associations, or incorporations under their wing, which would administer nonprofit voluntary insurance plans.

The CHAIRMAN. You would not want that run by the State? You would want the State medical associations to voluntarily develop the system?

Dr. Low. We make the statement in the last paragraph in the plan of national medical care, there should be a State agency.

The CHAIRMAN. You want a State to organize the plan, and the medical men should operate it?

Dr. Low. In conjunction with the State agency; yes.

The CHAIRMAN. In other words, the medical men would determine how it would operate and would determine the system of fees and the various methods in which the plan would be carried into effect. Would you recommend that you would have representatives of labor and other groups in the State to sit in on it and determine how it should be done?

Dr. Low. Not necessarily.

The CHAIRMAN. You do not believe the consumers, because they are not medical men, you do not believe that they would be of any benefit or value on the committee?

Dr. Low. I do not think the consumer under this proposed bill realizes what it is going to cost. Do you know what it is going to cost and what we are going to get?

The CHAIRMAN. Well, I did not ask you to state what it was going to cost. We are going into that at the proper time. Some people have made exaggerated estimates of what it is going to cost with a view to frightening the American people, but I think the cost of it is not so important. I think that this bill would work out eventually to reduce the cost of medical care in the country because of the improved health of the people.

At the present time the ordinary family is unable to protect itself because of fear of going to a doctor to get proper medical care, and as the result they frequently find that they have permitted conditions to develop to such a degree that they may not be able to cure themselves at all. So I believe that under this system, put into operation honestly and fairly carried out, it would result eventually in a saving to the country, a saving to industry, a saving to everyone.

I do not agree with you and your fears that this is communism or socialism.

Now, the medical profession, as you know, opposed the workmen's compensation laws in this country bitterly, fought them, and claimed that that program was socialistic at the time.

Mr. Green, of the American Federation of Labor, was on the stand here the other day, and dramatically told the story of the fight of the medical profession against the workmen's compensation laws in this country. They were permitting people in the various industries of the country to suffer serious injuries and industrial diseases and to die without any compensation. The only resort they had was a legal proceeding against the corporations, and 9 times out of 10 they would be defeated because of technicalities, or if they succeeded in winning, 50 percent of the recovery would have to go to the lawyers.

So that was a totally inadequate system, and Mr. Green as a State senator in the State of Ohio fought for workmen's compensation laws, and told the story of the opposition of the medical profession against that.

Is it not a fact that nearly every important improvement in our social life in this country has been opposed by conservative organizations such as yours all the way down through the history of the last 40 or 50 years? Is it not true that there was a very bitter fight in this country against a national income tax system? There has been a fight against every effort to improve the social conditions of the country. And when the people in this country were starving to death in the last depression, some 16,000,000 men were tramping the streets looking for something to eat, the conservative organizations of this country like

the American Bar Association and others fought the proposition that the Government should appropriate money to feed these starving people. So that I am not surprised that conservative organizations today are opposing a bill of this kind, because that is their record. They have opposed such legislation right along. They have opposed workmen's compensation, and other important laws like that, now universally accepted; no one today would propose that they be repealed.

But it seems to me that you are late in coming here testifying that some other kind of other system will do better than this. You have failed in all these years, yourself, to try to work out anything or contribute anything to the solution of the problem, and therefore I think while your argument is very eloquent it does not seem to me to be supported by your previous activities in support of a proper system of medical care in the country.

Are there any questions, gentlemen?

Senator DONNELL. I would like to ask a few. Doctor, you have been engaged in the private practice of medicine, have you not?

Dr. Low. Yes, sir.

Senator DONNELL. Have you been in medical societies?

Dr. Low. Yes, sir.

Senator DONNELL. Have you participated in the meetings of the medical societies?

Dr. Low. Yes, sir.

Senator DONNELL. You have been active in those?

Dr. Low. Yes, sir.

Senator DONNELL. And you have been selected as president of this National Association of American Physicians and Surgeons?

Dr. Low. Yes, sir.

Senator DONNELL. You found it necessary to make your own living during all these years?

Dr. Low. Yes, sir.

Senator DONNELL. And you have devoted what time you could to medical society work, is that right?

Dr. Low. Yes.

Senator DONNELL. Doctor, let me ask you this: Considerable emphasis has been placed upon the importance of this National Advisory Medical Policy Council which is referred to in the bill. I observe and my attention has been called to the fact that the Council is to consist of 16 members.

In the first place, as I mentioned earlier in the testimony, those appointees are to be appointed by the Surgeon General but with the approval of the Federal Security Administrator. The Federal Security Administrator is not always a doctor, is he, Dr. Low?

Dr. Low. No.

Senator DONNELL. Is the present one a doctor, do you know?

Dr. Low. I think not.

Senator DONNELL. Who is the present Federal Security Administrator?

Dr. Low. I do not know.

Senator DONNELL. It is Mr. Watson Miller, is it not?

Dr. Low. Oh, yes.

Senator DONNELL. He is not a physician?

Dr. Low. I do not believe so.

Senator DONNELL. The particular point I desired to address myself to was not the personnel of the present Federal Security Administration, but this: These 16 members are to be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical, dental, nursing service, education, operation of hospitals, laboratories, and other persons or agencies or organizations informed on the need for or the provisions of medical care, dental, nursing, hospitals, laboratories, or other services or benefits. We start out with 16. We have already heard, for instance, this morning from Dr. Robinson, who strongly advocated that the Negroes be given representation. We have had the suggestion, inferentially, that labor should be represented. I have no doubt there would be many other organizations and interests in our country which would have very persuasive reasons for desiring to be represented on this Council.

The point I make is this: the advisory council has numbers of more or less technical men. It is provided in subdivision (b), section 204, 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, including (1) professional standards of quality to apply to personal health service benefits; (2) designation of specialists and consultants—

et cetera.

Doctor, do you think there is any danger that if this advisory council, consisting of only 16 persons, shall have all these public representatives, as is provided in the bill:

in such proportion as are likely to provide fair representation to the principal interested groups that furnish and receive personal health services—

is there any danger of a council of that kind, composed of all these representatives, and with some medical and other representatives on it, being of such a nature as to not be able to cope with the questions of legislation applying to personal health benefits?

Dr. Low. I think that is true.

Senator DONNELL. Is that danger emphasized by the fact that the appointments to that board would be by a man who is not a doctor, or, made with the approval of a gentleman who is not required to be a doctor or in any way connected with the medical profession; is that danger emphasized by reason of that fact?

Dr. Low. I should think so.

Senator DONNELL. What part of the State of Colorado are you from?

Dr. Low. Pueblo.

Senator DONNELL. How long have you practiced medicine?

Dr. Low. Thirty-six years.

Senator DONNELL. What school are you a graduate of?

Dr. Low. The University of Colorado.

Senator DONNELL. The University of Colorado. You state in your testimony that your organization is financed entirely by membership fees and accepts no donations outside of its membership. What are those fees?

Dr. Low. \$10 a year.

Senator DONNELL. You get all the income, or, the association does, from that source?

Dr. Low. Yes, sir.

Senator DONNELL. That is all.

The CHAIRMAN. At this point I would like to read into the record a statement in connection with the statistics regarding the health condition of the country. I refer to Social Security Bulletin, January 1945, in which the following statement is contained:

SECURITY OF LIFE

Available statistics do not bear out the claim that the United States is the healthiest nation. Probably the best single basis for international comparison is the death rate among babies in their first year of life. In the years preceding the war in Europe, according to statistics of the League of Nations, seven countries had lower infant mortality rates than the United States. From 7 to 11 countries—the number differing for various age groups—had lower death rates among children and adolescents, and 20 or more countries had lower rates among persons aged 35-64. Death rates among the Negro population in the United States are typically higher than those of white persons. Even if international comparison is restricted to the white population, however, our death rate is by no means the lowest. In the expectation of life for whites boys at birth, the United States ranked fifth among the prewar nations; for white men at age 20, it ranked ninth; at age 40, twelfth; and at age 60, thirteenth.

Despite past progress in preventing sickness and prolonging life, the United States has not yet achieved for all its people—and in particular for those in the working ages—the level of security of life which has been attained in some other nations with much smaller economic resources.

Do you recognize that to be a correct statement of facts, Doctor?

Dr. Low. From what are you quoting, sir?

The CHAIRMAN. From the Social Security Bulletin, January, 1945.

Senator DONNELL. That is issued by the Social Security Board, is it, Mr. Chairman?

The CHAIRMAN. A Government agency.

Senator DONNELL. Yes, sir.

Dr. Low. That is their record. Those are their statistics.

The CHAIRMAN. Of course, Doctor, you recognize that there have been great changes taking place in this country in the last 30 or 40 years, tremendous changes have taken place?

Dr. Low. Yes.

The CHAIRMAN. We have gone from an agricultural economy to a highly industrialized economy during the last 40 years, you might say, advanced with great strides in the last 40 years; is that not true?

Dr. Low. Yes, sir.

The CHAIRMAN. Prior to that the situation with reference to the practice of medicine was entirely different. Now, in the big communities, we have millions of people employed in industrial plants where they meet with industrial diseases and industrial hazards, and sometimes their income is so low that it is impossible for them to secure the best possible medical care?

Dr. Low. What is wrong with the industrial medical plan under which those men are working? I am now connected with the Colorado Fuel & Iron Co. as a surgeon, and the plan is very acceptable to these people, and their dependents are getting a rate which is entirely consistent with the cost which you mentioned.

The CHAIRMAN. Yes, in some industrial plants they have developed some excellent plans, of course; notably the Kaiser system on the Pacific coast; and they have, of course, in the mining areas like in Colorado; also, they have plans there to take care of employees working in mines; but they do not take care of their families, those plans; is that no true?

Dr. Low. They do take care of their families under a reduction in hospital rates as well as fees.

The CHAIRMAN. What is the extent of the reduction in the hospital rates?

Dr. Low. The hospital rate is one-half the private rate.

The CHAIRMAN. And also the medical rates are reduced?

Dr. Low. The medical rates are reduced approximately one-half.

The CHAIRMAN. One-half.

Dr. Low. Surgical fees, and obstetrics, and medical care.

The CHAIRMAN. Still, of course, they have cases where for a large family having a great deal of sickness it would be a burden, even at half rates?

Dr. Low. Sure, but they could pay it off on pay roll deductions the same as under this proposed plan.

The CHAIRMAN. Yes, they could borrow money to pay it off or pay it in deferred payments?

Dr. Low. Senator, they have to pay these other things they have contracted for in advance—automobiles, iceboxes, and all that sort of thing.

The CHAIRMAN. But the expenses for medical care come sometimes when you are least expecting it and you have not budgeted for it, and it is sometimes quite difficult for them to pay it, and it embodies a debt, and sometimes continues as a burden over their heads for a number of years thereafter. We have carried on some studies of situations of that kind.

For instance, the New York Times publishes each year a list of the hundred neediest families, and those cases have been analyzed and it is found that largely their condition is due to the fact that they become involved in debt through sickness, illness in their family, at some stage of their lives which has followed them through and has finally placed them in a situation where they have become members of the hundred neediest cases in New York.

Thank you very much for your statement here, Doctor. I appreciate your presence.

Dr. Low. Thank you, sir. May I please ask permission to incorporate a statement of the secretary of this association, Dr. Frederick B. Exner, as a matter of record?

The CHAIRMAN. All right.

(The statement referred to is as follows:)

STATEMENT TO THE COMMITTEE ON EDUCATION AND LABOR OF THE UNITED STATES
SENATE IN THE MATTER OF SENATE BILL S. 1606, A BILL TO PROVIDE A NATIONAL
HEALTH PROGRAM

The bill under consideration has become the focal point in the struggle between two factions, both interested in providing the best possible medical care to the people of the United States. On the one hand we have those who would jettison our entire system for the distribution of medical care and would create over night a new system calculated to eliminate at one stroke all those factors which have

prevented too many people in this country from obtaining the medical care they need. On the other hand we have those who insist that we retain those essential aspects of our present system which they know to be necessary to and responsible for our ability to provide the best medical care in the world to those who are able to obtain it.

While charges of dishonesty, insincerity, and ulterior motives have been hurled by both factions, it must be admitted by any reasonable person that both factions are composed of honest, sincere, and intelligent persons who are working, each in his own way, to promote better medical care for the people. This being the case, it seems strange that the two groups cannot achieve more harmony and some degree of cooperation toward the common goal. The fact that they cannot do so is due in part to mutual distrust and intolerance. Underlying this, however, there has been a basic lack of acceptance and understanding by each party of facts, principles, and necessities which appeared central, basic, and inescapable to the other.

Recently the second faction, which centers in the medical profession, has realized the importance and force of the matters which seemed basic to the others, and have been promoting a compromise in the form of voluntary prepaid medical care under the control of the physicians. This may not be the best compromise, and may not even prove satisfactory, but it represents the first step by either side toward a solution of the dilemma, and I believe it should be given a full trial before being dismissed as unsatisfactory. In any case, the fact that the first attempt at a realistic compromise has come from the doctors would seem to indicate that it is easier to teach economics to doctors than to teach the facts of life regarding medical practice to economists, sociologists, and idealistic reformers.

Meanwhile the first faction are not only unwilling to offer or accept compromise, but seize upon the willingness of the doctors to compromise as an indication of weakness and are less willing than ever to admit any weakness in their own position. They are bending every energy toward the passage of Senate bill 1606, which would effectively destroy, once and for all, the practice of medicine as a profession and impose upon the physician the status of a technician.

It is easy to cry, and to deny, charges of "regimentation," "socialism," etc., but until the accusation is based on something more substantial than appeals to prejudice, and the denial is based on something more substantial than the vaguely worded expressions of good intentions in Senate bill 1060, neither need be considered seriously as an argument.

The total effect of the bill must be considered in the light of the realities of medical practice, rather than relying upon isolated phrases which are often in direct conflict with other provisions of the bill and are at best expressions of pious hope, comparable to a provision that the sun shall always rise in the west after tomorrow; and often miss completely the point that they were designed to cover.

An example is to be found on page 47, where we are told that: (f) The methods of administration, including the methods of payment to practitioners, shall— (2) promote personal relationships between physician and patient; this being the only provision in the bill designed to safeguard the doctor-patient relationship. It should be fairly obvious that whoever wrote this provision had no very clear idea of how, or even whether it could be carried out; and that it was merely introduced as a defense against the inevitable criticism that the bill will destroy the essential "doctor-patient" relationship. This is especially clear when you note that this is the only place in the bill where even a gesture is made toward preserving that relationship.

It should also be clear that the one who wrote this clause either did not know or did not want others to know that the essential aspect of the doctor-patient relationship is not one of "personal relationships," but of personal obligation and responsibility. The personal relationships of friendliness, genuine interest, cooperation, and mutual liking and respect are important and contribute immeasurably to good medical care, but they are of very minor importance as compared with the "fiduciary" relationship, which the courts for centuries have recognized as the central fact in the doctor-patient relationship, and which is negated by almost every provision regarding medical care in S. 1606.

When the bill as a whole is evaluated it must be solely in terms of its effect on the well-being of the individual patient. This does not mean its effect on the "public" or on any theoretical and abstract "economic man" or, perhaps, "medically needy man" who forms the unit of the public. It means each patient as a personalized and unique individual.

There are things which we do to people as units of the public, to safeguard or improve their health or that of the "public." These are "public health" activities and are a proper governmental function. They include those things which are done to people because they are people and without regard to individual needs or peculiarities. They include such things as vaccination, tuberculosis case-finding, iodization of water supplies, quarantine, etc. We need much more and better activity in these and many similar fields. These are matters which permit a high degree of standardization and permit a uniform product of which you may buy as much and as good quality as you are able and willing to pay for. It is well known that the scourge of tuberculosis could be completely eradicated in 10 to 15 years if every person had a chest X-ray yearly and the cases found were cared for. In spite of this we have not X-rayed more than a small fraction of the population once, much less once a year. Still the proponents of this bill will tell you that one of its incidental benefits will be that everyone will have not merely a chest film, but a complete physical examination at least once a year. Moreover they will tell you how the bill will benefit the pellagra-ridden South, with no thought for the fact that pellagra is a disease of poverty and malnutrition and that no amount of medical care can substitute for a decent standard of living. Bill S. 1606, however, does not propose to provide merely "public health service."

The proper care of an individual sick patient however, is a totally different matter. This is a matter which defies standardization. No one except the doctor who has examined the patient knows what the patient needs or what he should do or have done to him. The patient does not know, or he wouldn't have gone to the doctor in the first place. Another doctor cannot know unless he, too, has examined the patient. Certainly a lay social worker or administrator cannot know or he could qualify as a doctor. There is no possible way in which the patient can know what he should do or have done except to take the word of the doctor. He is under the compulsion of his illness or fear of illness to entrust his life and health to the honesty and judgment of the doctor he selects. He may, if he wishes, shop around and get opinions from several doctors, but still all he can do is decide which doctor he will trust, or decide to trust none of them and depend on himself, his neighbor, or his grandmother. The trust is inescapable if he is to have a doctor.

Out of this arises the "fiduciary" nature of the relationship between the doctor and the patient. When the doctor accepts a patient he says, in effect: "I accept your trust and the responsibility which it entails. I agree to act in your behalf in all matters pertaining to your health in accordance with your best interests, permitting nothing to interfere with the full and honest performance of what I deem best for you, and admitting no prior or superior obligations of a conflicting nature."

This implied agreement is not a figment of the imagination and is not to be dismissed lightly. It is recognized by common law both of England and America, and by the statutory law of most States as inseparable from the practice of any of the learned professions—medicine, the law, and the ministry. The presence of this professional responsibility is what distinguishes the practitioner of a profession from an artisan, craftsman, or technician. The practitioner who violates this trust is deemed guilty of malpractice and is liable for damages to the injured party. The State undertakes, through its licensing laws to assure that those who profess themselves learned in matters of health, and who hold themselves out as willing and able to accept this trust, shall be both trustworthy and competent to fulfill it. Your right to be a carpenter will not be rescinded because of moral turpitude, but your license to practice medicine or law will, and should.

This implied promise cannot be made in good faith however, if the physician is placed in a position where a third party can dictate what he may or may not do for his patient. This he does when he acts as the employee or agent of any party other than his patient. Again this is recognized by the law, both common and statutory, in the almost universal agreement that a practitioner may not practice his profession as the employee or agent of a corporation or an unlicensed person. "If such a course were sanctioned the logical result would be that corporations and business partnerships might practice law, medicine, dentistry, or any other profession by the simple expedient of employing licensed agents. And if this were permitted professional standards would be practically destroyed, and professions requiring special training would be commercialized to the public detriment. The ethics of any profession is based upon personal or individual responsibility. One who practices a profession is responsible directly

to his patient or client. Hence he cannot properly act in the practice of his vocation as an agent of a corporation or business partnership whose interests are in the very nature of the case commercial in character." *Ezell v. Ritholz* (188 S. C. 39, 198 S. E. 419). And the court might well have added: "or of any other person or agency whose interests are in any way divergent from those of the patient or client."

The idealists and reformers who, paradoxically enough, seem to think that every man has his price, say: "But surely, if you pay them enough, the doctors will take just as good care of the beneficiaries of this plan as they do of their private patients." The answer is "Yes." They will whether they are paid well enough or not—if they are permitted to. But they will not be permitted to do so. What the idealists overlook is the fact that whoever controls the purse strings necessarily controls what may or may not be done for the patient. The control may be slight and remote, especially if funds are plentiful, as in the armed forces in wartime. Or it may be immediate and stifling as it has been and will be again in the Veterans' Bureau. But somewhere, in some form, and at some point, the control will appear and be felt—and when it is, the care of the patient suffers. It suffers far more than at present when most doctors will give the patient the care he needs whether he can pay or not, and when the doctor is the one who decides how badly the patients needs the care.

You will be told that because of poor pay and lack of opportunity for advancement, research, and study, the Veterans' Bureau failed to attract doctors of high caliber, and that this accounts for the disgraceful quality of the care given the veterans. I tell you that administrative interference and limitations on the care they were permitted to give their patients made good, able, and conscientious men into third-rate doctors or drove them out of the service. The cumulative frustration of trying to provide good care and being balked at every turn eventually develops in any doctor an attitude of "What's the use of trying to do good work?" And I confidently predict that after the present house cleaning in the Veterans' Administration, in 5 or 10 or 20 years we will have another investigation and will find conditions as bad or worse than those we found a few months ago. And this will occur whether the veterans continue to be treated in veterans' institutions or whether they are farmed out to the medical profession at large.

And the same thing will happen, to a greater or lesser extent, to the care received by the population at large if Senate bill 1606 becomes law; and all the pious expressions of good intentions that you can write into the law will not alter it a particle. Neither will denials that the bill represents "a step toward regimentation." I don't care what you call it. The effect is the same.

Even the doctors' plan for prepaid medical care under the control of the physicians themselves is subject to the same criticism, but to a much lesser degree since the control is local and is close enough to the physician so that if he is seriously hampered he can do something about it. This is why the doctors have been so slow to accept such a plan. The plain fact is, however, that under our present arrangements far too many people lack medical care and the doctors' plan seems to offer fewer drawbacks than any scheme which has been devised and seems possible of adoption. Consequently, I believe it should be tried before considering any such plan as S. 1606, which would destroy the progress of years if not centuries and reduce the proud and honorable profession of medicine to the status of a trade, "to the public detriment."

F. B. EXNER, M. D.,

Secretary, Association of American Physicians and Surgeons.

The CHAIRMAN. The committee will adjourn until 2:30.

(Whereupon, at 1:30 p. m., Thursday, April 18, 1946, the committee adjourned to meet at 2:30 p. m., Thursday, April 18, 1946.)

AFTERNOON SESSION

(The hearing was resumed at 2:30 p. m.)

The CHAIRMAN. The committee will come to order.

The next witness will take the stand, please.

Will you state your name, full name, please, and the organization that you represent, and any other information you wish to give for the record.

STATEMENT OF VLADO A. GETTING, M. D., SECRETARY, THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS, AND COMMISSIONER OF PUBLIC HEALTH, BOSTON, MASS.

Dr. GETTING. My name is Dr. Vlado A. Getting, secretary-treasurer of the Association of State and Territorial Health Officers, and commissioner of Public Health of the Commonwealth of Massachusetts.

I have attached appendix I to this statement which follows page 18, which sets forth my training and experience.

The CHAIRMAN. Attached to this?

Dr. GETTING. Yes, sir; following page 18.

The CHAIRMAN. All right, you may proceed.

Dr. GETTING. I appear here today as secretary of the Association of State and Territorial Health Officers, and have been authorized by the executive committee to speak for the entire association, which represents the 48 States, the Territories, and the District of Columbia. I am at the present time commissioner of public health of the Commonwealth of Massachusetts, which position I have held since April 14, 1943. My curriculum vita is submitted herewith, together with a bibliography setting forth my background, training, and experience. (Appendix I is as follows:)

APPENDIX I

TRAINING AND EXPERIENCE OF VLADO A. GETTING, M. D., MASSACHUSETTS COMMISSIONER OF PUBLIC HEALTH

EDUCATIONAL

Graduate of Johns Hopkins University, bachelor of arts, 1931.

Graduate of Harvard University Medical School, doctor of medicine, 1935.

Received master's degree in public health, magna cum laude, Harvard, 1939.

Received doctorate in public health, cum laude, Harvard, 1940.

PROFESSIONAL

Assistant resident, Mattapan Sanatorium, Boston, 1935 (3 months).

Contract surgeon, United States Army, Fort Ethan Allen, Vt., 1935 (4 months).

Intern, Worcester City Hospital, Worcester, Mass., 1935-37.

Assistant Epidemiologist, Massachusetts Department of Public Health, Boston, 1937-39.

Technical director of mosquito survey, Massachusetts Department of Public Health, Boston, 1939.

Epidemiologist, Massachusetts Department of Public Health, Boston 1939-40.

Assistant district health officer, Massachusetts Department of Public Health, 1940-41.

District health officer, Massachusetts Department of Public Health, Boston 1941-42.

Commissioner of public health, Worcester, Mass., 1942-43.

Commissioner of public health, Massachusetts Department of Public Health, Boston, 1943 to date.

Research assistant in epidemiology and preventive medicine, Harvard School of Public Health and Harvard Medical School, 1939-40.

Assistant in epidemiology and preventive medicine, Harvard School of Public Health and Harvard Medical School, 1940-42.

Lecturer on public health practice, Harvard School of Public Health, 1943 to date.

Senior surgeon, United States Public Health Service Reserves, 1944 to date.

MEMBERSHIP IN MEDICAL AND EDUCATIONAL ASSOCIATIONS

Phi Beta Kappa (Hopkins).
 Delta Omega (Harvard).
 Delta Omega Honorary Public Health Fraternity.
 Fellow of the American Medical Association.
 Fellow of the American Public Health Association.
 Member of Massachusetts Public Health Association.
 Member of American Academy of Science.

PUBLICATIONS

Progress of Milk Regulations. The Commonwealth, 1938.
 Equine Encephalomyelitis in Massachusetts. Analysis of 1938.
 Massachusetts Mosquito Survey. Training course for field personnel, 1939.
 Mosquito-Vectors of Disease in Massachusetts. 1939.
 Report on Medical Progress; some epidemiological considerations of diphtheria.
 New England Journal of Medicine, October 31, 1940.
 Special Report of the Department of Public Health Relative to Varieties and
 Prevalence of Mosquitoes in the Commonwealth. December 1940.
 A Survey of the Mosquitoes of Massachusetts with a Discussion of the Relation
 of Mosquitoes to Disease. Final report, 1940.
 Outbreak, Follow-Up of Cases and Report of Mosquito Survey. New England
 Journal of Medicine, June 12, 1941.
 Civilian Public Health Problems in Wartime. New England Journal of Medicine,
 January 7, 1943.
 Insects and Rodents in Relation to Public Health in Wartime. Pests, May 1943.
 Epidemiologic Aspects of Food-Borne Disease. New England Journal of Medi-
 cine, June 10, 17, 24, 1943.
 Food-Borne Streptococcus Outbreaks. American Journal of Public Health,
 October 1943.
 A Food-Borne Streptococcus Outbreak—The Differentiation of Staphylococcus
 Enterotoxin From Toxic Substances Produced in Minceed Tissue Media by
 Homolytic Streptococci and Other Agents. American Journal of Hygiene,
 November 1943.
 Upgrading of Hospital Care is the Goal of Massachusetts Licensing Law. Hos-
 pitals, March 1944.
 Tropical Diseases in New England. Science Education, March 1944.
 Tropical Disease and Global War. American Journal of Medical Sciences,
 March 1944.
 Malaria in Massachusetts. New England Journal of Medicine, March 23, 1944.
 Staphylococcus and Streptococcus Carriers. American Journal of Public
 Health, August 1944.
 Food-borne Disease—Food Infections and Food Poisoning. Oxford Press, 1944.
 Seventy-five Years of Public Health in Massachusetts. Norfolk Medical News,
 November 1944.
 Schools of Public Health—Whither and How. Harvard Alumni Bulletin, 1944.
 Insect Vectors of Diseases. New England Journal of Medicine, March 1945.
 Fluorine and Dental Caries. New England Journal of Medicine. In press.

Dr. GETTING. The State and Territorial health officers are naturally
 in favor of any legislation which will benefit the public health of the
 Nation. We are, however, concerned that all such legislation should
 be administered efficiently and effectively in order that the people may
 derive the maximum benefit consistent with the minimum interference
 with their normal course of life. For over 75 years State departments
 of health have been charged with the responsibility of administering
 programs of public health. The association, therefore, is in favor
 in principle of any bill which will ultimately bring about an improve-
 ment in public health. The association, on the other hand, must call
 to the attention of the committee shortcomings in S. 1318 and in
 S. 1606, which, in its opinion, would be detrimental to the health of
 the people.

OBJECTIVES OF THE MASSACHUSETTS MEDICAL SOCIETY

As a member of the subcommittee on economics of the committee on postwar planning of the Massachusetts Medical Society, I assisted in the formulation of certain statements which, in my opinion, are applicable to both of these bills. They not only express the objectives of adequate medical care, but set forth the prerequisites for the success of an officially administered medical care program. These basic principles were adopted by the council of the Massachusetts Medical Society on January 9, 1946, and appear in the *New England Journal of Medicine* of March 7, 1946. They are as follows:

1. The objective of adequate medical care in our free society is to make available to everyone—regardless of race, color, creed, financial status, or place of residence—every known essential preventive, diagnostic, and curative medical service of high quality. The attainment of such medical care must necessarily be an evolutionary process which will require the cooperation of all concerned over a period of years.

2. The success of any plan for medical care is dependent on the mutual cooperation of the public, those rendering professional services and the administrative agencies. This cooperation can be obtained only if those rendering the services are convinced that they will have a continuing authoritative voice in the formulation and execution of policies and plans, thereby assuming their proper share of responsibility.

3. Provision of adequate medical care for those unable to obtain it by voluntary prepayment plans or by direct payment is the responsibility of the local or State government. Part of the burden of this responsibility may be assumed by charitable agencies. Federal grants-in-aid to State programs administered by State boards of health is an acceptable method of helping to meet this responsibility.

4. The medical care of those who are able to purchase it by voluntary prepayment plans or by direct payment is the responsibility of the individual.

5. Eligibility for receiving benefits under a program aided by Federal grants should be determined by the individual States.

6. The patient shall have free choice of his physician, group of physicians, clinic, or hospital from among those participating in any plan, provided that the physician, group of physicians, clinic, or hospital selected shall have the right to refuse or to accept the patient.

7. Physicians and other qualified persons rendering medical care shall receive adequate remuneration for their services.

8. The physician shall be free to elect or reject without prejudice participation in a medical-care plan. The rights of the physician as to the choice of methods by which he is to be paid shall be fully protected.

PROPOSED CHANGES IN TITLE I

The Association of State and Territorial Health Officers has made a careful and prolonged study of the Maternal and Child Welfare Act of 1945, S. 1318. Though in favor of its objectives, the association cannot recommend the passage of this bill in its present form. It is convinced that certain basic principles must be adhered to if a medical-care program is to be successful. As they apply to S. 1318, or I might say to the amendments proposed by Senator Pepper to the Wagner-Murray bill, these principles are as follows:

1. The extension of public health facilities and services is a primary necessity. At the present time, there is a delay between the development and the utilization of knowledge in medical progress. The establishment of more health departments would reduce this and make the benefits of new procedures and facilities available to the people.

2. Prevention is more fundamental than care. It is an integral

part of any health program and should have precedence over medical care.

3. Medical care should be extended as needed but should be limited to individuals unable to provide such care for themselves.

The Pepper bill does not meet the cardinal need, namely, the extension of public health facilities and programs into communities not served at the present time. As Haven Emerson pointed out in the book entitled "Local Health Units for the Nation" which was prepared in 1945 under the auspices of the commonwealth fund for the subcommittee of local health units of the committee on administrative practice of the American Public Health Association; approximately 40,000,000 of the people of the continental United States are living in communities where local health services have either not been undertaken at all, or, if provided for, are under the direction of part-time and generally untrained or experienced health officers. It seems apparent, therefore, that the basic need of this country is the expansion of present public health facilities so that the benefits of preventive medicine may be available to all, rather than the provision of medical care for a selected group of the population. To us, the Association of State and Territorial Health Officers, it appears to be poor administrative practice to set up a medical-care program for the treatment of the sick before adequate measures have been undertaken to reduce the extent of preventable illness. Curative medicine assumes its proper role only after public health facilities have been made available to insure, insofar as is possible, optimal health for the people. It is, moreover, a fundamental policy of the association that medical care is primarily the responsibility of the family which the Government should assume only when the family is otherwise unable to secure it. Since this bill is not based upon a prepayment plan comparable to the Blue Cross, in which participants pay on an insurance basis for medical or hospital care, it cannot provide for universal coverage unless the Government assumes the responsibility for medical care of all persons in the special classes listed regardless of economic status. Because of the vital importance of this point, I repeat that while in favor of its objectives, the association cannot approve S. 1313 in its present form inasmuch as it does not limit the extension of medical care to the medically indigent, as defined by the several individual States.

1. It is the opinion of the Association of State and Territorial Health Officers that State health departments are not prepared to undertake a medical-care program for maternal and child health unless consideration is given to their ability to expand and participate. The association, therefore, recommends that the bill be modified to permit a gradual development of the program over a period of years, limiting it in the first year to children under 1 year of age and extending it by the tenth year of operation to include all children up to the age of 18 years. Preventive, diagnostic, school health, and related facilities would necessarily be made available to all children.

2. The association has recommended that the age limit be reduced from 21 to 18 years, since in the opinion of the members, and individual who has reached his eighteenth birthday can no longer be considered a child. The reasons are self-evident. He has matured sufficiently

both mentally and physically to assume responsibility for himself; he is eligible for draft; and in some States he may vote. Moreover, at this age some individuals are married and raising families of their own. Finally, if the age were left at 21 years, it would be possible for a returning veteran to receive care under this program which is intended for children.

3. State-administered programs: Experience with the emergency maternal and infant care program has shown that in order to administer medical care programs efficiently for the benefit of the public, they must be designed and operated by the States rather by the Federal Government. (a) The States should be able to determine domicile and financial eligibility. (b) They must be able to administer the program in accordance with State laws and to formulate major policies and administrative procedures. It is impossible for 1 pair of shoes to fit 48 pairs of feet. Similarly, it is impossible for a Federal program designed on a national level to meet the needs of the various States and Territories. (c) The States should have authority to establish rates of remuneration for services rendered under their programs by the following means:

The Federal agency should annually establish a stipulated remuneration schedule for each type of medical care rendered by physician, dentist, and other professional personnel or organizations thereof and should match dollar for dollar additional funds appropriated by the States for such professional services rendered, provided that such Federal matching funds shall in no instance exceed 50 percent of those stipulated in the original Federal schedule. Remuneration schedules should be established by the Federal agency only after conferences with the association of State and Territorial Health Officers and with representatives of the professions rendering such services, in order that adequate payment may be furnished to physicians and others in those States in which additional funds are not available to increase the fees paid for professional services. This administration of the medical care program would enable a differential rate of payment from one State to another, based upon the appropriation of funds by the State legislatures to supplement funds made available as grants-in-aid from the Federal Government. Moreover, a State should not be required to include financial participation for the medical and other professional care aspects of the program. Methods of payment to physicians or groups of physicians should be determined by the States.

(d) The administration of this program should not be so circumscribed by regulations formulated by the Federal Government as to impose upon the various States standards of procedure which in their opinion are neither desirable nor for the benefit of the people. The Federal agency should require reports based only on such data as are necessary for the operation of the plan. Requests for additional reports other than those specified in the rules and regulations approved by the Association of State and Territorial Health Officers should be made known to the State health agencies at least three months prior to the period to be covered by such reports. Moreover, the State health agency should be informed at least three months prior to the setting up of additional regulations—such regulations not to be made more frequently than once each quarter. Similarly State health departments should give notice in advance to the professions of any

changes in regulations. (e) The Federal agency should not require the State health agency to furnish it with a line-by-line detail regarding the State budget. Moreover, all new regulations, changes in reports, plans, etc., should be submitted in advance, whenever practical, to the Association of State and Territorial Health Officers.

4. Advisory committees: The bill does not provide the professions with a continuous, authoritative voice in the formulation of policies and plans: (a) On the State level, professional advisory committees including such representatives of the medical, dental, hospital, nursing, and public health associations, as are recommended by them, should be appointed by the State health agency with the understanding that such professional advisory committees be given the right and the facilities to make public their recommendations; (b) similarly, on the Federal level, general advisory as well as technical committees should be set up representing the professional organizations and others interested in the problems connected with maternal and child health services and medical care for mothers and children.

5. Voluntary prepayment plan. It is the opinion of the association that the bill should contain specific recommendations permitting State health agencies to enter into agreements for the provision of medical and hospital services with voluntary nonprofit organizations such as the Blue Shield and the Blue Cross.

6. Deficiency appropriations: The Federal agency should guarantee to the States sufficient funds to operate the plan, as approved, under the following conditions: (a) An emergency such as an epidemic; (b) the distribution of unusual amounts of unforeseen care; (c) Other unpredictable factors requiring the State to exceed its allotment for the administration of the program.

7. The administrative agency to be a Federal department of health: (a) The Association of State and Territorial Health Officers has, on numerous occasions, expressed the need for a coordinated Federal health program. It has been the experience of the various State health officers that a great deal of duplication exists. Duplicate reports, audits, and other inefficient operative procedures could be eliminated by the unification of the Children's Bureau of the Department of Labor, the United States Public Health Service of the Federal Security Agency, and other agencies of the Federal Government dealing with public health, into a single department of public health or of public health and welfare under the direction of a cabinet secretary: (b) it is, therefore, the recommendation of the association that until such time as a Federal department of health is established this bill be entitled "Maternal and Child Health and Welfare Act of 1945"; that title I be administered by the United States Public Health Service; that title II be administered by the Department of Labor; and that adequate changes be made throughout the bill, particularly in title III, to bring about this change.

8. Other changes: Since time does not permit detailed discussion of the numerous changes which the association recommends in Senate 1318, we have prepared the attached amendment (appendix II) and submit it on behalf of the association.

Would it be proper to insert that in the record?

The CHAIRMAN. Yes.

(Appendix II is as follows:)

APPENDIX II

SUGGESTED AMENDMENT OF S. 1318 SUBMITTED ON BEHALF OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS BY VLADO A. GETTING, M. D., DR. P. H., MASSACHUSETTS COMMISSIONER OF PUBLIC HEALTH, AND SECRETARY-TREASURER OF THE ASSOCIATION.

(79th Cong., December 7, 1945)

A BILL To provide for the general welfare by enabling the several States to make more adequate provision for the health and welfare of mothers and children and for services to crippled children, and for other purposes

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

TITLE I—MATERNAL AND CHILD HEALTH SERVICES

APPROPRIATION

Sec. 101. For the purpose of enabling each State to provide and maintain services and facilities to promote [the physical and mental health of mothers during the maternity period, and of children, including medical, nursing, dental, hospital, and related services and facilities required for maternity-care, preventive health work and diagnostic services for children, school health services, care of sick children, and correction of defects and conditions likely to interfere with the normal growth and development and the educational progress of children, and to develop] *general public health programs for mothers and children according to the following schedule: (a) medical, nursing, dental, hospital and related services and facilities required for the physical and mental health of all mothers, who qualify in accordance with section 103, during the prenatal, confinement, and postnatal period. (b) medical, nursing, dental, hospital, and related services and facilities required for physical and mental health, care for sick children, correction of defects and conditions likely to interfere with normal growth and development for all children, who qualify in accordance with section 103, under 1 year of age during the first year of operation of the program, to be extended in such manner as to include all children up to the age of 18 years by the tenth year of operation of the program. (c) preventive, diagnostic, school health, and related services and facilities for all children under 18 years of age, and the development of more effective measures for carrying out the purposes of this title, including demonstrations and the training of personnel for State and local maternal and child health services, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1946, the sum of \$50,000,000 and for each year thereafter a sum sufficient to carry out the purposes of this title. The sums authorized under this section shall be used for making payments to States which have submitted to and had approved by the [Chief of the Children's Bureau] Surgeon General, State plans for developing such programs and providing such care and services.*

ALLOTMENTS TO STATES

Sec. 102. (a) For the fiscal year ending June 30, 1946, and for each year thereafter, the [Secretary of Labor] Administrator of the Federal Security Agency shall allot to each State, out of the sums appropriated pursuant to section 101, such part of \$5,000,000 as he finds that the number of children under [twenty-one] *eighteen* years of age in such State bore to the total number of children under [twenty-one] *eighteen* years of age in the United States, in the latest calendar year for which the Bureau of the Census has available statistics.

(b) For the fiscal year ending June 30, 1946, and for each year thereafter, in addition to the allotments made under subsection (a), the [Secretary of Labor] Administrator of the Federal Security Agency shall allot to the States, out of the sums appropriated pursuant to section 101, the amount remaining after the amount allotted under subsection (a) has been deducted, taking into consideration for each State such factors as (1) the number of mothers, and of children under [twenty-one] *eighteen* years of age in the State for whom the services and care as provided for in section 101 are to be made available, and the cost of furnishing such services and care to them, (2) the special problems of

maternal and child health, and (3) the financial need of the State for assistance in carrying out the State plan.

(c) *The federal agency shall annually establish a stipulated remuneration schedule for each type of medical care rendered by physicians, dentists, other professional persons or organizations thereof and shall match, dollar for dollar, additional funds appropriated by the State for such professional services rendered provided that such federal matching funds shall in no instance exceed 50% of the original federal set remuneration. Such remuneration schedules shall be established only after conference with the State and territorial health officers and with representatives of the professions rendering such services in order that such remuneration furnishes adequate payment of physicians and others in those States where additional funds are not available to increase the fees paid for professional services.*

APPROVAL OF STATE PLANS

SEC. 103. (a) A State plan for maternal and child health services under this title must—

(1) provide for financial participation by the State;

(2) provide for a State-wide program or for extension of the program each year so that a State plan adequate to carry out the purposes specified in section 101 will be **[in effect]** available in all political subdivisions of the State, not later than **[July 1, 1955]** ten years after the approval of the State plan;

(3) provide that as services and facilities are furnished under the plan they shall be available to all mothers and children domiciled in the State or locality who are determined by the State health agency to be eligible and who elect to participate in the benefits of the program, and that there will be no discrimination because of race, creed, color, or national origin; **[and no residence requirements];**

(4) provide for the administration of the plan by the State health agency or for the supervision of the administration of the plan by the State health agency, and for appropriate coordination of the plan with the general public-health and medical-care program of the State health agency: *Provided*, That in carrying out the purposes of this title, the State health agency may develop agreements or cooperative arrangements with other State or local public agencies whose functions include the provision of services similar or related to the services furnished under the State plan;

[(5) be made part of the State plan for maternal and child health services submitted in accordance with the provisions of title V, part 1, of the Social Security Act;]

(6) provide such methods of administration as are necessary for the proper and efficient operation of the plan, including methods relating to the establishment and maintenance of **[(A) 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,] (B) standards for professional personnel rendering medical, dental, nursing, and related types of care or service and standards for hospital and other institutional care and services, such standards to be established by the State health agency after consultation with professional advisory committees, [appointed by the State health agency,] which shall include representatives of medical, dental, hospital, nursing and public health associations, who shall be recommended by said associations and others; all of whom shall be appointed by the State health agency with the understanding that the professional advisory committees reserve the right and are provided the facilities to make public their recommendations, and (C) such methods of administration of medical care as will insure (1) the right of mothers and children, or persons acting in their behalf, to select, from among those meeting standards prescribed by the State health agency in accordance with methods set forth in the State plan, the physician, hospital, clinic, or health service agency of their choice (provided that the physician, hospital, clinic, or health service agency selected may refuse to accept the case), and where no such selection is made, the State plan shall set forth the method by which care will be made available; (2) a high quality of care by providing for adequate remuneration, to be determined by the State health agency after consultation with the professional advisory committees, for the persons and institutions providing medical care and related services; opportunities for postgraduate training of professional**

and technical personnel; and such use of health centers, hospitals, clinics, and health service agencies, public and voluntary, as will achieve the satisfactory distribution and coordination of preventive, diagnostic, consultative, and curative services for mothers and children furnished by general practitioners, specialists, public health personnel, laboratories, and others; (3) payments [to individual physicians] for care furnished under this title on a per capita, salary, per case, [or] per session [basis,] or [in the case of consultations or emergency visits] on a fee-for-service basis, *the method of payment to be elected by the individual or organization rendering the services, provided that the individual or organization rendering the services shall not accept supplemental payment;* (4) payments to individuals or organizations for care furnished under this title may exceed, but not fall below, the stipulated federal remuneration for such care, the amount in excess to be determined by each State in accordance with section 102 (c); and (5) purchase of care from [public or voluntary] hospitals and other health service agencies included under the State plan on a basis related to cost for providing such care, *provided that the hospital or health service agency shall not accept supplemental payments;*

(6) provide for notification to the individual or organization rendering care furnished under this title by the State health agency of additional rules and regulations one month in advance whenever practicable;

(7) provide for [adequate] dissemination of information in the State with regard to the services and facilities available under this title;

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

(9) provide for cooperation with medical, health, hospital, nursing, education, and welfare groups and organizations in the State;

(10) provide (a) for a general advisory council appointed by the State health agency and composed of members of the professions or agencies, public and voluntary, that furnish care or services under the State plan, *who are recommended by such groups*, and of other persons representing the public who are informed on the need for and problems related to the provision or receipt of maternal and child health services and medical care of mothers and children. *PROVIDED*, That whenever the State health agency administers the program of services to crippled children, the same general advisory council shall serve both the maternal and child health and the crippled children programs, and (b) for technical advisory committees appointed by the State health agency composed of medical and other professional groups concerned with the administration or operation of the State plan, and

(11) provide for granting to any mother, or persons 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] review before a representative of the State health agency.

(b) The [Chief of the Children's Bureau] Surgeon General shall (1) approve any plan which fulfills the conditions specified in subsection (a), *provided that the State plan shall not be required to include financial participation for the medical and other professional care aspects of this Act as provided in section 101 (a) and (b) except for the administration thereof*, (2) make known in the rules and regulations as provided in title V, section 501, the reports to be submitted by the States, such reports to be based only on such data as are necessary for the operation of the plan with the exception that requests for additional reports not specified in the said rules and regulations be made known to the State health agency at least three months prior to the period to be covered by such reports, (3) inform the State health agency at least three months prior to the setting-up of additional regulations, such regulations to be made not more frequently than once each quarter, (4) not require the State health agency to furnish the Surgeon General line by line details with regards to the State budget, such details being left to the discretion of the State, and (5) obtain approval, whenever practicable in advance by the conference of State health officers of any new request or change in reports, plans, regulations or other requirements as noted in subsections (b) (2) to (b) (4) above.

PAYMENTS TO STATES

SEC. 104 (a) From the sums appropriated therefor and the allotments available under section 102 (a) the Secretary of the Treasury shall pay to each State which has an approved plan for maternal and child-health services, for each fiscal year or part thereof, beginning with the fiscal year ending June 30, 1946, an amount, which shall be used exclusively for carrying out the purposes of the State plan, and which shall be matched dollar for dollar by State or State and local funds *as determined by the State* and made available for the purposes of this Act as set forth in section 101.

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

(1) The **Secretary of Labor** *Administrator of the Federal Security Agency* shall **from time to time, but not less often than semiannually,** *quarterly or 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 in such year or part thereof in accordance with the provisions of subsection (a), and (B) such other data as to such estimated expenditures, and such investigation as he may find necessary.

(2) The **Secretary of Labor** *Administrator of the Federal Security Agency* 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** *Administrator of the Federal Security Agency* finds that his estimate for any prior fiscal year or part thereof for such State plan was greater or less than the amount which should have been paid to the State under subsection (a) for such year or part thereof; except that such increases or decreases shall not be made to the extent that such sum has been applied to make the amount certified for any prior year or part thereof greater or less than the amount estimated by the **Secretary of Labor** *Administrator of the Federal Security Agency* for such prior year or part thereof.

(3) The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay to the State, in such installments and at the time or times fixed by the *Administrator of the Federal Security Agency* **Secretary of Labor,** the amount so certified.

(c) The **Secretary of Labor** *Administrator of the Federal Security Agency* shall **from time to time** *quarterly or semiannually* certify to the Secretary of the Treasury the amounts to be paid to the States from the allotments available under section 102 (b), and the Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, make payments of such amounts at the time or times specified by the **Secretary of Labor** *Administrator of the Federal Security Agency*.

(d) *The Surgeon General shall guarantee to the States sufficient funds to operate the plan as approved by the United States Public Health Service if (A) because of an emergency such as an epidemic; (B) because of an unusual amount of unforeseen care distributed; (C) because of other unforeseen factors—the State has exceeded the allotment made to it for the administration of this program.*

FEDERAL ADVISORY COMMITTEES

SEC 105. The **Chief of the Children's Bureau** *Surgeon General* shall formulate general policies for the administration of this title after consultation with (1) a conference of State health officers, and (2) an advisory committee composed of **professional and public members and, as necessary, technical advisory committee, which he shall appoint** *members who are recommended by professional organizations and of other persons representing the public who are informed on the need for and problems related to the provision or receipt of maternal and child health services and the medical care of mothers and children, and, as necessary, technical advisory committees which shall include representatives of medical, dental, hospital, nursing, and public health associations, who shall be recommended by said associations and others; all of whom shall be appointed by the Surgeon General with the understanding that the conference of State health officers, the general advisory committee and technical advisory committee reserve the right and are furnished the facilities to make public their recommendations.*

TITLE II—SERVICES FOR CRIPPLED CHILDREN

APPROPRIATION

SEC. 201. For the purpose of enabling each State to provide and maintain services and facilities for the care and treatment of children who are crippled, otherwise physically handicapped, or suffering from conditions which lead to crippling or physical handicaps, including services for locating such children, for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare for such children *in accordance with section 203*, and to develop more effective measures for carrying out the purposes of this title, including demonstrations and the training of personnel for State and local crippled children's services, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1946, the sum of \$25,000,000 and for each year thereafter, a sum sufficient to carry out the purposes of this title. The sums authorized under this section shall be used for making payments to States which have submitted to and had approved by the [Chief of the Children's Bureau.] *Surgeon General* State plans for developing such programs and providing such care and services.

ALLOTMENTS TO STATES

SEC. 202. (a) For the fiscal year ending June 30, 1946, and for each year thereafter, the [Secretary of Labor] *Administrator of the Federal Security Agency* shall allot to each State, out of the sums appropriated pursuant to section 201, such part of \$2,500,000 as he finds that the number of children under [twenty-one] *eighteen* years of age in such State bore to the total number of children under [twenty-one] *eighteen* years of age in the United States, in the latest calendar year for which the Bureau of the Census has available statistics.

(b) For the fiscal year ending June 30, 1946, and for each year thereafter, in addition to the allotments made under subsection (a), the [Secretary of Labor] *Administrator of the Federal Security Agency* shall allot to the States, out of the sums appropriated pursuant to section 201, the amount remaining after the amount allotted under subsection (a) has been deducted, taking into consideration for each State such factors as (1) the number of crippled children under [twenty-one] *eighteen* years of age in the State for whom the services and care provided for in section 201 are to be made available, and the cost of furnishing such services and care to them, (2) the special problems of crippled children, and (3) the financial need of the State for assistance in carrying out the State plan.

(c) *The federal agency shall annually establish a stipulated remuneration schedule for each type of medical care rendered by physicians, dentists, other professional persons or organizations thereof and shall match, dollar for dollar, additional funds appropriated by the State for such professional services rendered provided that such federal matching funds shall in no instance exceed 50 percent of the original federal set remuneration. Such remuneration schedules shall be established only after conference with the State and territorial health officers and with representatives of the professions rendering such services in order that such remuneration furnishes adequate payment of physicians and others in those States where additional funds are not available to increase the fees paid for professional services.*

APPROVAL OF STATE PLANS

SEC. 203. (a) A State plan for crippled children services under this title must—

- (1) Provide for financial participation by the State;
- (2) provide for State-wide program or for extension of the program each year so that a State plan adequate to carry out the purposes specified in section 201 will be [in effect] *available* in all political subdivisions of the State, not later than [July 1, 1955] *ten years after approval of the State plan*;
- (3) provide that as services and facilities are furnished under the plan, they shall be available to all crippled children *domiciled* in the State or locality who *are determined by the State health agency to be eligible and who elect to participate* in the benefits of the program, and that there will be no discrimination because of race, creed, color, or national origin; [and no residence requirements;]

(4) 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, and for appropriate coordination of the plan with the maternal and child-health program of the State health agency *with the understanding that only one plan will be required from States in which Titles I and II are administered by the same State agency: Provided, however, That prior to July 1, 1950, in States in which another State agency is already charged by State law with administrative or supervisory responsibility for a program of services for crippled children, and is operating a plan approved by the [Chief of the Children's Bureau] Surgeon General until title V, part 2, of the Social Security Act, such other State agency may administer a plan of services for crippled children under this title: And provided further, That in carrying out the purposes of this title, the State agency may develop agreements or cooperative arrangements with other State or local public agencies whose functions include the provision of services similar or related to the services furnished under the State plan;*

[(5) be made part of the State plan for services for crippled children submitted in accordance with the provisions of title V, part 2, of the Social Security Act when the same State agency is administering both State plans for services for crippled children;]

(5) provide such methods of administration as are necessary for the proper and efficient operation of the plan, including methods relating to the establishment and maintenance of **[(A) 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,]** (B) standards for professional personnel rendering medical, dental, nursing, and related types of care or service and standards for hospital and other institutional care and services, such standards to be established by the State agency after consultation with professional advisory committees **[appointed by the State agency,]** *which shall include representatives of medical, dental, hospital, nursing and public health associations, who shall be recommended by said associations and others; all of whom shall be appointed by the State health agency with the understanding that the professional advisory committees reserve the right and are provided the facilities to make public their recommendations,* and (C) such methods of administration of medical care as will insure (1) the right of crippled children or persons acting in their behalf, to select, from among those meeting standards prescribed by the State agency in accordance with methods set forth in the State plan, the physician, hospital, clinic or health service agency of their choice (provided that the physician, hospital clinic, or health service agency selected may refuse to accept the case), and where no such selection is made, the State plan shall set forth the method by which care will be made available; (2) a high quality of care by providing for adequate remuneration, *to be determined by the state health agency after consultation with the professional advisory committees,* for the persons and institutions providing medical care and related services; opportunities for postgraduate training of professional and technical personnel; and such use of health centers, hospitals, clinics, and other health service agencies, public and voluntary, as will achieve the satisfactory distribution and coordination of preventive, diagnostic, consultative, and curative services for crippled children furnished by general practitioners, specialists, public health personnel, laboratories, and others; (3) payments **[to individual physicians]** for care furnished under this title on a *per capita, salary, per case, [or] per session [basis,]* or **[in the case of consultations or emergency visits on]** a fee-for-service basis, *the method of payment to be elected by the individual or organization rendering the services, provided that the individual or organization rendering the services shall not accept supplemental payment from persons receiving such services;* (4) payments to individuals or organizations for care furnished under this title may exceed but not fall below the uniform federal allotments to the States for such care, the amount in excess to be determined by each State in accordance with section 202 (c); and (5) purchase of care from **[public and voluntary]** hospitals and other health service agencies included under the State plan on a basis related to cost of providing such care, *provided that the hospital or health service agency shall not accept supplemental payment;*

(6) provide for notification to the individual or organization rendering care furnished under this title by the State health agency of additional rules and regulations 1 month in advance whenever practicable;

(7) provide for [adequate] dissemination of information in the State with regard to the services and facilities available under this title;

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

(9) provide for cooperation with medical, health, hospital, nursing, education, and welfare groups and organizations, and with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children;

(10) provide (a) for a general advisory council appointed by the State agency and composed of members of the professions or agencies, public and voluntary, that furnish care or services under the State plan, *who are recommended by such groups*, and of other persons representing the public who are informed on the need for and problems related to the provision or receipt of crippled children services: *Provided*, That whenever the State health agency administers the program of services to crippled children, the same general advisory council shall serve both the maternal and child health and crippled children's programs; and (b) for technical advisory committees appointed by the State agency composed of medical and other professional groups concerned with the administration or operation of the State plan; and

(11) 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] review before a representative of the State health agency.

(b) The [Chief of the Children Bureau] *Surgeon General* shall (1) approve any plan which fulfills the conditions specified in subsection (a), *provided that the State plan shall not be required to include financial participation for the medical and other professional care aspects of this Act as provided in section 101 (a) and (b) except for the administration thereof*, (2) make known in the rules and regulations as provided in title V, section 501, the reports to be submitted by the States, such reports to be based only on such data as are necessary for the operation of the plan with the exception that requests for additional reports not specified in the said rules and regulations be made known to the State health agency at least three months prior to the period to be covered by such reports, (3) inform the State health agency at least 3 months prior to the setting-up of additional regulations, such regulations to be made not more frequently than once each quarter, (4) not require the State health agency to furnish the *Surgeon General* line by line details with regard to the State budget, such details being left to the discretion of the State, and (5) obtain approval whenever practicable in advance by the conference of State health officers of any new request or change in reports, plans, regulations or other requirements as noted in subsections (b) (2) to (b) (4) above.

PAYMENT TO STATES

SEC. 204. (a) From the sums appropriated therefor and the allotments available under section 202 (a), the Secretary of the Treasury shall pay to each State which has an approved plan for services to crippled children, for each fiscal year or part thereof, beginning with the fiscal year ending June 30, 1946, an amount, which shall be used exclusively for carrying out the purposes of the State plan, and which shall be matched dollar for dollar by State or State and local funds, as determined by the State and made available for the purposes of this Act as set forth in section 201.

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

(1) The [Secretary of Labor] *Administrator of the Federal Security Agency* [shall from time to time, but not less often than semiannually,] quarterly or 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 in such year or part thereof in accordance with the provisions of subsection (a), and (B) such other data as to such estimated expenditures and such investigation as he may find necessary.

(2) The [Secretary of Labor] *Administrator of the Federal Security Agency* 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] *Administrator of the Federal Security Agency* finds that his estimate for any prior fiscal year or part thereof for such State plan was greater or less than the amount which should have been paid to the State under subsection (a) for such year or part thereof; except that such increases or decreases shall not be made to the extent that such sum has been applied to make the amount certified for any prior year or part thereof greater or less than the amount estimated by the [Secretary of Labor] *Administrator of the Federal Security Agency* for such prior year or part thereof.

(3) The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay to the State, in such installments and at the time or times fixed by the [Secretary of Labor] *Administrator of the Federal Security Agency* the amount so certified.

(c) The [Secretary of Labor] *Administrator of the Federal Security Agency* shall [from time to time] *quarterly or semiannually* certify to the Secretary of the Treasury the amounts to be paid to the States from the allotments available under section 202 (b), and the Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, make payments of such amounts at the time or times specified by the [Secretary of Labor] *Administrator of the Federal Security Agency*.

(d) *The Surgeon General shall guarantee to the States sufficient funds to operate the plan as approved by the United States Public Health Service if (A) because of an emergency such as an epidemic; (B) because of an unusual amount of unforeseen care distributed; (C) because of other unforeseen factors—the State has exceeded the allotment made to it for the administration of this program.*

FEDERAL ADVISORY COMMITTEES

SEC. 205. The [Chief of the Children's Bureau] *Surgeon General* shall formulate general policies for the administration of this title after consultation with (1) a conference of [executive] *State health* officers of State agencies administering the program for crippled children under this title, and (2) an advisory committee composed of *members who are recommended by professional organizations and of other persons representing the public who are informed on the need for and problems related to the provision or receipt of maternal and child health services and the medical care of mothers and children, and, as necessary, technical advisory committees which shall include representatives of medical, dental, hospital nursing, and public health associations who shall be recommended by said associations and others; all of whom shall be appointed by the Surgeon General with the understanding that the conference of State health officers, the general advisory committee and technical advisory committees reserve the right and are furnished the facilities to make public their recommendations.*

The [Children's Bureau] *United States Public Health Service* is authorized to pay to each person appointed by the [Chief of Children's Bureau] *Surgeon General* to an advisory committee compensation at the rate of \$25 a day while serving on business of the committee, and actual traveling and subsistence expenses while so serving away from his place of residence.

TITLE III—CHILD-WELFARE SERVICES

Since the Health Department is not concerned with this title, no amendments have been proposed.

TITLE IV—ADMINISTRATION

OPERATION OF STATE PLANS

SEC. 401. (a) In the 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] *Surgeon General*, if the [Secretary of Labor]

Administrator of the Federal Security Agency, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, find that in the administration of the plan there is a failure to comply substantially with any provision required by section 103, or section 203, respectively, to be included in the plan, he shall notify such State health agency that further payments will not be made to the State under such plan (or, at 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 or shall limit further certifications to services in which there is no such failure;

(b) In the case of any State plan for child-welfare services 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 303 to be included in the plan, he shall notify such State health agency that further payments will not be made to the State under such plan (or, at 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 or shall limit further certifications to services in which there is no such failure;

(c) In the case of any State plan for child-health services or for services to crippled children which is not approved by the Surgeon General, opportunity shall be granted the State agency for a fair review;

(d) In the case of any State plan for child-welfare services which is not approved by the Chief of the Children's Bureau, opportunity shall be granted the State agency for a fair review.

STUDIES AND INVESTIGATIONS

SEC. 402. The [Children's Bureau] *Federal Security Agency and the Department of Labor shall make and aid the financing of such studies, demonstrations, investigations, and research as will promote the efficient administration and operation of this Act.*

APPROPRIATION

SEC. 403. [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.] *There is hereby authorized to be appropriated for the fiscal year ending June 30, 1946, the sum of \$3,750,000 for all necessary expenses of the Federal Security Agency in administering the provisions of titles I and II of this Act, and a sum of \$1,250,000 to the Department of Labor for the administration of title III of this Act, and in developing and promoting effective measures for carrying out the purposes of this Act, including studies, demonstrations, investigations, and research, the training of personnel for Federal, State, and local service, 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 Act; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this title.*

TITLE V—GENERAL PROVISIONS

SEC. 501. [The Chief of the Children's Bureau, with the approval of the Secretary of Labor, shall make and publish such rules and regulation as may be necessary to the efficient administration of this Act.] *(a) The Surgeon General with the approval of the Administrator of the Federal Security Agency, and after conference with State health authorities as provided in section 105, shall make and publish such rules and regulations as may be necessary to the efficient administration of titles I and II of this Act;*

(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 title III of this Act.

SEC. 502. [The Chief of the Children's Bureau shall submit each year to the Congress a full report of the administration of this Act.] (a) *The Surgeon General shall submit each year to the Congress a full report of the administration of titles I and II of this Act.*

(b) *The Chief of the Children's Bureau shall submit each year to the Congress a full report of the administration of title III of this Act.*

SEC. 503. When used in this Act, the term "State" means any State of the United States, the District of Columbia, or any Territory or possession of the United States.

SEC. 504. 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.

SEC. 505. *At such time when a Federal department of health or health and welfare is created, such department shall be empowered to administer this Act and all the provisions contained therein.*

Dr. GETTING. The changes, as italicized in this draft, would bring about an expanded public health program with special emphasis on maternal and child health. Titles I and II would be administered by the Surgeon General of the United States Public Health Service, while title III would be administered by the Children's Bureau of the Department of Labor. Under this amendment of Senate 1318, the program would be administered and formulated by the States with approval by the United States Public Health Service. It provides for the setting up of domicile and other eligibility requirements by the State. It leaves to the State the establishment of a fee schedule supplementing that provided by the Federal Government to be paid out of funds appropriated for this purpose by the State legislature. It provides for a gradual expansion of the program over a 10-year period as determined by the facilities of the individual States.

While the association is in accord with the principles involved in Senate 1318 it is the consensus of the association that a more effective procedure for making possible the extension of public-health facilities to all the people in the Nation would be the passage of legislation lifting the ceilings on section 314 of Public Law 410 of the seventy-eighth Congress and on title V of the Social Security Act. It is, therefore, the recommendation of the association of State and Territorial Health Officers that before the passage of such special legislation as S. 1318 designed to benefit only mothers and children, legislation should be passed which would make possible the extension of complete preventive services through the establishment of efficient local health departments in all parts of the country. To the public health administrator, it seems obvious that a medical-care program should follow rather than precede a program aiming at the prevention of disease. A medical-care program should be administered by the health authorities after requisite steps have been taken, first, to prevent sickness; second, to improve health; and, third, to prolong life. These objectives can only be attained by the establishment of local health departments staffed by trained and experienced personnel, which, having attained proficiency in conducting a public health program, can subsequently administer a medical-care program efficiently and effectively.

The Association of State and Territorial Health Officers has carefully reviewed Senate 1606. It is in principle in favor of title I of this bill, which authorizes grants-in-aid to States to extend public-health services, to increase maternal and child health services, and to provide medical care for the needy. It is naturally desirous of sup-

porting a bill which seeks to promote the development of public health and which would make essential preventive, diagnostic, and curative medical services available to everyone. However, the association does not believe that the passage of this bill in its present form would insure this objective.

1. Title I, Grants to States for health services. It is the opinion of the association that the lifting of the ceiling on section 314 (a), (b), (c) of Public Law 410 of the seventy-eighth Congress and the lifting of ceilings on section 502 (b) and section 512 (b) of title V of the Social Security Act would be more effective in accomplishing the expansion of public health services than the passage of this title. At the last meeting of the Association of State and Territorial Health Officers held in Washington April 7-12, 1946, the following resolutions were passed:

(Public Law 410, section 314 (a), (b), (c))

Whereas over 40,000,000 people in the United States are living in areas that are not served adequately by health departments under the direction of either full-time or part-time trained personnel; and

Whereas these individuals are thereby deprived of receiving the benefits of preventive medicine and public health; and

Whereas the health and welfare of these citizens is thereby endangered and is therefore a threat to the entire Nation; and

Whereas, venereal diseases, tuberculosis, and other communicable diseases are a major problem throughout the United States; and

Whereas additional funds as grants-in-aid are needed by the States and Territories of the United States in order to enable the public to attain optimal health so as to be of the greatest possible asset to their communities and to the Nation: Be it

Resolved, That the Association of State and Territorial Health Officers requests the Surgeon General of the United States Public Health Service and the Administrator of the Federal Security Agency, and the Representatives in Congress, to make available for the fiscal year 1947 \$15,000,000 under section 314 (a) of Public Law 410 of the Seventy-eighth Congress for the control and treatment of venereal diseases; a sum of \$20,000,000 under section 314 (b) of Public Law 410 of the Seventy-eighth Congress for the control and treatment of tuberculosis; and \$30,000,000 under section 314 (c) of Public Law 410 of the Seventy-eighth Congress for the extension of general public health facilities, including the control of cancer, industrial hygiene, the control and treatment of crippling diseases, and other public health measures; be it further *Resolved*, That for succeeding fiscal years such sums be appropriated under these sections as may be necessary to carry out the intent of such sections.

Whereas over 40,000 people in the continental United States are living in areas not served by health departments employing trained, full-time or part-time personnel; and

Whereas maternal and child-health activities are an integral part of public health; and

Whereas, selective-service physical examinations revealed an unexpectedly and discouragingly large number of defects in our young men and women, and

Whereas, such defects could have been, in many instances, prevented or arrested in progress during the life of the individual while in school, and

Whereas, better follow-up services for school health programs should be established, and

Whereas, additional funds are necessary to expand not only school health services but health supervision for the infant and well child conferences and pre-school conferences, and

Whereas, the saving of life through maternity programs, both of the mother and the newborn infant, is an asset to the nation; be it *Resolved*, That the Association of State and Territorial Health Officers request the Children's Bureau and their Representatives in Congress to take whatever action is necessary to increase the grants-in-aid made available to States under part 1 of title V of the Social Security Act; that \$10,000,000, under section 502 (b) be made available during the fiscal year 1947; and that such sums be made available during

the years thereafter as may be appropriated as necessary to meet the purpose of part 1 of title V of the Social Security Act.

Whereas, services for crippled children are limited because of the inability of the States to furnish care for these individuals, and

Whereas, in every State there is a register of crippled and handicapped children far in excess of the means of the individual State to meet the need, and

Whereas, crippled children are those not afforded the necessary opportunity for optimal health and the remedial correction of their defects, and

Whereas, many children with physically crippled conditions and other handicapped conditions, such as rheumatic heart disease, epilepsy, hard of hearing, and similar conditions, are not receiving adequate medical care because of the inability of the family to secure such care, and

Whereas, many of these defects could either be corrected or minimized, thus enabling the children to grow up into self-supporting citizens and assets to the community; be it therefore

Resolved, That the association of State and Territorial Health Officers request the Children's Bureau of the Department of Labor and their Representatives in Congress to seek additional funds under part 2 of title V of the Social Security Act, as amended; be it further

Resolved, That these funds be made available under section 512 (b) for the fiscal year 1946, and that such funds be appropriated thereafter as to meet the needs of this act; be it further

Resolved, That the title of part 2 be further amended to read "Services for crippled and other handicapped children." so as to enable the care of such handicapped conditions as are not readily defined under the term "crippled."

If the grants-in-aid are increased, part A and part B of title I, Senate 1606 become unnecessary.

2. Part C, Grants to States for medical care of needy persons. The association believes that the medical care of persons otherwise unable to procure such care is a governmental responsibility. However, we believe that such a program should be administered by the State health departments, as outlined in the suggested amendment of Senate 1318. The addition of the male adult, and the woman who is not pregnant, to Senate 1318, would in effect, create a complete medical-care program. Moreover, it is the opinion of the association that the Federal agency responsible for the administration of a Federal grant-in-aid program for the medical care of needy persons should be the United States Public Health Service until such a time as a Federal Department of public health is created. We believe that the placing of this responsibility in the Social Security Board on the Federal level and in the departments of welfare on the State level would create undesirable duplication, inefficient administration, and considerable confusion in the minds of the public—all of which would tend to make medical care unavailable to those for whom it is intended. It is the opinion of the association that the inclusion of cash payments to individuals is not apt to result in any improvement in the public health. Benefits should be in a service basis rather than on a cash basis.

3. Title II, Prepaid personal health service benefits. This is compulsory health insurance and would, to a large extent, duplicate some of the benefits under S. 1318 and under section C of title I. The reading of this bill, throughout its various titles, leads us to the conclusion that it has failed to present a coordinated program either of public health or of medical care. Certainly the passage of either S. 1318 or of part C of title I, S. 1606, and the simultaneous passage of title II would lead not only to duplication but to an intolerable state of administrative confusion. It is, therefore, the recommendation of the Association of State and Territorial Health Officers that before

undertaking any expansion of a medical care program or any compulsory health insurance program, a detailed study should be made as to the necessity for and the requirements of a comprehensive public health program. This should be established before a medical care program. As has already been explained, there are not enough health departments in the United States at the present time to provide adequate minimal public health services for all the people. Moreover, it seems logical to try to prevent sickness and death before providing for governmental care of the sick:

Detailed criticism of S. 1606 follows.

TITLE I—GRANTS TO STATES FOR HEALTH SERVICES

PART A—GRANTS TO STATES FOR PUBLIC HEALTH SERVICES

Section 314:

Page 2, (b) : This is amended to include care of tuberculous patients. We assume this means maintenance of sanatoria beds which the United States Public Health Service on advice of the Association of State and Territorial Health Officers does not permit at present due to the limitation of grant-in-aid funds. The lifting of the ceiling would enable Federal assistance for the care of tuberculous patients.

Page 4, (c) : The Surgeon General sets up regulations to specify the degree of matching required of the States. These regulations should be made only after consultation with the Association of State and Territorial Health Officers.

Page 5, (f) (1) : This states that the United States Public Health Service is to train personnel for State and local health work. It is suggested that such training should be the function of the State rather than the Federal agency and that funds for this purpose should be allocated to the several States.

The \$5,000,000 cited in line 12 need not be reduced thereby, since the United States Public Health Service will probably wish to train personnel for their use.

Page 6, (2) (B) : We suggest that the wording of line 1 should read "not later than 10 years from the approval of the State program" instead of "not later than the beginning of the fiscal year ending June 30, 1950". In its present wording the bill provides for too rapid expansion.

Page 6, (2) (E) : The words within the parentheses applying to merit systems should be excluded.

Page 6, (2) (F) : Advisory councils do not contain representatives of professional organizations. We suggest that the wording of this section should be patterned after section 204A on pages 41-43.

Page 6, (2) (G) : A rewording is suggested in order to limit the authority of the United States Public Health Service regarding requests. The following wording should replace this section: (1) Make known in the rules and regulations the reports to be submitted by the States, such reports to be based only on such data as are necessary for the operation of the plan with the exception that requests for additional reports not specified in the said rules and regulations be made known to the State health agency at least 3 months prior to the period to be covered by such reports, (2) inform the State health agency at least 3 months prior to the setting up of additional regulations, such

regulations not to be made more frequently than once each quarter, (3) not require the State health agency to furnish the Surgeon General with line-by-line details regarding the State budget, such details being left to the discretion of the State, and (4) obtain approval, whenever practicable in advance by the conference of State health officers of any new request or change in reports, plans, regulations or other requirements.

Page 7, (2) (H): This section should include voluntary agencies such as the Blue Shield and the Blue Cross. We believe that it is desirable to utilize existing facilities even though they are not governmental.

Page 7, (2) (I): The State administering agency should be required to consult with professional advisory committees before issuing regulations, which in turn should be issued only after due notice. Whenever practicable, notification regarding additional rules and regulations should be given 1 month in advance to the individual or organization rendering such care as is furnished under this title by the State health agency.

Page 9, (5) (C): The matching requirements are too high for all States, and especially for low-income States. It is our recommendation that States should be required to meet only nominal matching requirements.

Page 10, (6): The word "semiannually" should be changed to "quarterly and in advance." The words in line 24, page 9, through line 1, page 10, reading "from time to time but but not less frequently than semiannually," should be omitted.

Page 11, (i): This should include a statement to the effect that such regulations shall be promulgated only at stated intervals; for example, either quarterly or semiannually. In addition, provision must be made for the publication of the advice of the State health authorities should this be contrary to the regulations of the Federal agency.

Page 12 and 13 (1): It is our understanding that the regular operation of health departments including hospitalization and medical care of all patients would be possible under this subsection, but that the maintenance of hospital beds, as such, would be limited to those ill with infectious diseases. At present, health departments conduct programs in cancer control, industrial hygiene, and other fields and operate hospitals caring for conditions such as cancer, chronic diseases, and rheumatic fever. Under this section it would be possible for a health department to maintain a tuberculosis sanatorium but not a cancer hospital. It is the opinion of the Association of State and Territorial Health Officers that this section should be broadened to include any hospital which is maintained by a department of public health. This would naturally differ from one State to another. We also assume that under this section it would be possible for a state health department to work out a medical-care program and to pay a hospital on a service-rendered basis for the hospitalization of infectious diseases.

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

It is the conviction of all State health authorities that grants to States for maternal and child health services should be made through the United States Public Health Service and not through the Depart-

ment of Labor. It is recommended, therefore, that whenever the words "Department of Labor" occur in this section, the words "Federal Security Agency" should be substituted. Wherever the words "Children's Bureau" occur, the words "United States Public Health Service" should be substituted; and whenever the words "Secretary of Labor" occur, the words "Federal Security Administrator" should be substituted. Also, the title "Surgeon General" should be substituted for that of "Chief of the Children's Bureau."

If part B is to be administered by the United States Public Health Service as recommended, many portions of part B could be omitted entirely. A section describing the scope of the program could be included as a subsection under section 314 since general provisions; that is, approval of plans, grants of funds, and so forth, would be applicable under part A, title I.

Furthermore, the Association of State and Territorial Health Officers recommends that when a Federal department of health or of health and welfare is established, the divisions of the Children's Bureau which deal with public health, or else the entire bureau (except those portions dealing with child labor) should be transferred to it.

Section 122:

Page 14, (a): All reference to merit systems should be omitted. This section should be amended in a manner similar to section 314 (f) (2) on pages 5-7.

Page 15, (4): The general criticisms made under part A apply also to the various sections of part B. It is the interpretation of the Association of State and Territorial Health Officers that part B, Maternal and Child Health Services, does not provide for the medical care of children and women during prepartum, partum, and postpartum periods. It does, however, provide medical care for crippled children. It is subject to criticism in that care is provided without regard to economic status. The State health authorities are convinced that the determination of eligibility, as it applies both to economic and domiciliary status, should be a function of the State.

Section 123:

Page 16. The same criticisms apply to services for crippled children as to maternal and child health services. These should be administered by the United States Public Health Service until such a time as a Federal Department of Health is established. Section 123 could then be set forth as a subsection to 314, part A, title I.

Section 124, page 17, section 125, page 19; section 126, page 21; section 127, page 22; section 128, page 23; section 129, page 25; and section 130, page 25, could be made integral parts of section 314, part A. They are subject to the same criticisms as similar portions of section 314.

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

Part C provides for a medical care program for needy individuals which is to be administered on the Federal level by the Social Security Board and on the State level by departments of welfare. Four medical care programs—for crippled children, and for those suffering from infectious diseases, tuberculosis, venereal diseases, and certain other illnesses—are provided under parts A and B, to be administered on the Federal level by two agencies, the United States Public

Health Service and the Children's Bureau, and on the State level, by the health departments. Part C would therefore set up a fifth medical care program. This would tend to cause further inefficiency and duplication, and by setting up different regulations, to make the coordination of medical care programs administered both on the Federal and on the State level extremely difficult. It is, therefore, recommended by the State health authorities that, in order to simplify procedures for the patient and to eliminate confusion, inefficiency, and duplication, all medical care programs should be administered on the State level by the State departments of health and on a Federal level by the USPHS, or by the Federal Department of Health when it is created. Moreover, they might all be combined into a single medical care program.

Senator DONNELL. The USPHS, that is under the FSA, is it not?
Dr. GETTING. The Federal Security Agency.

Senator DONNELL. That is not under the Social Security Board?

Dr. GETTING. No, sir. The Social Security Board is part of the Federal Security Agency.

If the medical care program is administered by the State health departments, the determination of eligibility with respect to economic and domiciliary status should be the responsibility of the State. In part C, the words "United States Public Health Service" should be substituted for "Social Security Board" and the words "State Health Department" for "State public assistance agency." Adequate care should be provided for the needy in institutions for chronic diseases, in nursing homes, or in custodial institutions on condition that such institutions meet standards as set by the State health department and approved by the Federal Department of Health.

Section 132. This is subject to the criticisms which apply to corresponding sections of parts A and B.

Page 27, (a) (4). We object to the words "fair hearing." This should read "fair review by representatives of the State health department."

Page 27, (5). All reference to merit systems (lines 11-17 should be omitted).

Page 27, (6): The same criticisms apply as to similar sections under parts A and B; viz, that the requests upon the Federal agency for reports by the State should be limited in accordance with the suggestions made for S. 1318—(1) make known in the rules and regulations the reports to be submitted by the States; such reports to be based only on such data as are necessary for the operation of the plan, with the exception that requests for additional reports not specified in said rules and regulations be made known to the State health agency at least 3 months prior to the period to be covered by such reports, (2) inform the State health agency at least 3 months prior to the setting-up of additional regulations, such regulations not to be made more frequently than once each quarter, (3) not require the State health agency to furnish the Surgeon General with line by line details regarding the State budget, such details being left to the discretion of the State, and (4) obtain approval in conference with the State health officers of any new request or change in reports, plans, regulations or other requirements in advance whenever practical.

Page 28, (8): This should be modified in accordance with our criticism; viz, that States should set up their own eligibility requirements.

Page 28, (b) : If States are to make substantial appropriations for matching Federal funds it would seem desirable that domicile requirements—not residence requirements—should be insisted upon. By the term “domicile,” we mean that a person has the intention of making his home in the State in which he requests treatment. Thereby (2) (B) becomes unnecessary. Again in our opinion matching requirements should be nominal.

Section 136:

Page 34, (b) (1) : It is a recommendation of the State health authorities that if a medical care program is to be promulgated by the Government, it should be a service program and that no cash benefits as provided in (A) and (B) should be given. It is the experience of insurance companies and many others that cash payments to patients are not usually employed to meet the costs of medical and hospital care. Too often, such payments are utilized for permanent waves or for new hats. Hence, (b)-(A) on page 34 should be omitted.

TITLE II—PREPARED PERSONAL HEALTH SERVICE BENEFITS

Title II outlines the sixth separate medical care program to be included in this one bill. Although administered by the United States Public Health, it is a Federal program operated by the National Government. The first portion of the bill eliminates the States as operating agencies. State agencies may become “agents” of the United States Public Health Service, but they have no authority in formulating policies. It is the opinion of the Association of State and Territorial Health Officers that a federally administered medical care program would be a mistake. Such a program would attempt to set up regulations on a national level to the detriment of the public, the professions, and the agencies rendering the services. Medical care programs should be State functions administered by the State health departments.

States may receive Federal grants-in-aid, but they should preserve their constitutional rights and retain responsibility for the health of their people. State health departments should formulate regulations, determine eligibility and benefits, and administer the programs.

The CHAIRMAN. If it was left to the States, the States might have varying laws with reference to who would be entitled to practice medicine. That is true, is it not? In some places they permit osteopaths to practice just the same as medical doctors?

Dr. GETTING. That is correct.

The CHAIRMAN. And so each State would have a different system?

Dr. GETTING. As to the the qualification of medical practice?

The CHAIRMAN. Yes.

Dr. GETTING. That is a constitutional right.

The CHAIRMAN. Also have different sets of regulations governing the manner in which the law would be administered?

Dr. GETTING. That is correct. And it is our recommendation that the States should also set up eligibility and domicile requirements.

The CHAIRMAN. For the profession?

Dr. GETTING. For the recipients of any medical care program, because if the State governments are to appropriate any funds, they want to make sure that they can control the expenditure of funds for the citizens of their respective States.

In relation to the benefits and limitations imposed upon benefits as specified under the law—and I am referring in general, to pages 15 and 16 of my statement—it is the consensus of the State health officers that those benefits should be set up by regulation and not by law, since they have to be changed from time to time.

We also are opposed to the idea of paying cash benefits to patients and believe that a service program would obtain the objective. It has been the experience that too often cash benefits given to patients are expended for permanent waves rather than for hospital or doctor bills.

Section 203:

Page 38, (e) and (f): The word "health" should be inserted before "departments" in line 3. In every place thereafter where the words "State or local department or agency" occur, as used in line 7, the word "health" should be inserted before "department" so that it may read "State or local cooperating health department or agency."

Page 38, (g): This authorizes the formulation of rules and regulations by the Surgeon General after consultation with representatives of the departments or agencies concerned. It should read "after consultation with State health authorities." The same criticism applies to this as to section 314 (i) of title I, part A, on page 11.

Page 39 (i): The United States Public Health Service should make agreements directly with the State departments of health and not with local agencies or political subdivisions of States. Arrangements with political subdivisions of the State or with local health agencies should be made by the State health department. The appointment of State advisory committees should be the function of the State health officer while the appointment of local committees should be the function of the local health officer. This section should be modified in accordance with the local health officer. This section should be modified in accordance with this criticism. The selection of committee membership from panels is satisfactory.

Liason between the United States Public Health Service and State or local health departments should be made only upon request of the State health officer. This is in accordance with present policies for public health practice.

Section 204:

Page 41: Adequate facilities should be given to the National Advisory Medical Policy Council when it is established for the publication of its findings and recommendations.

Section 205:

Page 45: Regarding methods and policies and administration the association of State and territorial health officers subscribe to the basic principles adopted by the council of the Massachusetts Medical Society. They are as follows:

1. The objective of adequate medical care in our free society is to make available to everyone—regardless of race, color, creed, financial status, or place of residence—every known essential preventive diagnostic and curative medical service in high quality. The attainment of such medical care must necessarily be an evolutionary process which will require the cooperation of all concerned over a period of years.

2. The success of any plan for medical care is dependent on the mutual cooperation of the public, of those rendering professional services and of the administrative agencies. This cooperation can be obtained

only if those rendering the services are convinced that they will have a continuing authoritative voice in the formulation and execution of policies and plans, thereby assuming their proper share of responsibility.

3. Provision of adequate medical care for those unable to obtain it by voluntary prepayment plans or by direct payment is the responsibility of the local or State government. Part of the burden of this responsibility may be assumed by charitable agencies. Federal grants-in-aid to State programs administered by State boards of health is an acceptable method of helping to meet this responsibility.

4. The medical care of those who are able to purchase it by voluntary prepayment plans or by direct payment is the responsibility of the individual.

5. Eligibility for receiving benefits under a program aided by Federal grants should be determined by the individual States.

6. The patient shall have free choice of his physician, group of physicians, clinic, or hospital from among those participating in any plan, provided that the physician, group of physicians, clinic, or hospital selected shall have the right to refuse to accept the patient.

7. Physicians and other qualified persons rendering medical care shall receive adequate remuneration for their services.

8. The physician shall be free to elect or reject without prejudice participation in a medical-care plan. The rights of the physician as to the choice of methods by which he is to be paid shall be fully protected.

It is important to bear in mind that a medical care program should be flexible enough to be operated on a State basis in such a way that local conditions may be met more equitably than by any Federal plan imposed upon all 48 States. Therefore, the decision as to the selection of specialists, size of fees, and similar matters should be delegated to the States.

Section 206:

Page 51: Similarly, the hospitals participating in the plan should be determined by the State health officer and not by the Surgeon General. The Surgeon General may set regulations imposing minimum standards for hospital participation. However, providing that the hospitals comply with such regulations and providing that the State may make stricter regulations as desired, the choice of hospitals participating in the program should be left to the State.

Section 207:

Page 53: Appeals made by a patient or on behalf of a patient, by a physician or on behalf of a physician, by a hospital or on behalf of a hospital, should be heard by the State health department or its staff, and not by the Surgeon General or his staff. This should not take the form of a quasi-judicial hearing by the department, but should be a fair review by representatives of the department delegated to perform such functions.

Section 210:

Page 57: Limitations upon available benefits should be made by the State departments of health in accordance with the general policies formulated by the Surgeon General. Provision should also be made that, except as limitations are imposed upon benefits, patients should not be permitted to make supplemental payments to physicians or hospitals.

It is suggested that limitations upon benefits for medical care might be more efficiently administered if such limitations were made by regulation rather than by law. Pages 57 through 60 should be amended so that States may be permitted to make limitations upon benefits by regulations subject to the approval of the Surgeon General.

Page 63: The association is strongly in favor of grants-in-aid for medical education and for research, as well as for the prevention of disease and disability. The advancement of medical science is dependent upon continuous research. The war has amply demonstrated the need for an expansion of research by means of Federal subsidy. Due to the expense of such education medical and public health schools will require fiscal assistance in order to train the additional doctors, nurses, dentists, and other personnel required for the development of any expanded program.

Section 214:

Page 67, (h): Hospital benefits are limited by the amounts which may be paid for services rendered. It seems illogical to regulate by law the limitations under different paragraphs when no limitation is imposed on the size of the payments received under other benefits. It is therefore recommended that if any limitation is placed on the size of the fees paid by hospital benefits, it should be made by regulation rather than by law and should be amendable to adjustment from time to time. It is further recommended that beginning with line 22 on page 68, the portion permitting hospitals to receive supplemental payments should be removed. Hospitals should be specifically prohibited from exacting payments from patients when expensive facilities are furnished which are not included in the ordinary payments to hospitals for hospital benefits. Such extras should be paid by the State health agency after review by a professional advisory committee. However, patients should be permitted to use prepayment hospital benefits for semiprivate or private facilities to supplement ward service. Cash supplemental payments to hospitals or physicians should be specifically excluded.

In reviewing this bill, the only reference to cash benefits is found in title I, part C, page 34, line 9. If cash payments in lieu of medical services are proposed in connection with any other part of this bill, the Association of State and Territorial Health Officers would be opposed to them. However, the association is in favor of sickness benefits in compensating a wage earner in part for wages lost during an illness.

CONCLUSION

The Association of State and Territorial Health Officers wishes to express its appreciation to the Senate Committee on Education and Labor for this opportunity to present its views on such all-important health legislation. We have made certain constructive criticisms which we believe would vastly improve the resources of the American public for the attainment of optimal health. While the association is in favor of the objectives of both S.1318 and S.1606, and while we would like to see these objectives achieved as soon as possible, we cannot approve either of these bills in their present form.

Our primary need is the establishment of sufficient local health departments to permit the extension of preventive services to all of the American people. We, therefore, favor those portions of these

bills which provide for the expansion of public health facilities and services to convey to all the fruits and benefits of preventive medicine. National health is a positive asset. It can be acquired only through the development of adequate public health facilities, which would not only safeguard the public against the dangers of poor sanitation, infectious disease, preventable disability and deficiency disease, but make it possible for them to develop mentally and physically to the maximum limits of their ability. The attainment of this goal of optimal health for all of the people is within our reach. Gentlemen, by lifting the ceilings and increasing the appropriations of section 314 of Public Law 410 and of title V of the Social Security Act we could accomplish this purpose.

Some phases of medical care, including the treatment of tuberculosis, venereal disease, communicable disease, crippled children, cancer, rheumatic fever, and other conditions, are now being administered by State health departments. Such care is made available, however, to individuals who are not able to provide these services for themselves. All of these programs should be extended by means of larger grants-in-aid to the State health departments.

Similarly, medical care should be provided for the needy. In the interest of efficient administration and the welfare of the patient, this program should also be administered by the Federal Department of Health and by the State health departments.

After we have become proficient in administering these proposed expansions of existing medical care and public health programs—and then only—will we be ready to consider further extension of medical care. This gradual expansion, gentlemen, would bring about a progressive and natural evolutionary development advantageous to the American public. The association believes that the sudden overwhelming expansion as envisioned in S.1606 of a multiple medical care program administered by numerous agencies on both Federal and State levels would not only prove too costly but be confusing to the public. We therefore recommend that the Nation-wide development of adequate public health facilities and the promotion of medical care for the needy should constitute sufficient expansion at the present time.

The CHAIRMAN. I notice you have appended Senate bill 1318 and the proposed amendments that you are suggesting.

Dr. GETTING. Yes, sir. The words omitted have dotted lines drawn through them and the new language has been italicized. Many of the details which we have suggested have to do with the administrative aspects of these medical-care programs and are very important, from our point of view, and we should like to make it possible for a State to administer its own program with, perhaps, the setting up of only major policies and, shall we say, minimum standards on the Federal level. We do not believe that it is necessary to make such voluminous reports to the Federal agencies, for example, that the State of Virginia would have to send an annual budget weighing 22 pounds.

The CHAIRMAN. Doctor, I appreciate the study that you have given to this matter and your statement will be studied very carefully by the committee.

Senator DONNELL. May I ask a few questions?

The CHAIRMAN. Yes, sir.

Senator DONNELL. I want to join in the statement that our chairman has made, too, that this is a very exhaustive and carefully prepared statement, and I have no doubt that our committee will study it with interest and no doubt will profit.

I want to ask you a very few questions.

The Association of State and Territorial Health Officers, as you indicated in your statement, represents the 48 States, the Territories, and the District of Columbia?

Dr. GETTING. That is correct, sir.

Senator DONNELL. And you gentlemen have no interest in this matter except one of public welfare?

Dr. GETTING. That is our only interest.

Senator DONNELL. Doctor, as I understand it, from the conclusion of your statement, you believe that the sudden, overwhelming expansion as envisioned in S. 1606 of a multiple medical-care program, administered by numerous agencies on both Federal and State levels, would not only prove too costly, but be confusing to the public?

Dr. GETTING. Yes.

Senator DONNELL. I am wondering whether or not your association has any figures at hand as to the probable cost per year of the administration of title II, prepaid personal health service benefits of S. 1606?

Dr. GETTING. The only figures we can give you about the administration of a medical-care program has been with the emergency infant-care program. There the Congress has allowed $2\frac{1}{2}$ to $2\frac{3}{4}$ percent for administration from Federal funds. We have had to put additional funds into this and it is costing between 5 and 10 percent for the administration of the program by the State health departments, depending upon the size of that program in that particular State.

Senator DONNELL. Perhaps, Doctor, I used the term "administration" in too broad a sense, rather than the strictly technical correct sense.

What I had in mind was whether or not your association has had any figures or estimates as to the total amount of money that would be required to pay the expenses of the primary personal health service benefits that are prescribed in title II of S. 1606; that means, doctor bills, all of the employees, the medical services, everything that would be required per annum for the operation of that title.

Dr. GETTING. The experience, I believe, on the west coast, has demonstrated that the average cost per capita of a complete medical-care program is approximately \$34. That was several years ago. Surveys conducted by dental societies have indicated that the average need for dental care is \$30 per capita for an adult.

If I think that under an insurance program which brings about an additional stimulation and inducement to people to obtain additional medical care, this cost would be substantially increased. So I think that the lowest figure you could assume would be \$70 per capita, and a more accurate figure might be, perhaps, \$100.

Senator DONNELL. From \$70 to \$100 per capita?

Dr. GETTING. That is my opinion.

Senator DONNELL. Your opinion. I understand. As I recall the testimony, this bill, as it is now drawn, would probably apply, I think, Mr. Chairman, to from 105,000,000 to 112,000,000 of our population. Am I correct in my recollection?

The CHAIRMAN. I believe those are the figures.

Senator DONNELL. If it were 105,000,000 people, Doctor, and the per capita cost of it were \$70, the lower of the two figures which you mentioned, that would be, as I figure it, \$7,350,000,000 a year.

Dr. GETTING. Approximately.

Senator DONNELL. And if it were \$100 per capita, it would be \$10,000,000,000 per year. That is correct, is it not?

Dr. GETTING. I believe this is correct. I get confused with so many zeros.

Senator DONNELL. I do, too. Let us see. Start out here with 105,000,000 people and we add two ciphers on here for \$100 a person, would we not?

Dr. GETTING. That is right.

Senator DONNELL. Then punctuating off like this, we would get \$10,000,000,000. I think I lopped off five hundred millions inadvertently.

Dr. GETTING. That is right.

Senator DONNELL. So, your estimate, as I understand it, which I take it is merely an estimate, for the cost of title II, prepaid personal health service benefits, if applicable to 105,000,000 people would be from \$7,350,000,000 per year to \$10,500,000,000 per year?

Dr. GETTING. That is my estimate.

Senator DONNELL. If it were applicable to 112,000,000 people instead of 105,000,000 people, it would be $11\frac{1}{2}/105$ of those respective figures?

Dr. GETTING. Yes. If you have the medical care of the needy included, your total expenditure covering approximately 90 percent of the population would be correspondingly increased, so that you might have, let us say, 130,000,000 times \$100, which would give you \$13,000,000,000, I believe.

Senator DONNELL. So that, Doctor, I call to your attention the figures that have previously been mentioned here in our testimony of the total operations of the Wagner-Murray bill, S. 1050, which is more comprehensive; that is, which has various features not included in S. 1606, the total expense of that bill, including, as I understand, S. 1606, are estimated variously as follows:

(1) Based on Senator Wagner's figures and remarks, \$11,625,000,000; (2) based on the Tax Foundation Study, \$11,787,000,000 (3) based on Professor Muntz' estimate, \$13,405,000,000; and (4) based on Gerhard Hirschfeld's study, \$14,625,000,000.

I gather from your testimony that certainly you would not think these figures are unduly large that I have quoted to you for the entire operations of S. 1050, including the operation also of S. 1606. Am I correct in that statement?

Dr. GETTING. Yes. I would modify it in this way, that those figures as based there, probably did not include complete dental care, but did include other aspects, whereas my figures include dental care and do not include complete coverage, such as indicated in S. 1050.

Senator DONNELL. Doctor, you also, I observe, in your testimony emphasize at several points the importance of recognizing the responsibility of the local or State governments?

Dr. GETTING. Yes.

Senator DONNELL. For instance, I observe at page 2, when you are quoting from the basic principles adopted by the council of the Massachusetts Medical Society on January 9, 1946, you quote this:

Provision of adequate medical care for those unable to obtain it by voluntary prepayment plans or by direct payment is the responsibility of the local or State government.

Does that represent your own personal judgment, likewise?

Dr. GETTING. Senator, in this statement I have alluded to the Constitution where it states that the health and welfare of the people has been delegated to the State as its responsibility, in that it is not specifically delegated to the Federal Government.

Senator DONNELL. In other words, you are proceeding on the theory, which, in the minds of some of the people nowadays, seems to have been outmoded and in the minds of some of the rest of us has not, that the Federal Government has not been delegated any authority except that which has been conferred upon it?

Dr. GETTING. That is correct, sir.

Senator DONNELL. And that as the tenth amendment to the Constitution of the United States, the powers not delegated to the Federal Government—

Dr. GETTING. Are specifically reserved—

Senator DONNELL. To the States or the people specifically?

Dr. GETTING. That is right.

Senator DONNELL. You adhere to that?

Dr. GETTING. Not only do I adhere to it, but from my experience as a city and health officer, and also working on other local levels, it has been my experience that those best able to judge the needs of the people are those who are closest to the people, and, therefore, any program which is intended to be national in scope, unless it is decentralized to a State or even lower level, is apt to have many features about it which would not meet the needs of the people.

Senator DONNELL. So you would not regard your views with respect to the retention of power of authority in local governments to be based solely upon some technical construction of the Constitution, but to be based, first, upon the Constitution itself, the substance of it, and in the second place, upon a strong, practical, sound, common-sense reason as you have observed in your actual practice?

Dr. GETTING. That is right.

Senator DONNELL. Is that right?

Dr. GETTING. Yes, sir.

Senator DONNELL. I observe, for instance, and I shall not tarry over each reference, but on page 17, I note you say that:

Our primary need is the establishment of sufficient local health departments to permit the extension of preventive services to all of the American people.

That is based on the same consideration, I take it?

Dr. GETTING. Yes, indeed.

Senator DONNELL. Now, Doctor, I want to ask also whether or not in view of the fact that there are quite a number of suggestions that you have made here with respect to S. 1606, you think it would be at all helpful to have another bill drawn rather than to try to adopt all of these various suggestions into the draft that we now have?

Dr. GETTING. Senator, frankly, I believe that a simple amendment of section 314 of the Public Law 410, in order to lift the ceilings and

broaden the definition of general public health, would sufficiently expand our public health facilities and enable the States to provide a medical care program for the needy, and that within the scope and facilities of the States, that is all that we can do for the next few years.

I think it would be a sad mistake, no matter how laudable the motive behind it, for the Federal Government to start on a medical care program. And I say no matter how laudable its desire may be, not do so until it is sure that it can administer it efficiently and effectively. We cannot do it now. We cannot do it for the next 5 years, maybe 10 years. That, time can only tell. We do not have the personnel. We do not have the facilities. We do not have the hospitals nor the doctors nor the nurses; until we have them, it would be very foolish to do so.

Senator DONNELL. You recommend, then, as I understand it, additional funds for the Public Health Service and amendments of Public Law 410?

Dr. GETTING. That is right. And title V, that is, subtitle of the Social Security Act.

Senator DONNELL. Public Law 410, that is what is called the public health law?

Dr. GETTING. That is correct.

Senator DONNELL. And that is what you refer to, at the bottom of page 17, or your testimony, where you say: "Gentlemen, by lifting the ceilings and increasing the appropriations of section 314 of Public Law 410 and of title V of the Social Security Act we could accomplish this purpose"?

Dr. GETTING. That is correct, sir. I would also wish to remind you, Senator, that it is absolutely necessary that if public health programs expand as I think, properly, they should expand, that there be unification on the Federal level of the agencies that deal with the States, similarly unification on the State level as needed. And at the last annual meeting in 1945, of the association, a resolution was passed to that effect, sent to this committee, to the President of the United States, to various other congressional and governmental agencies.

The resolution, in effect, stated that it is the considered opinion of the State health departments that a Federal department of health, and not necessarily health, welfare, and education, but of health, should be formed with a Cabinet officer at its head, and a permanent career man, a physician, trained in administration, should be at the head, with appropriate career assistants. Only in that way can we be sure that then the administrators of tax funds can fairly and properly account for the expenditures to the people.

Senator DONNELL. Doctor, I do not know whether in the details which you have so fully specified in your testimony, you have covered this particular point or not.

I am going to ask it of you, however, and if it is already covered, I know that you will tell me.

I call to your attention in S. 1606, on page 51, subdivision (1) of section 205. I would like to know whether or not you can tell me the meaning of the term "collective responsibility," as used in that subdivision.

It reads: In each local area the provision of general medical or general dental benefit for all individuals entitled to receive such benefit 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.

Dr. GETTING. Senator, we have not taken up that point specifically in the statement which we have submitted, for the simple reason that in reading this bill, we were convinced that this bill was probably, and again this is only our opinion, drawn up with the assistance of the various agencies that are responsible for the administration of various parts of this bill, and, therefore, this bill perpetuates those individual administrations, and while it pays verbiage to a unification of this administration, no sincere effort is made in this bill to actually bring about such unification.

This section (1) on page 51, I think, refers perhaps to medical ethics more than anything else, and it means that the physicians have a moral obligation and the dentist, too, to take care of the sick people in their area, and that is the only interpretation I can put on this.

Senator DONNELL. I am very much obliged to you, Doctor.

It is very difficult to be certain what is the legal connotation of the language, "collective responsibility" there, whether there is a legal duty that is undertaken to be imposed, or whether it is merely a moral obligation. I might interpolate this, that I had always understood that the function of law was to set forth legal obligations rather than moral obligations. So I would start with the presumption that the intention of the draftsman of this act was to create some type of legal obligation. Then it may be, as you well suggest, that what is referred to here is merely a moral obligation, but if it is, I respectfully submit for the consideration of our committee, and to have it in the record, that I think we should consider that subject section as to whether or not, if it is merely moral obligation, anything should be specified by law creating moral obligations or whether we should confine ourselves to the function of legislation.

I notice, also, Doctor, in your testimony you mention now and then, in the early portion of it, advocacy of placing certain functions under the Public Health Service, as I recall it.

The Public Health Service has medical, dental, and nursing staffs, does it not?

Dr. GETTING. That is correct.

Senator DONNELL. This bill, S. 1606, has numerous functions. For instance, under part C, at page 26, "Grants to States for medical care of needy persons," confers various responsible duties on the Social Security Board, does it not?

Dr. GETTING. It does.

Senator DONNELL. Social Security Board, as I understand it, has no health or medical staff, am I correct in that understanding?

Dr. GETTING. They have no staff comparable to the United States Public Health Service. I think they have loaned advisers from other governmental agencies.

And, in my opinion, the placing of a medical care program in the Social Security Agency is in error.

Senator DONNELL. You think it should, if it is to be at all, under the Federal Security Agency, it should be under the Public Health Service rather than under the Social Security Board, am I right in that?

Dr. GETTING. If this bill passes as it is now, we have six medical care programs.

Senator DONNELL. That is, if S. 1606 passes?

Dr. GETTING. Yes, sir.

Senator DONNELL. What are those six programs? Will you please state them for our record?

Dr. GETTING. You have medical care for tuberculosis, medical care for venereal diseased patients; you have medical care for infectious, communicable diseases, all under part I, all administered by the United States Public Health Service. Also, in title I, you have medical care for crippled children, administered by the Department of Labor.

Senator DONNELL. Does the Department of Labor have a medical staff?

Dr. GETTING. They do, but they should not. It should all be in one department. That is, in the Children's Bureau. The Social Security Board is responsible for medical care of the needy. And, finally, you have the medical-care program of the compulsory insurance program, which is administered by the United States Public Health Service, but there the United States Public Health Service just ignores the State government, as such. They can make contracts, and, therefore, actually what would happen is that State employees would be acting as unpaid agents or employees of the Federal Government and would be liable in Federal courts, not in State courts, as has been proved in several court cases. I think it was Texas and Indiana. I am not quite sure of those two States. That was relative to the administration of that portion of the bill.

Moreover, the Federal Government is authorized to bypass the State government entirely and to make contracts with subdivisions; that is, cities and towns and counties, which, in my opinion, is extremely poor administration. The Federal Government should have contact with State governments, and only through State governments should the local governments be dealt with in a program of this kind.

Senator DONNELL. One other question.

Referring to section 207 (b) of S. 1606, you will observe at the bottom of page 53 and the top of page 54, this language:

In the administration of subsection (a), the Surgeon General shall, et cetera, et cetera, and just for a moment, return to section 207 (a), which is the section that provides that—

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 the title, and from participating hospitals, and, et cetera, et cetera.

Now, the particular thing I wanted to ask you about is under subsection (b) of 207. It says:

"In the administration of subsection (a)—
from which I have just quoted to you—

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.

Here is particularly what I am leading up to. It then proceeds; that is, section 207 (b) as follows:

The provisions of subsections (e) and (f) of section 205 of such Act—

which I take it is the Social Security 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—

with the provision here about the certification of payments and assignments of moneys.

Subdivision (f) of section 205 of the Social Security Act, which I have before me, reads as follows, on page 14:

No person so subpoenaed or ordered shall be excused from attending and testifying or from producing books, records, correspondence, documents, or other evidence on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture; but no person shall be prosecuted or subjected to any penalty or forfeiture for, or on account of, any transaction, matter, or thing concerning which he is compelled, after having claimed his privilege against self-incrimination, to testify or produce evidence, except that such person so testifying shall not be exempt from prosecution and punishment for perjury committed in so testifying.

Doctor, I understand from this section (f) that I have read to you; that is, 205 (f) of the Social Security Act, that a person coming in a proceeding there cannot be excused from testifying on the ground that the testimony or evidence required of him may tend to incriminate him.

I understand also that subdivision (b) of section 207 of S. 1606, that the provisions of this subdivision (f) that I have read from the Social Security Act, are applicable to S. 1606.

The point I am getting at is this, and I would like to have your judgment on this, do you understand that in view of those facts it would be possible for a practitioner to be brought in before this appeal body, set up by the Surgeon General, not a court, but some appeal body, and could be required to testify we will say, on a matter involving some criminal offense, like abortion, if I may mention that, and that the practitioner would be compelled to testify under the terms of these two sections read together, the only right that he would have would be that in testifying he would be able to claim his privilege against self-incrimination; in other words, his testimony could not be used against him in a criminal proceeding, but could be required to divulge all of those facts involving crime, and my question is, do you so understand the application of those two sections, one to the other?

Dr. GERRING. Well, Senator, first of all, I would like to explain that I am a physician and not a lawyer, and I have found, in all instances where there is cross-reference between one act or another, that even on going to the attorney general's office for an opinion—that is, the State attorney general—I have not always been able to obtain a formal opinion which he could assure me would stand in court.

And in the past, when we have been subpoenaed and required to bring certain testimony into court, we have been instructed that while we can be subpoenaed and we may have to bring those records into court, we are not obliged to divulge them to a lawyer of either party, except upon the express order of the judge, in which case we have to.

I think that in all fairness I would have to say that, in my opinion, this matter of privileged information, as to how it shall be handled, is not clear in my mind and it would have to be clarified before this became a law if we were to effectively administer it.

Senator DONNELL. I have not given it very great amount of thought myself, but the point, I think, is one that is of high importance, and certainly should be considered.

As I understand it, just very briefly to recapitulate, the Surgeon General can set up these appeal bodies. I do not recall any particular qualifications that are required by way of legal knowledge on the part of the appeal bodies. And the provisions of 205 (f) of the Social Security Act seem to be incorporated by reference in S. 1606, which, I think, would justify, at least tentatively, the inference that a physician coming before this appeal body could be required to testify to anything that they might ask about, subject only to the protection that what he said could not be used against him in a criminal proceeding.

I submit that not as any dogmatic or final statement, but as a point that I think should be considered very carefully. And I judge from your response you think that study should be given to it, too, before the measure should be enacted into law.

Am I correct?

Dr. GETTING. Yes, sir. I would even go further than that. In my opinion, and that of the association, the delegation of authority to the Surgeon General of hearing appeals, or to his representatives, on matters of this type is in error.

Senator DONNELL. I may say, Doctor, if I may interrupt, in fairness to the draftsman of the act, it is provided that such powers and duties; that is to say, of the Surgeon General, are subject to the limitations and rights of judicial review, contained in section 205 of the Social Security Act, but he does have the right, as I have indicated, to establish what the act terms necessary and sufficient appeal bodies, just as I have indicated.

Dr. GETTING. The reason I say they are in error is this: That the Surgeon General should not be responsible for the operation of this program except on a national level. On a local level it should be under the jurisdiction of either a local department of health or State department of health. Then the State department of health, over the local department of health, should be the appeal body. And they should not be in the form of quasi-judicial hearings, but in the form of fair review, with appeal to the courts. A hearing, in the language of some of the State laws, means a quasi-judicial procedure with cross-examination and with all of the prerogatives of a formal quasi-judicial hearing. They are extremely time consuming. They would be an administrative block in that it would increase the cost of administration. And all you really want is to make sure that either the physician or the hospital or the patient has a fair review of his case. Then if counsel, on the part of the plaintiff, feels that he has not had a fair review, he can appeal to the court. If the State administers it, it will be the State court; if it is federally administered, it would be the Federal court.

Senator DONNELL. I think I should add, in fairness, that while there are no qualifications that I now observe which are required of these appeal bodies or their members, there are two provisos in section 207 which I had not observed and which I think should be incorporated in the record, namely,

Provided, That with respect to any complaint or dispute involving matters or questions 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.

There are those two provisos, and to that extent my statement about the absence of any provision for qualifications is in error and should be modified.

I think that is all I want to ask, and I thank you very much, sir.

The CHAIRMAN. I thank you, Doctor.

Your recommendations and views as expressed here will, of course, be given very careful study.

Dr. GETTING. May I state that either I or any officers or members of the association would be glad to be of any assistance to the committee at any time in any matters dealing with this type of legislation.

Senator DONNELL. Your letterhead just gives Boston, Mass., as your address.

Is there any further address?

Dr. GETTING. Care of the State Hospital.

The CHAIRMAN. Thank you, Doctor. These views that you have expressed here are the views of your organization?

Dr. GETTING. That is correct.

The CHAIRMAN. And do you approve of every recommendation that you have made here personally?

Dr. GETTING. Personally, I do, because the way this statement was made, letters were sent out to all of the States, and their criticism was then compiled by me personally, and the matter of the statement was then summarized and the complete meeting of the association passed upon it.

The CHAIRMAN. Thank you again, Doctor.

This will conclude the meeting today. We will meet tomorrow morning at 10 o'clock.

(Thereupon, at 3:35 p. m., Thursday, April 18, 1946, the committee recessed to reconvene Friday, April 19, 1946, at 10 a. m.)

NATIONAL HEALTH PROGRAM

FRIDAY, APRIL 19, 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, Aiken, and Donnell.

The CHAIRMAN. The committee will come to order, please. Yesterday we had on the witness stand Dr. Low, representing the Association of American Physicians and Surgeons. I wish, in connection with his testimony, to insert in the record some literature from that organization, in which the organization states its position. In this literature we find the following statement:

The Association of American Physicians and Surgeons is an organization of physicians who contract and agree not to participate in systems of State medicine; therefore, when a majority of the physicians of the Nation become members of the AAPS, systems of State medicine cannot be operated.

The best available legal advice concurs with the validity and legality of the actions proposed by this line of reasoning. Opinions of the legal counsel of the association have been made available to attorneys of medical organizations throughout the Nation, and there have been no disagreements with the first objective of the AAPS to so organize ethical physicians that they may determine and enforce the conditions under which they will or will not give their services.

(The document referred to is as follows:)

NOW, DOCTOR, IT'S YOUR MOVE! BUT YOU MUST ACT QUICKLY!

Thursday, May 24, 1945, was "S. R. Day" (start of regimentation) for American system of the private practice of medicine. On that day Senator Wagner, (New York) and Representative Dingell (Michigan) introduced their new, modified social-security bill, which includes compulsory health insurance; and which, regardless of "fancy" wording, if passed by Congress, will destroy the freedom of American medicine.

There is one way that you can guarantee your right to the private practice of medicine and stop bureaucratic encroachments on your profession: Join the Association of American Physicians and Surgeons and thereby contract and agree with your colleagues throughout the Nation that you will not participate in schemes of political medicine.

Systems of regimented medicine cannot operate without the participation of a substantial majority of physicians. When a majority have joined A. A. P. S., as it now appears they will, there can be no bureaucratic control of American medicine.

It's your move, doctor! The forces of political medicine have made another move—an entering wedge into the future of the medical profession. Not until a majority of physicians have enrolled under the banner of AAPS will they be safe from further, deeper inroads into their professional security.

It isn't too late, if you act now!

An application blank will be found on the back of this folder. Sign it today! Mail it today! Add your strength to the thousands and thousands of physicians throughout the Nation who have determined to remain free.

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS.
 ANDREW J. SULLIVAN, M. D., *President*.
 H. W. DETRICK, M. D., *Secretary*.

Turn to pages 2 and 3 for an analysis and interpretation of some of the regimentering features of the new Wagner-Murray-Dingell bill. Also you will find the answers to any questions you may have regarding the Association of American Physicians and Surgeons.

This folder is being sent to all eligible physicians including members of AAPS, for their information.

AAPS IS NOT A UNION

The AAPS is not a "union," as the term is ordinarily understood today. A labor union employs the strike to gain its objectives, whereas members of the AAPS are "employed" by their patients, against whom they will never "strike." The AAPS is not an organization to deal with the present employers of its members. On the contrary, it is strongly organized to protect its members from the uninvited intrusion of a usurping, would-be employer—a State or Federal bureau. Physicians need no union under the present American system of medical practice; the AAPS is established to protect and preserve that system as against a system of political medicine under which practitioners would need a union, as State and Federal employees.

Act today in the interests of your priceless American heritage of freedom for yourself and your patients.

Sign this application—mail it today.

AAPS permanent headquarters are now located at 11 South La Salle Street, Chicago 3, Ill.

APPLICATION FOR MEMBERSHIP

ASSOCIATION OF AMERICAN PHYSICIANS AND
 SURGEONS, INC.

11 South La Salle Street, Chicago 3, Ill.

Name ----- M. D.
 First Middle Last
 Office address -----
 Street City State
 Residence address -----
 Street City State
 Member of ----- Medical society -----
 County society or its equivalent State

I agree to abide by the articles of incorporation, by-laws, and lawful orders and rulings of the Association of American Physicians and Surgeons, Inc. I further agree that my membership shall ipso facto terminate if and when I violate any lawful rule, regulation, or by-law of this Association.

Date of application ----- 19 ----- Signed -----
 Witness -----

Except for members of the armed forces, interns and students, dues (\$10.00 annually) must accompany application.

HERE ARE FACTS OF THE NEW WAGNER-MURRAY-DINGELL BILL

(TITLE 2—NATIONAL SOCIAL INSURANCE SYSTEM)

Introduced into Congress May 24, 1945

It proposes this

The bill provides for the Surgeon General, under the supervision of the Federal Security Administrator, to administer the act, after "consultation" with the Advisory Council.

The 16 members of the Council are appointed by the Surgeon General with the approval of the Federal Security Administrator.

Membership of the Council "shall include medical and other professional representatives and public representatives in such proportions as are likely to

provide fair representation to the principal interested groups that furnish and receive personal health service."

The Surgeon General, with the approval of the Federal Security Administrator, is authorized to negotiate and periodically renegotiate agreements or cooperative working arrangements 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" * * *

"Every individual entitled to receive general medical benefit shall be permitted to select those from whom he shall receive such benefit, subject to the consent of the practitioner * * * the Surgeon General may prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or a group of practitioners may undertake to furnish general medical benefit" * * *.

"Services which shall be deemed to be specialist or consultant services shall be those so designated by the Surgeon General * * * after consultation with the Advisory Council" * * *.

"The Surgeon General shall publish and otherwise make known in each local area to individuals entitled to benefit * * * the names of medical practitioners * * * who have agreed to furnish services" * * *.

"Payments from the trust fund to general medical and family practitioners * * * for services * * * shall be made:

"1. On a basis of fees for services rendered * * * 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" * * *.

This will happen

It is evident that the Surgeon General and the Federal Security Administrator are to be the dictators of this compulsory health insurance scheme, since they are only obliged to "consult" with Council members of their own choosing.

There is no assurance that physicians will not be outnumbered by lay individuals. In fact, if the bill means what it says, physicians will be outnumbered on a ratio of approximately 1,000 to 1.

If physicians committed themselves to participation, their "fees or wages and working arrangements" would be at the mercy of the "periodical renegotiation."

In the first instance, it is free choice of patient and of physician, if all physicians participate. In the second, the free choice privilege is eliminated.

The Surgeon General is not bound to follow any advice received from his appointed group. This is tremendous responsibility and certainly dangerous authority to vest in one man and his chosen group of advisers.

This is positive proof that the bill recognizes the legality and the validity of the AAPS principle, "that physicians have a right to refuse participation."

In the final analysis, physicians' "fees or wages" are determined by one person. The purse strings are controlled by the Federal Government and whoever "pays the bill" will eventually control medicine.

SUMMARY

"Title 2—National Social Insurance System" of the Wagner-Murray-Dingell bill is a scheme for compulsory health insurance controlled by the Government. It would destroy the American system of the private practice of medicine. It would limit, if not eliminate, the important, democratic right of free choice of physician or of patient.

Application of the bill would result in the physician's employer, his patient, being replaced by a Federal or State bureau.

Bureaucratic invasions of the medical profession must be halted until voluntary health insurance plans, under the control of physicians, can be universally applied, wherever such plans are in the public interest.

The most effective way of accomplishing this objective is for physicians to join the Association of American Physicians and Surgeons and thereby contract not to participate in schemes of state and socialized medicine, which are inimical to the public interest.

THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS CAN GUARANTEE THE PRESERVATION OF THE PRIVATE PRACTICE OF MEDICINE IN AMERICA

IT'S REASONING IS AS FOLLOWS

State medicine is a system that operates to distribute medical care;
 Medical care cannot be distributed without the participation of physicians;
 Therefore a system of state medicine cannot operate without the participation of physicians.

The courts have always upheld the right of an organization of individuals to do, at least in the absence of malice, whatever an individual may lawfully do. Even the Wagner-Murray-Dingell bill respects the right of the individual physician to refuse participation in its scheme for state medicine. It makes provision only for our voluntary participation. Hence:

An individual physician may lawfully refuse to participate in a system of state medicine;

An organized group may lawfully do anything an individual may lawfully do;
 Therefore physicians as an organized group may lawfully refuse to participate in systems of state medicine.

And test this:

Systems of state medicine require more medical service and therefore more physicians than systems of private practice;

There are not more than enough physicians to supply the services required under the present system of private practice;

Therefore a system of state medicine would require the participation of at least a substantial majority of physicians.

Final conclusion, based upon the above:

Physicians may lawfully organize to refuse participation in systems of state medicine, which cannot operate without the participation of at least a majority of physicians;

The AAPS is an organization of physicians who contract and agree not to participate in systems of state medicine;

Therefore when a majority of the physicians of the nation become members of the AAPS, systems of state medicine cannot be operated.

The best available legal advice concurs with the validity and legality of the actions proposed by this line of reasoning. Opinions of the legal counsel of the Association have been made available to attorneys of medical organizations throughout the nation, and there have been no disagreements with the first objective of the AAPS: To so organize ethical physicians that they may determine and enforce the conditions under which they will or will not give their services.

AAPS IS A POSITIVE ORGANIZATION

It is for American liberty and American freedom in medicine.

It is for the universal application of the insurance principle to the costs of medical care under voluntary plans organized and controlled by the medical profession, wherever such plans are in the public interest.

It is for the American Medical Association and its contributions to the public health and the science of medicine.

It is for complete democracy in medical organization, and provides that every member shall have a voice and a vote in its affairs.

It is for the kind of positive action that will earn good relations with the public for organized medicine.

It is for the preservation of American liberty for American physicians and American patients.

THE PITTSBURGH MEDICAL BULLETIN HAS THIS TO SAY ABOUT AAPS

* * * "The Association of American Physicians and Surgeons will do much to determine the condition under which physicians will give their services, by their refusal as an organization to participate in any Federal or State-controlled practice of medicine. With such refusal, which is within legal procedures, no politically controlled medicine can function in this country. This organization has shown more determination and courage than any other such organization in medicine. It does not oppose or interfere with the American Medical Association nor the National Physicians Committee. It is an aggressive organization which

does not hesitate to show its teeth to the politicians who would control medicine as well as every profession and industry in this country if possible. It is the two-fisted organization which means to eliminate the negative and accentuate the positive as far as medicine is concerned.

"If you believe in the American method of private practice of medicine and want to preserve it, why not join the Association of American Physicians and Surgeons!"

Reprinted from The Pittsburgh Medical Bulletin—March 10, 1945.

SPEAKERS ARE AVAILABLE

You are urged to discuss the AAPS at hospital staff and society meetings. Upon invitation, speakers are available to address society and other group meetings of physicians.

Since the first of the year these additional medical organizations have endorsed AAPS:

- | | |
|---|--|
| Allen County Medical Society, Fort Wayne, Ind. | San Diego, County Medical Society, San Diego, Calif. |
| Alameda County Medical Association, Oakland, Berkeley and Alameda, Calif. | Orange County Medical Society, Santa Ana, Calif. |
| Lorain County Medical Society, Lorain, Elyria and Oberlain, Ohio. | Illinois State Homeopathic Association, Elk-Cameron County Medical Society, Ridgway and St. Marys, Pa. |
| Christian County Medical Society, Taylorville, Ill. | Wapecello County Medical Society, Ottumwa, Iowa. |
| Allegheny-Barrett County Medical Society, Cumberland, Md. | Executive Committee of the Council of the Michigan State Medical Society, LaPorte County Medical Society, LaPorte and Michigan, City, Ind. |
| Wayne County Medical Society, Detroit, Mich. | Adams County Medical Society, Decatur and Berne, Ind. |
| Riverside County Medical Society, Riverside, Calif. | Fayette County Medical Society, Connellsville and Uniontown, Pa. |
| San Bernardino County Medical Society, San Bernardino, Calif. | Oak Park and River Forest Physicians Club, Oak Park and River Forest, Ill. |
| Portage County Medical Society, Kent, Ohio. | Lower Snake River Physicians Club, Ontario, Oreg. |
| Weld County Medical Society, Greeley and LaSalle, Colo. | Albany County Medical Society, Albany, N. Y. |
| Jackson County Medical Society, Jackson, Mich. | King County Medical Society, Seattle, Wash. |
| Rock Island County Medical Society, Rock Island and Moline, Ill. | Summit County Medical Society, Akron, Ohio. |
| DuPage County Medical Society, Elmhurst and Naperville, Ill. | |
| DeKalb County Medical Society, DeKalb and Sycamore, Ill. | |

The **CHAIRMAN**. The American Medical Association apparently does not agree with this organization. I wish to read from an article from the *Journal of the American Medical Association*, February 23, 1946, volume 130, number 8, entitled "The Public Relations of American Medicine," Morris Fishbein, M. D., editor, *Journal of the American Medical Association*. It contains the following statement:

The American Association of Physicians and Surgeons has, according to fairly well substantiated rumor, received \$10 from each of 6,000 physicians who have subscribed to its principles. Just what it has accomplished other than to state its objectives and to get them out in the press is not clearly apparent. This group, however, proposes that the physicians of the United States strike against the sick public in case the Government of the United States should establish compulsory sickness insurance. Such an action would be contrary to all the tradition of medical science covering the responsibility of the physician to the sick. No official body of the American Medical Association has ever ventured even the thought that physicians would neglect to minister to the sick as evidence of their opposition to the law of the nation.

The **CHAIRMAN**. I also wish to insert in the record some other literature showing the application forms of this Association of American Physicians and Surgeons.

(The document referred to is as follows:)

ASSOCIATION OF AMERICAN PHYSICIANS, AND SURGEONS, INC.,
Chicago 3, Ill., December 13, 1945.

DEAR DOCTOR: President Truman, on November 19, issued a directive to Congress for a national health program. Senators Wagner and Murray and Representative Dingell introduced bills S. 1606 and H. R. 4730 to carry out the President's recommendations.

Regardless of statements to the contrary, the new measure provides for compulsory health insurance and socialization of American medicine.

In addition to the bureaucrats, the A. F. of L. and the C. I. O., other influential individuals have raised their voices in support of socialized medicine. They include: Eleanor Roosevelt, the esteemed Bishop Hass, Paul Hunter, publisher of Liberty Magazine, and many others from every field of endeavor.

The forces of political medicine are powerful and are well organized. They mean business.

The American medical profession must act now. We must mean business, too, in order to stop the onslaught of these planners who would eliminate the American system of the private practice of medicine. There is a way: Join the Association of American Physicians and Surgeons and thereby contract and agree with thousands of your colleagues that you will not participate in schemes of political medicine.

Systems of federal or state medicine cannot operate without the participation of a substantial majority of physicians. When a majority have joined AAPS, as it now appears they will, there can be no bureaucratic control of American medicine.

Already thousands of your colleagues throughout the Nation have joined AAPS. Hundreds of your fellow physicians in the State of Massachusetts are members of our association.

Since the first of the year, more than 30 medical groups have endorsed the objectives of the association. Recent endorsements include the following:

- | | |
|--|---|
| Middlesex East District, Melrose, Mass. | San Diego County Medical Society, San Diego, Calif. |
| King County Medical Society, Seattle, Wash. | Alameda County Medical Society, Oakland, Berkeley and Alameda, Calif. |
| Albany County Medical Society, Albany, N. Y. | Jackson County Medical Society, Kansas City, Mo. |
| The Columbus Academy of Medicine, Columbus, Ohio | South Central Section of the American Urological Association |
| Wayne County Medical Society, Detroit, Mich. | Chicago Medical Society, Chicago, Ill. |
| Allen County Medical Society, Fort Wayne, Ind. | |

These endorsements from your colleagues, and the society of your own State, prove the objectives of AAPS and the soundness of its plan to guarantee the preservation of the private practice of medicine in America. Join today and add your strength to the thousands of physicians who have determined to remain free.

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS,
HAROLD T. LOW, M. D., *President*.

Sign the application on the back of this letter and mail it today.

(This letter is being sent to all eligible physicians, including members of AAPS, for their information.)

APPLICATION FOR MEMBERSHIP

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

11 South La Salle St., Chicago 3, Ill.

Name _____, M. D.
 First Middle Last

Office address _____
 Street City State

Residence address _____
 Street City State

Member of _____ Medical society _____
 County society or its equivalent State

I agree to abide by the articles of incorporation, bylaws, and lawful orders and rulings of the Association of American Physicians and Surgeons, Inc. I further agree that my membership shall ipso facto terminate if and when I violate any lawful rule, regulation, or bylaw of this association.

Signed_____

Date of application_____19___

Witness_____

If a member of the armed forces :

Rank_____ Branch of service_____

Mailing address_____

If a medical student or intern :

Student at_____ School of medicine

Date of matriculation_____19___ ; Class graduate in_____19___

Intern at_____ Hospital

_____ Street City State

Date internship will be completed_____19___

Mailing address_____

Except for members of the armed forces, interns, and students, dues (\$10.00 annually) must accompany application.

The CHAIRMAN. The first witness this morning is Dr. Cary.
Dr. CARY. Yes, sir.

STATEMENT OF DR. EDWARD H. CARY, CHAIRMAN OF THE BOARD OF TRUSTEES OF THE NATIONAL PHYSICIANS COMMITTEE

The CHAIRMAN. Dr. Cary, you may proceed.

Dr. CARY. I want to thank you, Mr. Chairman, for the invitation to appear and offer testimony before this important Committee on Education and Labor of the Senate.

My being present is the result of an interchange of seven or eight telegrams between Senator Murray and our headquarters in Chicago. In answer to the first invitation we requested the privilege of having seven witnesses appear, each one of whom would briefly cover a different aspect of the problem. We stated :

We believe the issues involved in S. 1606 are of such importance that attempts to present all phases of our viewpoint by one person at one session would be grossly inadequate.

In effect, Senator Murray replied that the overcrowded schedule of witnesses practically precluded the possibility of allowing more than one witness to appear. I should like to file for the record copies of the telegrams that finally resulted in my being here and undertaking the task of placing in evidence, the point of view and testimony on behalf of the National Physicians Committee on S. 1606.

(The telegrams referred to are as follows:)

TELEGRAMS EXCHANGED BETWEEN SENATOR MURRAY AND THE NATIONAL PHYSICIANS COMMITTEE LEADING TO TESTIMONY OF DR. EDWARD H. CARY BEFORE THE COMMITTEE ON EDUCATION AND LABOR ON FRIDAY, APRIL 19

WASHINGTON D. C., *March 13, 1946.*

THE NATIONAL PHYSICIANS COMMITTEE,
The Pittsfield Building, Chicago,

Shall appreciate your arranging to present testimony on national health bill S. 1606 on morning of Wednesday, April 17. Please confirm with name of person who will represent your organization.

JAMES E. MURRAY,
Chairman, Education and Labor Committee.

CHICAGO, *March 15, 1946.*

HON. JAMES E. MURRAY,
Chairman, Committee on Education and Labor,
Capitol Building, Washington, D. C.

Retel appreciate invitation to present testimony on Senate bill 1606 on April 17. It is our desire to present seven witnesses each of whom will briefly cover a different aspect of this problem. Please confirm and names of witnesses will be submitted promptly.

JOHN M. PRATT,
Administrator, National Physicians Committee.

WASHINGTON, D. C., *March 21, 1946.*

JOHN M. PRATT,
Administrator, National Physicians Committee,
The Pittsfield Building, Chicago:

Re tel March 15 deeply regret that already overcrowded schedule of witnesses on S. 1606 hearings makes it very difficult for committee to allow organizations to present testimony by more than one witness. Would greatly appreciate your having additional testimony presented in form of written statements. Such statements will become a part of the record and will be brought to attention of the committee. Your cooperation in this matter will be appreciated.

JAMES E. MURRAY,
Chairman, Education and Labor Committee.

CHICAGO, ILL., *March 22, 1946,*

SENATOR JAMES E. MURRAY,
Committee on Education and Labor, Washington, D. C.:

Reference your telegram of 21st believe the issues involved in 1606 are of such importance that attempt to present all phases of our viewpoint by one person at one session would be grossly inadequate. Will you please advise how much time might be assigned a representative who would attempt to present all phases of evidence sustaining our viewpoint. We shall greatly appreciate your advising us in this connection at the earliest possible time.

JOHN M. PRATT,
Administrator, National Physicians Committee.

WASHINGTON, D. C., *March 26, 1946.*

JOHN M. PRATT, *Administrator,*
National Physicians Committee, the Pittsfield Building, Chicago.:

Re tel March 22 should appreciate your arranging for one representative of your organization to testify in person and briefly following the testimony of the American Medical Association on April 17. A more elaborate presentation can be printed in the record of the hearings and will certainly be brought to the attention of every member of the committee.

JAMES E. MURRAY,
Chairman, Education and Labor Committee.

WASHINGTON, D. C., March 27, 1946.

JOHN PRATT, *Administrator,*
National Physicians Committee, the Pittsfield Building, Chicago.:

I should greatly appreciate your letting me know before end of week whether you will testify on national health bill S. 1606 on morning of Wednesday, April 17 as suggested in previous telegram to you. Hearings to begin early next week making it necessary that committee have confirmation from each witness.

JAMES E. MURRAY,
Chairman, Education and Labor Committee.

MARCH 29, 1946.

Senator JAMES E. MURRAY,
Committee on Education and Labor, Washington, D. C.:

With reference your telegram of twenty-seventh instant. I have been instructed to advise that the time allotted for testimony is wholly insufficient and that it is an absurdity to attempt to adequately cover the complicated and important problem of Government distribution of medical care with only one witness. Notwithstanding, Dr. Edward H. Cary, chairman of the National Physicians Committee board of trustees will come to Washington and testify on national health bill, S. 1606, on morning of Wednesday, April 17. In addition, a statement for the record will be filed.

JOHN M. PRATT,
Administrator, National Physicians Committee.

WASHINGTON, D. C., April 16, 1946.

JOHN M. PRATT,
National Physicians Committee, the Pittsfield Building, Chicago:

In order to facilitate scheduling of witnesses should appreciate your arranging to change date of Dr. Cary's testimony from April 17 to either Monday, April 15, or Friday, April 19. Please send return wire as to which date you prefer.

JAMES E. MURRAY,
Chairman, Education and Labor Committee.

CHICAGO, ILL., April 5, 1946.

Senator JAMES E. MURRAY,
Committee on Education and Labor, Washington, D. C.:

Dr. Cary will be in Washington to testify before Committee on Education and Labor on Friday, April 19.

JOHN M. PRATT,
Administrator, National Physicians Committee.

WASHINGTON, D. C., April 11, 1946.

JOHN M. PRATT,
National Physicians Committee, the Pittsfield Building, Chicago:

This is confirmation that Education and Labor Committee is expecting to hear testimony by Dr. Cary on behalf of National Physicians Committee at 10 a. m. on Friday, April 19. Suggest Dr. Cary check with my office regarding room in which hearings will be held on that day on his arrival here.

JAMES E. MURRAY,
Chairman, Education and Labor Committee.

Dr. CARY. I welcome the opportunity to approve, with qualifications, portions of this bill and register our unqualified opposition to other parts of this proposed legislation. Our position is well known.

In a superficial review of the testimony that has been offered before this committee, it is obvious that an effort has been made to classify the witnesses on the basis of radicals or reactionaries, liberals or con-

servatives. For more than 40 years, I have been practicing medicine. I can claim some knowledge of the scientific advancement in medicine during this period. I have tried, with some degree of success, to keep abreast of these unparalleled developments. I should like to stress a fact that is generally recognized. The most radical and most ruthlessly revolutionary forces in the world are the cold, unalterable findings of science. Imaginings, theories, speculations, and vain desires inevitably must give way before established truth. I am a devotee of science. I accept its dictum and hence must be voted as a radical and in this sense even a revolutionary.

EXPENDITURES OF THE NATIONAL PHYSICIANS COMMITTEE

On Tuesday evening of this week, April 16, during the discussion period after "The American Forum of the Air" broadcast over a Nation-wide network, a proponent of this legislation stated: "The National Physicians' Committee has spent \$1,000,000 for the publication and distribution of one pamphlet."

This in some respects is a flattering statement. This amount is more than the total that has been spent by the National Physicians' Committee over a period of 6 years of operation. Some interest has been manifested in these expenditures. The committee's expenditures by years have been:

For 12 months ending October 31, 1940, \$150,131.29; for 12 months ending October 31, 1941, \$63,438.70; for 12 months ending October 31, 1942, \$77,657.73; for 12 months ending October 31, 1943, \$151,937.31; for 12 months ending October 31, 1944, \$223,176.48; for 12 months ending October 31, 1945, \$239,017.72; total expenditures, 6 years, \$905,359.23.

During this period we received, in the form of voluntary contributions from individual physicians and physician groups, \$492,079.04, or 54.3 percent of the total expenditures. These came from slightly more than 22,000 doctors. More than 90 percent of other revenue came from 97 business firms generally classified as manufacturing pharmacists and allied industries. We have never received one dollar of contributions from any commercial insurance company.

Immediately preceding the opening of these hearings, namely on Friday, March 29, 1946, the "leftist" New York daily newspaper, PM, published a double-page spread devoted to a diatribe against the committee, of which I am chairman. I would like to place this in the record.

(The document referred to is as follows:)

[PM, Friday, March 29, 1946]

AMA-DRUG TRUST AXIS SPONSORS CAMPAIGN OF LIES AGAINST WAGNER-MURRAY HEALTH BILL

(By Albert Deutsch)

PEDDLE PROPAGANDA PILLS TO DRUG AMERICAN PUBLIC

A sordid tale of medical intrigue and unprincipled propaganda, conducted behind a hypocritical mask of professional dignity, may be unfolded in the course of the Senate hearings on the Wagner-Murray-Dingell bill for national health insurance, which start next week. The tale hangs on a \$300,000-a-year smear campaign loosed against the bill and its sponsors, including the President, by an alliance of reactionary medical and drug manufacturing interests.

The campaign is godfathered and fostered by the American Medical Association. It is financed largely by big patent-medicine companies. It is spearheaded by a dummy agency for organized medicine and masterminded by an ex-advertising man who once did the same job for an anti-New Deal committee created and headed by publisher Frank Gannett.

The propaganda front for organized medicine, as noted before in these columns, is the National Physicians Committee for the Extension of Medical Service (NPC). Its headquarters, like that of the AMA, is in Chicago. The NPC is an offshoot of a so-called physicians committee organized in 1938 by Frank Gannett within the Committee to Uphold Constitutional Government to fight progressive health legislation and line up the medical profession for Gannett and against the New Deal. It is headed by John M. Pratt, an old advertising hand, who also directed the old Gannett group.

Pratt, a genial, shrewd operator in his late 50's, told me recently in Chicago that the NPC had distributed over 25,000,000 pamphlets and circulars throughout the country in its campaign against the W-M-D bill. It has flooded the Nation's press with propaganda that distorts the aims and contents of the bill. It has succeeded in getting more than 3,000 full-page advertisements in newspapers scattered throughout the country by an ingenious campaign wherein the mats for the ads are furnished free of charge and direct instructions are given to advertising managers on how to line up local drug stores, medical societies and industrial houses to pay for the ad.

In an effort to influence editorial opinion directly, the NPC recently ran a series of full-page paid advertisements in every newspaper-trade organ, urging editors to fight the W-M-D bill.

NPC propaganda circulars and pamphlets are distributed in huge quantities through drug stores (the Walgreen chain is a notable example), employes of which have been instructed to hand them to each customer. NPC posters attacking the W-M-D are prominently displayed on many hospital walls and in doctors' offices. Thousands of patients are getting NPC propaganda leaflets stacked neatly within the bills mailed by their doctors. Powerful drug companies have ordered their salesmen to distribute NPC literature to all customers and to crusade personally against the W-M-D bill with all they meet. These companies have a potent reason for fearing the bill's passage: it would cut tremendously into patent-medicine profits. Private insurance firms have also been mobilized in this unholy alliance against the bill.

Pratt told me that nearly \$300,000 had been raised by the NPC during the fiscal year ending last October. About \$50,000 of this sum had been put into a reserve "war fund" in anticipation of the final showdown over the bill.

I asked Pratt where the money had come from. He replied:

"About \$125,000 came from drug manufacturers. About \$130,000 came from physicians. (Local and State branches of the NPC have been organized throughout the U. S. A. to raise funds from doctors.) The rest came from miscellaneous sources."

Pratt didn't identify these miscellaneous sources, but it is understood that they represent mainly medical and hospital supply companies.

Besides its direct campaign, the NPC lays down the line to State and local medical societies and feeds them with a constant stream of propaganda material. These societies obediently follow the line handed down by the advertising man who actively heads the NPC.

While the American Medical Association denies any official connection with the NPC, it is an open secret that an intimate association exists between them.

Dr. Chester I. Ulmer, chairman of the NPC's New Jersey branch, let the cat out of the bag some time ago when he stated that the NPC was created because the AMA would forfeit its present tax-exempt status as a nonprofit scientific and educational organization if it openly waged a propaganda campaign against pending legislation. Nearly all members of the NPC board of trustees are former presidents of the AMA or highly placed officials in its ruling hierarchy. The AMA has repeatedly and officially indorsed the NPC.

Dr. Morris Fishbein, AMA factotum and editor of the AMA Journal, gave tangential credence to this tax-exempt reason for the NPC front in an anti-Wagner bill strategy meeting in Chicago last month. He ought to know. He was chief obstetrician at the birth of the NPC. He has taken an intimate part in its counsels. He has helped considerably in planning its strategy. Here are revealing excerpts from Dr. Fishbein's recent speech on The Public Relations of American Medicine, as printed in the AMA Journal of February 23, 1946:

"The National Physicians Committee has supported the policies of the house of

delegates and has, by a variety of technics, extended its point of view to the American people.

"The National Physicians Committee has been most effective of all the organizations striving to mold public and legislative opinion in the field of medical care. Its efforts have been repeatedly endorsed by the house of delegates of the American Medical Association. This agency has used syndicated newspaper publicity and editorial opinion, newspaper advertising, pamphlets, radio, direct-by-mail solicitation, education, and every other technic of public relations in its work. Currently some thousands of representatives of medical industries are encouraging everyone whom they meet or interview to communicate directly with the Congress expressing opposition to the compulsory sickness insurance feature of the national health program and to the Wagner-Murray-Dingell bill. In * * * efficiently and economically used. The medical profession owes a great debt of gratitude to the distinguished physicians who serve as the directing board of the national physicians committee and to the staff who carry out so effectively the policies that this board establishes."

Let us examine some of this NPC propaganda so highly praised by Fishbein and the MA hierarchs.

The NPC propaganda throws every bogey word in the book at the W-M-D bill and its sponsors. It calls the bill Nazi, Fascist, Communist, Collectivist, and Socialist. It says the bill would "regiment" both doctors and patients under a politically controlled "medical dictatorship." It attributes sinister, ulterior motives to the bill's sponsors, including President Truman. It falsifies the bill's provisions.

The main propaganda weapon of the NPC is a 24-page pamphlet entitled "Showdown on Political Medicine," which has been distributed by the millions as a purported "primer on the meaning of President Truman's message to Congress on Medical Care and Health (Nov. 19, 1945) and the new W-M-D bills.

The pamphlet finds "acceptable" three provisions in the W-M-D bill providing for Federal grants to States for control of tuberculosis and venereal disease; extension of maternal and child health services through Federal aid; and Federal grants to States to provide medical care for the needy. It frowns on a fourth provision—for Federal funds to aid medical education and research.

The main bulk of the pamphlet is filled with an all-out attack on the bill's vital provision—the one establishing a national compulsory health insurance system giving virtually complete hospital and medical service, together with limited dental and nursing care, to all Americans who work for a living, and to their dependents.

The pamphlet teems with misleading statements and distorted interpretations. Here are two samples:

Referring to President Truman's estimate that the broad health insurance program should be financed by about 4 percent of annual earnings up to \$3,600 a year, the pamphlet implies that the total burden of cost would be placed on the workers. The fact is that the bill's sponsors have repeatedly made it clear that pay roll taxes would be shared equally by workers and their employers.

The pamphlet implies that the bill would make all doctors "work as employees of the Government." In fact, the bill preserves the doctor's status as a free agent, contracting for his medical services under any one of three broad methods of payment. No doctor is compelled to join, he can stay out if he chooses.

The most widely distributed NPC literature is a little folder entitled "Political Medicine," which is a condensation of the Showdown pamphlet. Here are some typical samples of the irresponsible statements contained therein:

"(3) Fix the qualifications for specialists.

"(4) Determine the number of individuals for whom any doctor or dentist may provide service.

"(5) Determine what hospitals or clinics may provide service for patients and under what conditions."

The truth: The Federal Security Administrator is a Federal official, not necessarily a "political appointee." He would no more be "dictator" of medical care than he now is of the efficient, nonpolitical Public Health Service administered by famed Surgeon General Thomas Parran. The Surgeon General would, in consultation with a advisory council and in accordance with local conditions, set minimum standards of quality for doctors and other professionals and also for hospitals. Any doctor or hospital meeting these standards could enter the health insurance system. Limits would be put on patients on a doctor's books to prevent over-loading on a particular doctor with consequent substandard service. There is nothing sinister in these provisions, as the NPC folder implies.

BUREAUCRATIC ARMY

"Based on experience in other countries, it would take at least 300,000 lay bureaucrats to administer this system of politically distributed medical care. If you needed a doctor you might have to apply to a Bureau."

The figure represents a wild, unfounded and grossly exaggerated guess. Considerably less than 300,000 people would be needed. The system could be run largely by those already handling the social security program. Note the unfair bogey words—"bureaucrats" and "politically distributed." There is no political distribution of social security today. An insured person who wants to see a doctor will go to him directly; he won't have to apply to any "Bureau."

"GERMANY HAD SYSTEM

"Under Hitler Germany had a similar system. It was not so comprehensive. What Happened?

"Shortly after VE-day, Col. Edward D. Churchill, Allied Mediterranean forces' surgical

* * * * *

"In Nazi philosophy, your race and politics mattered far more than your brains and talents. Without doubt a similar condition would develop here under a system of politically distributed medical care."

This is unprincipled smear language. Germany had a limited health insurance for 50 years before Hitler came to power. The plan had nothing whatever to do with Nazism. Racial and religious discrimination are today rampant in American medicine, as revealed in recent official reports.

"TWO THINGS TO REMEMBER

"1. Political distribution of medical care would entail making a public record of the characteristics and the most intimate and sacred personal relationships of each and every patient. The privacy of every human being would be invaded and violated. It can be imagined how the information might be used by the curious and the unscrupulous."

This is a blatant untruth. Medical records would be handled on the same confidential basis as they are in private practice. The intimate doctor-patient relationship would be retained intact. Medical records would most certainly be kept as inviolate as are individual unemployment and old age insurance records today.

Soon after President Truman sent his health message to Congress and the new Wagner-Murray-Dingell bill embodying his recommendations was introduced, the NPC sent a form letter to every newspaper editor in the United States suggesting how extra money could be made by running canned advertisements provided free by the propaganda agency. The letter stated:

"To the editor:

"President Truman's message to Congress of Monday, November 19, represents unqualified approval of strictly totalitarian concepts and methods.

"We are also enclosing a series of five advertisements. For these advertisements local sponsorship may be secured for payment of costs. Already we have mailed to newspapers on specific request more than 1,000 mats of these advertisements. It would be helpful if they were called to the attention of your advertising department.

"Sincerely,

"NATIONAL PHYSICIANS COMMITTEE FOR L. M. S.
"JNO. M. PRATT

"Administrator"

Here is one of the 3,000-plus NPC ads printed on this basis:

"Trojan horse tactics in America."

That advertisement represents a dastardly slur on President Truman and the congressional sponsors of the health bill, broadly implying that they desire to use compulsory health insurance as a wedge toward opening the way to a "collectivist state."

Here is another example of an NPC smear advertisement which appeared in a number of newspapers.

"Doctor rationing Do you want it in America?"

The W-M-D bill makes no suggestion of doctor rationing. Neither does it provide for a belt-line stamp system as represented in the cartoon. Sick patients

will go directly to doctors of their choice, as they do now—only there will be far greater freedom of choice, actually. There will be no stamp lines.

Here is a sample of the kind of full-page "editorials" inserted in newspaper trade periodicals as paid advertisements as a means of influencing editorial opinion. This one, replete with familiar bogey words, appeared in the widely read journal, Editor and Publisher:

AN EDITORIAL FOR EDITORS

"Politicians—possibly to extend tenure in office—have advanced proposals which would transfer to minions of the Federal Government the actual task of distributing medical care to 110,000,000 people. Such procedures would involve making the doctor subordinate to the bureaucrat. It would mean the regimentation of the medical profession—if it worked."

The implied smear on the sponsors of the W-M-D bill is obvious and needs no discussion.

When President Truman sent his health message to Congress, the NPC sent out an emergency circular to all American physicians in an effort to panic them into rushing checks from \$25 to \$100 to help finance a redoubled propaganda campaign. The circular read:

EMERGENCY BULLETIN

"Announcement made Monday of White House demand for immediate congressional enactment compulsory health insurance law. Free medical, nursing, hospital care and dentistry under political auspices would require minimum fund of \$1,000,000,000. Obviously this beginning of final show-down on collectivist issue."

The Truman message envisaged no "free" care; it clearly stated that the beneficiaries would contribute to the insurance fund. The NPC circular, in keeping with the other propaganda, substituted "political" for "Government" auspices. It implied, as did the other literature, that the estimated \$1,000,000,000 annual cost (it would actually be closer to 3,000,000,000) represented an added burden. The present American medical bill totals nearly \$4,000,000,000 for generally inadequate service. Health security would be no more "collectivist" than our present social security system.

The following letter shows how hospital supply houses were mobilized behind the NPC propaganda campaign:

"HOSPITAL INDUSTRIES COMMITTEE OF THE NATIONAL PHYSICIANS COMMITTEE
FOR THE EXTENSION OF MEDICAL SERVICE

"Dedicated in the public interest to preserving for doctors of medicine
the distribution of medical service in the United States

"On Monday, August 13, the Hospital Industries Association Committee (which was designated at the last Directors meeting of the Hospital Industries Association) met in Chicago to discuss ways and means of effectively coordinating the efforts of our industries with those of the National Physicians Committee for the Extension of Medical Service.

"Be it resolved that we as a committee representing the Hospital Industries Association and other business and industrial firms register full approval of the activities of the National Physicians Committee, pledge the financial support of our individual firms, and recommend to all members of this Association and to business and industrial leaders generally that they give voluntary moral and financial support to this uniquely effective agency."

"Within a short time you will receive additional communications indicating the line of action which your industry committee will follow in this most important project.

"Yours very truly,

HOWARD M. FISH, *Chairman.*

The opportunistic advertising geniuses who spearhead the NPC drive have left no stone unturned in getting ammunition for their assault on the W-M-D bill. They even resurrected a speech delivered by the late Samuel Gompers 30 years ago, opposing all types of social insurance. This speech was reprinted in part in poster form, and widely circulated, as the following letter indicates:

"We are enclosing a copy of the spectacular statement made by Samuel Gompers, president of the American Federation of Labor, on December 5, 1916.

"As you know, the Gompers statement has been widely used as a bulletin board display in hospitals and other places throughout the United States.

"One of the foremost drug manufacturers has decided to display the Gompers statement on all bulletin boards in his plants. We can provide additional copies of the Gompers statement like the sample enclosed on request.

"Sincerely,

"NATIONAL PHYSICIANS COMMITTEE FOR E. M. S."

This poster is evidently intended to influence working people against the W-M-D bill. No reference is made to the fact that the entire attitude of organized labor toward social insurance has changed in the last generation. Until 1931, in fact, the American Federation of Labor officially opposed unemployment and old-age insurance. No responsible labor leader can be found who opposes social security today. Here is an excerpt from the NPC poster reprinting the Gompers speech:

"SAMUEL GOMPERS ON COMPULSORY HEALTH INSURANCE

"WHAT IS IT? WHAT ARE THE IMPLICATIONS?"

"An address by Samuel Gompers, delivered in Washington, D. C.,
December 5, 1916

"The introduction of compulsory social insurance in cases of sickness, or compulsory social insurance in cases of unemployment, means that the workers must be subject to examinations, investigations, regulations and limitations. Their activities must be regulated in accordance with the standards set by governmental agencies. To that we shall not stand idly by and give our assent * * *"

The CIO and the AFL now not only endorse social insurance; they seek a broad extension. They are in wholehearted support of the Wagner-Murray-Dingell bill. The use of the Gompers statement of 1916 is a symbol of how far behind the times the NPC line is.

It is unfortunate that this AMA-inspired, NPC-conducted propaganda is being issued in the name of the American medical profession. The profession has been subjected to an incessant bombardment of this kind of tripe in its medical journals, with little opportunity to get at the truth. The NPC, in smearing the W-M-D bill, may wind up by discrediting the medical profession in the eyes of the public.

Dr. CARY. The publication of this childish attack is too opportune to take on even the semblance of coincidence. I quote from the first paragraph:

A sordid tale of medical intrigue and unprincipled propaganda, conducted behind a hypocritical mask of professional dignity, may be unfolded in the course of the Senate hearings on the Wagner-Murray-Dingell bill for national health insurance, which start next week.

Further quoting from this remarkable story:

The main propaganda weapon of the National Physicians' Committee is a 24-page pamphlet entitled "Showdown on Political Medicine" which has been distributed by the millions as a purported "primer on the meaning of President Truman's message to Congress on medical care and health (November 19, 1945) and the new Wagner-Murray-Dingell bills."

I wish to present this pamphlet for the record.
(The pamphlet referred to is as follows:)

SHOWDOWN ON POLITICAL MEDICINE

A primer on the meaning and implications of President Truman's message to Congress on medical care and health, and the new Wagner-Murray-Dingell bills (S. 1606, H. R. 4730) in question-and-answer form.

SOCIALIZED MEDICINE WITH A VENGEANCE

On November 19, 1945, Senators Wagner and Murray and Representative Dingell introduced new health bills in Congress.

They would authorize grants-in-aid to States to extend the Public Health Service, increase maternal and child-health services, and provide medical care for the needy. Provision is made for State participation with local control and administration. With safeguards, these are acceptable proposals; but the bills also instruct the Surgeon General of the Public Health Service, under direction of the Federal Security Administrator, to provide "full medical, dental, nursing, and laboratory care and hospitalization for 110,000,000 people." This is socialized medicine with a vengeance—political distribution of all medical service.

The proposals are more sweeping and more far-reaching than any ever attempted in any country, with the possible exception of Russia. (See text, p. 7 of this booklet.)

PROLOGUE

On September 6, 1945, President Truman in a special message to Congress, outlined an economic bill of rights. One of these was "the right to medical care and the opportunity to achieve and enjoy good health." These are worthy objectives. They are approved by everyone.

Obviously, immediately after the delivery of this message, the most skillful and adroit word architects and phrase makers of the administration's drafting services were put to work under pressure. The result was a second message. It is a classic in phraseology and circumlocution.

This document was placed in the hands of the newspapers throughout the United States, marked "Confidential." It carried the injunction: "To be held in strict confidence and no portion, synopsis, or intimation to be given out or published until the reading of the President's message has begun in either the Senate or House of Representatives."

On November 19, 1945, the President's message was read to the Congress. On the same day, almost immediately after the reading of the message, Senator Robert Wagner of New York and Senator James Murray of Montana introduced a new bill (S. 1606—National Health Act of 1945) in the Senate. Congressman John Dingell of Michigan introduced an identical Bill (H. R. 4730) in the House of Representatives. Presumably these bills were to provide legislation to create the administrative mechanisms for and establish legal authority to implement the proposals of the President's message.

All of the evidence now indicates that the reverse of this presumption is true and that the President's message was designed to build approval of and develop support for the Wagner-Murray-Dingell bills (S. 1050, H. R. 3293), introduced into the Congress on May 24, 1945.

The President stated, of the proposals in this message: "This is not socialized medicine." It is believed that either Mr. Truman was ill-advised or that he did not understand the inevitable result of enacting into law the proposals of the Wagner-Murray-Dingell bills. Actually, they would establish a dictatorship in all matters relating to medical care and health in the United States.

What the politicians say is not important. What the clauses of the bills provide is vital. In this crisis it is essential that the meanings of these proposals be fully understood.

In the following pages a sincere effort has been made to define and make apparent the meaning and implications of the new Wagner-Murray-Dingell bills.

SHOWDOWN ON POLITICAL MEDICINE

In concise questions and answers

Question. What were the specific recommendations made by President Truman in his November 19 message to Congress?

Answer. In his November 19 message, President Truman recommended the use of Federal funds to aid in:

- (a) Construction of hospitals and related facilities.
- (b) Expansion of the Public Health and Maternal and Child Health Services.
- (c) Medical research and education.
- (d) Prepayment of medical costs.
- (e) Protection against loss of wages from sickness and disability.

Question. Did President Truman state that his proposals were not socialized medicine?

Answer. Yes. Twice in his message, President Truman stated with reference to his recommendations: "This is not socialized medicine."

Question. Why did President Truman twice emphasize this statement?

Answer. In the text of his message he answers this question. He stated, "Socialized medicine means that all doctors work as employees of Government. The American people want no such system."

Question. What do you think this means?

Answer. This means that President Truman and the sponsors of previous Wagner-Murray-Dingell legislative proposals are full conscious of the fact that the American people are opposed to and want nothing to do with political distribution of medical care.

Question. Would the recommendations, if enacted into law, bring about socialized medicine in the United States?

Answer. The term "Socialized medicine" is not a defining one. It means different things to different people. Actually, the proposals that have been embodied in the Wagner-Murray-Dingell bills would provide political distribution of medical care in its most vicious and most dangerous form. The proposals would introduce a system more far reaching than any Government medical-care program ever attempted in any country with the possible exception of Russia.

Question. Why did the President make such recommendations to Congress?

Answer. No one but the President himself can answer this question. It appears, however, that the recommendations were made to create approval of and build support for the provisions of the Wagner-Murray-Dingell bills introduced into the Congress on May 24, 1945.

Question. What happened after the reading of the President's message?

Answer. Senators Wagner and Murray and Representative Dingell introduced into the Congress new bills (S. 1606 and H. R. 4730) to create administrative machinery and establish authority to provide medical care for all men, women and children in the United States.

Question. What are the provisions of these bills?

Answer. The bills provide:

(a) Grants-in-aid to States for treatment and control of venereal disease and tuberculosis and the extension of the Public Health Service.

(b) An extension of maternal and child health services through grant-in-aid to States.

(c) Grants-in-aid to States provide medical care for the needy.

(d) Health services for all Social Security beneficiaries and all of their dependents.

(e) Federal funds to subsidize medical research and education.

Question. Are all parts of these bills objectionable?

Answer. No.

(a) The medical profession and the public, when it is explained, are in favor of steps to be taken to provide treatment and control of tuberculosis and venereal disease and extending the public-health services through grants-in-aid to States with State control and local administrative authority.

(b) On the basis of transferring the Children's Bureau operations from the Department of Labor to the Public Health Service, the medical profession and, when explained, the public are in favor of extending maternal and child-health care to all mothers and children "where payment for such service would be a hardship," through grants-in-aid to States with State control and local supervision.

(c) The medical profession and the public, when it is explained, are in favor of Federal grants-in-aid to supplement funds of State and local agencies to provide full medical care and hospitalization to all persons for "whom the payment for such services would be a hardship."

In connection with these three proposals, the following text appears in the bills—the Surgeon General, the Chief of the Children's Bureau, or the Social Security Board "shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed * * *" This provides reasonable protection against political exploitation. (E. page 6—lines 22, 23, 24, page 14—lines 14, 15, 16, page 27.¹)

Hence, it is seen that with reasonable safeguards, the first three parts of the Wagner-Murray-Dingell bills are acceptable proposals.

¹ The references are to sections, lines, and page numbers of S. 1606.

Question. What about the last two proposals?

Answer. The fourth step in the procedure, under the Wagner-Murray-Dingell bills would establish authority and the machinery for the Federal Government to provide "prepaid personal health service benefits."

Question. What is meant by "personal health service benefits"?

Answer. The term "personal health service benefits" includes general medical benefits, special medical benefits, general dental benefits, special dental benefits, home nursing benefits, laboratory benefits, and hospitalization benefits (esc. 214, p. 65).

Question. For whom will these services be provided?

Answer. For all Social Security beneficiaries and their dependents (sec. 201, p. 35). In addition to this, provision can be made for the inclusion of other persons or groups not now covered under the provisions of the Social Security Act (sec. 209, p. 55).

Question. For how many people would such service be available?

Answer. Approximately 110,000,000 people under existing laws—presumably, under the new proposal, 130,000,000 people.

Question. How much would the providing of such services cost?

Answer. President Truman, in his message, stated that the providing of the medical care outlined in his proposals would approximate 4 percent of wages. The term "wages" means the income of both employed persons and self-employed individuals up to \$3,600 per year (sec. 217, p. 72). On the basis of all previous estimates, this would approximate \$4,000,000,000 annually.

Question. How would such comprehensive services be made available?

Answer. The bill states "The Surgeon General of the Public Health Service shall perform the duty imposed upon him by this act under the supervision and direction of the Federal Security Administrator" (sec. 203, pp. 35 and 36) and "the Surgeon General is hereby authorized and directed to take all necessary and practical steps to arrange for the availability of benefits" (lines 10, 11, 12, p. 36).

Question. Would the Surgeon General have full control of the expenditure of this \$4,000,000,000 without outside interference?

Answer. The Surgeon General, with the approval of the Federal Security Administrator, is authorized and instructed to provide medical care, dental care, laboratory care, nursing care, and hospitalization for all of these people. The act reads: "The Surgeon General is hereby authorized and directed to take all necessary and practical steps * * * to arrange for the availability of the benefits" (sub. B. p. 36).

Question. Is the Surgeon General required to establish an Advisory Council?

Answer. Yes.

The bills would establish a National Advisory Council. It would consist of the Surgeon General, as Chairman, and 16 members. The Surgeon General, with the approval of the Federal Security Administrator, appoints the 16 members (sec. 204, pp. 41 and 42).

Question. What are the functions of the Advisory Council?

Answer. The Advisory Council shall advise the Surgeon General (line 18, p. 43).

Question. What else is it authorized to do?

Answer. The Advisory Council shall:

- (1) Hold at least two meetings each year (line 18, p. 42).
- (2) Receive compensation at a rate not to exceed \$25 per day for time spent in attending meetings and time devoted to official business (line 5, p. 43).
- (3) Establish special advisory, technical, regional or local committees or commissions (subsec. C, p. 44).

Question. What would be the functions of these committees appointed by the National Advisory Council?

Answer. With reference to the functions of these committees, the act reads: "to advise upon general or special questions," et cetera. Their function is to advise (line 21, p. 44).

Question. Is the Surgeon General to appoint any other committees?

Answer. Yes—The act reads: "Except with respect to States or local areas for which other arrangements have been made, the Surgeon General shall appoint local area committees to aid in the administration of this title" (line 12, p. 39).

Question. What are the functions and authority of these local area committees?

Answer. They are given authority to do one thing—"make reports." The act reads: "Such committees are hereby authorized to make annual and special

reports with recommendations, if any, to local area officers and to the Surgeon General through his State or regional officers" (lines 6, 7, and 8, p. 40).

Question. What other authority has the Surgeon General?

Answer. The Surgeon General, with the approval of and under the direction of the Federal Security Administrator has, among other responsibilities, authority to:

(1) Hire doctors, specialists, dentists, nurses, laboratory technicians, and establish rates of pay (sec. C—pp. 36 and 37).

(2) Establish fee schedules for physicians' and dentists' services (subsec. G—p. 48).

(3) Fix the qualifications for specialists. The act reads: "Specialist or consultant services shall be those designated by the Surgeon General" (subsec. C—p. 45).

(4) Determine the number of individuals for whom any doctor or dentist may provide service (subsec. J—p. 50).

(5) Determine what hospitals or clinics may provide service for patients and under what conditions (subsec. B—p. 52).

(6) Negotiate or renegotiate contracts or agreements with representatives of public agencies, nonprofit groups, and individuals, for the purpose of providing full medical benefits to all Social Security beneficiaries and their dependents (subsec. C—p. 36).

(7) Make reports to Congress (line 16—p. 41).

Question. Would such a system allow the patient free choice of physician?

Answer. The patient would only have choice of a physician from those who agreed to work under the plan and on condition that the Surgeon General has not so limited that physician's practice as to preclude the acceptance of more patients.

Question. Could such a system be introduced in the United States and still allow for physicians to maintain private practice?

Answer. If all of the provisions of this proposed legislation were put into operation, the process would destroy the private practice of medicine in the United States.

Question. Why do doctors so relentlessly and vigorously oppose these measures?

Answer. Because in every instance where the Government has interfered in the distribution of medical care, it has resulted in:

(1) A serious deterioration in the quality of medical care.

(2) It has destroyed the initiative and the incentives of the individual doctor.

(3) It has robbed the medical profession of its independence and its self-respect.

Question. What about medical education and medical research?

Answer. "The Surgeon General is authorized and directed to administer grants-in-aid to nonprofit institutions and agencies engaging in research or undergraduate or postgraduate professional education" (sec. 213—p. 63).

Question. How much money would be available for this purpose under the proposed legislation?

Answer. For the year 1946—\$10,000,000. For the calendar year 1947—\$15,000,000. For each calendar year thereafter, 2 percent of the amount expended for benefits under the proposed legislation.

Question. How much would this 2 percent total?

Answer. It is estimated that this 2 percent would approximate \$80,000,000 annually.

Question. Would the Surgeon General have full authority to expend or allocate this research-educational fund?

Answer. Yes. The Surgeon General is supposed to consult his advisory council. However, the advisory council has no authority. The act reads: "the Surgeon General is hereby authorized and directed to administer grants-in-aid * * *" (lines 23 and 24—p. 63). The Surgeon General would have authority to expend the sums regardless of the advice of the advisory council.

Question. What would it cost a wage earner to secure medical service under such a plan?

Answer. No provision for pay-roll tax deductions is made under the new bills.

Question. Why was the bill introduced without some provision for a special tax to meet the cost?

Answer. It has been stated on good authority that no provision was made for pay-roll tax deductions in order that the bill might be referred to the friendly Committee on Education and Labor in the Senate rather than the Finance Com-

mittee and to the friendly Interstate and Foreign Commerce Committee in the House rather than the Ways and Means Committee which must deal with all matters affecting taxation.

Question. How will funds be collected to pay this cost?

Answer. It is anticipated that the bill will be amended to provide for pay-roll deductions of wage earners and deductions from the income of the self-employed up to \$3,600 per year. In his message President Truman stated, "a broad program of prepayment for medical care would need total amounts approximately equal to 4 percent of such earnings."

Question. If the amendments provided for pay-roll deductions of 4 percent from the pay envelope of the employee, what would the service cost him each year?

Answer. If the annual earnings were \$1,000 the cost would be \$40. If the annual earnings were \$2,000, the cost would be \$80. If the annual earnings were \$3,000, the cost would be \$120. If the annual earnings were \$3,600, the cost would be \$144.

Question. If two or more people in the family were employed, would the deduction be made from the income of each one?

Answer. Yes. If there are two workers earning approximately equal incomes, the cost would be doubled. If there were three workers earning approximately equal incomes, the cost would be multiplied by three.

Question. Actually, is this socialized medicine as it was defined by President Truman?

Answer. Yes. In his message, President Truman said: "Socialized medicine means that all doctors work as employees of Government." The President's proposals anticipate:

(1) The Federal Government collecting a vast fund out of the earnings of workers of between 3 and 4 billion dollars annually.

(2) Placing the expenditure of this vast sum in the hands of one man, the Surgeon General (under the direction of the Federal Security Administrator), who under the provisions of the Wagner-Murray-Dingell bills is instructed to provide medical, dental, nursing and laboratory care and hospitalization for all people. He would hire doctors and establish rates of pay, etc. (See p. 15 of this booklet.)

Yes, this would be "socialized medicine" in its most vicious and dangerous form.

CONCLUSIONS

The cards are now "face up on the table." The final "showdown" on political medicine is at hand.

For all practical purposes, Title II—Prepaid Personal Health Service Insurance—of the May 24, 1945 Wagner-Murray-Dingell bills (S. 1050—H. R. 3293) and Title II—Prepaid Personal Health Service Benefits of the November 19, 1945 Wagner-Murray-Dingell bills (S. 1606—H. R. 4730) are identical in intent.

These are classical documents. A careful study reveals a remarkable admixture of unimportant verbiage and softening phrases intended to divert attention or to deceive, combined with terse, decisive cold steel directives.

These directives, with the authority provided, would establish the Federal Security Administrator as a medical dictator in the United States. He would be clothed with the power and saddled with the responsibility to provide medical, dental, nursing, and laboratory care and hospitalization for every man, woman, and child in this country. The Surgeon General of the Public Health Service is designated as his administrative officer.

The enactment of the bills into law would destroy the private practice of medicine in the United States. Practically it would make all expectant mothers, all mothers and all children to the age of 21 wards of the "State." Enactment would place the expenditure of more than \$4,000,000,000 annually in the hands of one man—the Surgeon General of the Public Health Service with the approval of the Federal Security Administrator.

It would entail the most vicious and dangerous aspects of socialized medicine. It is estimated that 300,000 bureaucrats would be necessary to administer the system. It would establish machinery for the political distribution of medical care.

The concept is strictly totalitarian. The mechanisms, if adopted and placed in operation, would establish a core of collectivist control under which freedom of enterprise in any form could not long survive. President Truman has given these proposals his blessing.

An unusual crisis of great peril is at hand.

Every person—worker, merchant, doctor, lawyer, businessman—who desires to keep the deadening hand of politics out of the sick room should protest. All of those really interested in preserving our American way of life should register definite and vigorous opposition with their Congressmen and Senators.

Write to them—write or telegraph your protest—today.

HEALTH SECURITY PROGRAM

THE NATIONAL PHYSICIANS COMMITTEE FOR THE EXTENSION OF MEDICAL SERVICE

The management committee has been instructed by the board of trustees to take all necessary steps designed to:

(a) Encourage the medical profession to active participation in the development of plans and the more general use of existing facilities to provide for easy payment of insurance against unusual or prolonged illness;

(b) Educate the people to the importance, nature and value of prepayment facilities (within the framework of principles approved by the medical profession), now available for meeting the costs of unusual illness;

(c) Investigate conditions relating to and inform industry concerning the principles underlying sound participation with employees in prepayment plans for meeting the cost of unusual or prolonged illness and hospitalization;

(d) Inform private insurance underwriters of the opportunity that is being offered through cooperation in Nation-wide efforts to provide group insurance policies for those needing or desiring insurance against the hazards of unusual illness;

(e) Encourage the more generous use of Government funds administered at State and local levels to insure effective medical care for the indigent.

(f) Encourage contributors and friends to a greater degree of participation in the efforts of the National Physicians Committee in this constructive program.

The National Physicians Committee is utilizing to maximum capacity its resources and organizational strength in ceaseless efforts to preserve in the United States our system of private enterprise to the end that: Doctors of medicine may retain, in the public interest, their personal independence—their individual and collective integrity and effectiveness.

Understanding of purpose is sought and cooperation is welcomed in the belief that joint efforts will result in the attainment of these objectives.

NATIONAL PHYSICIANS' COMMITTEE FOR THE EXTENSION OF MEDICAL SERVICE

A non political * * * non profit organization devoted to—

1. The task of securing the most widespread distribution of the most effective methods and equipment in medicine and surgery.

2. Familiarizing the public with the facts in connection with the values, the methods, and the achievements of American medicine.

Maintained exclusively by voluntary contributions.

Needing, for maximum effectiveness, the systematic organized support of all county and sectional medical societies, insurance underwriters, and interested units of business and industry.

BOARD OF TRUSTEES

- | | |
|---|--|
| Dr. Edward H. Cary, Chairman, Dallas. | Dr. Wingate M. Johnson, Winston-Salem. |
| Dr. William F. Braasch, Secretary, Rochester. | Dr. Thomas A. McGoldrick, Brooklyn. |
| Dr. George H. Coleman, Treasurer, Chicago. | Dr. Wm. R. Molony, Los Angeles. |
| Dr. F. F. Borzell, Philadelphia. | Dr. J. Milton Robb, Detroit. |
| Dr. John H. Fitzgibbon, Portland. | Dr. Edward H. Skinner, Kansas City. |
| Dr. Edward J. McCormick, Toledo. | Dr. Lawrence R. Wharton, Baltimore. |
| Dr. Leland S. McKittrick, Boston. | Dr. Raymond L. Zech, Seattle. |
| Dr. Wm. J. Carrington, Atlantic City. | John M. Pratt, Administrator. |

Dr. CARY. The pamphlet finds "acceptable" three provisions in the W-M-D bill—and I shorten the Wagner-Murray-Dingell bill to the W-M-D bill—providing for Federal grants to States for control of tuberculosis and venereal disease; extension of maternal and child

health services through Federal aid; and Federal grants to States to provide medical care for the needy.

The main bulk of the pamphlet is filled with an all-out attack on the bill's vital provision—the one establishing a national compulsory health insurance system giving virtually complete hospital and medical service, together with limited dental and nursing care, to all Americans who work for a living, and to their dependents.

This is a fairly accurate statement. For the record, we want to make it perfectly clear that the National Physicians' Committee for the Extension of Medical Service, at this time and at all times during its existence, has devoted its efforts toward extending better and better medical care to more and more people in the United States, and will vigorously work to achieve this better and better medical care for more and more people.

The reasons for the National Physicians' Committee's approving the first three clauses of the Wagner-Murray-Dingell bill and opposing the compulsory health insurance provisions, are obvious and clear-cut.

ENDORSEMENT OF TITLE I

Referring to part A of S. 1606, titled "Grants to States for Public Health Service," page 1 of the bill, the medical profession and the public, when it is explained, are in favor of steps to be taken to provide treatment and control of tuberculosis and venereal disease and extending the Public Health Services through grants-in-aid to States with State control and local administrative authority.

Part B of S. 1606, titled, "Grants to States for Maternal and Child Health Services," page 13 of the bill; with minor amendments this section would become acceptable and would provide an effective mechanism for the achievement of very desirable objectives.

PROPOSED AMENDMENTS TO TITLE I

Over a long period of time, the medical profession has maintained that the activities of the Children's Bureau should be placed under the supervision of the Surgeon General of the Public Health Department. It is believed that this is not only a desirable but an almost necessary feature, leading to the coordination of various health activities throughout the United States.

The second suggested change has to do with the centralizing of training of health service personnel. It is not considered that this is a deciding factor. It is considered to be a desirable one, with the idea of imposing upon State agencies the responsibilities for training maternal and child care personnel.

The really vital and essential change can be accomplished by slight modification in subsection 8 of section 122, at the top of page 16. This paragraph should be altered to read as follows:

Provide that as services and facilities are furnished under the plan, they shall be available to all mothers and all children in the State of locality who are unable to pay for such services without hardship, and where such hardship is confirmed by the local unit of the State agency.

It is obvious that such a change is fundamental. However, such a modification of section 8 would insure effective maternal and child care for every mother and every child in this country. It would re-

lieve the Federal Government of a financial obligation that would run into billions of dollars and expenditure annually. It would maintain the independence of the medical profession and insure to all the highest possible quality of medical care.

Part C, titled, "Grants to States for Medical Care of Needy Persons," page 26 of the bill; it is our studied opinion that by the addition of some 12 or 15 words in section 181 of part C of S. 1606, provision could be made for the achievement of the avowed objectives of all the protagonists of compulsory health insurance in this country. The changes would be:

Line 5, inserting the words "including hospitalization" after the word "care," and deleting in line 6 the word "needy" and inserting after the word "persons" the words "to whom the payment for such services would be a hardship." This vital paragraph would then read as follows:

For the purpose of enabling each State to provide medical care including hospitalization as far as practicable under the conditions in such State, for persons to whom the payment for such services would be a hardship 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.

End of the suggestion for amending that subsection.

Thus, modified section B of S. 1606 would create the machinery for establishing State agencies which would be provided with funds to insure full medical care through local groups to every man, woman, and child in the United States.

Under such provisions, all the objectives so extensively detailed under title II of S. 1606 would be provided, but would require the "matching" of all Federal funds with State funds for the accomplishment of the purpose. This would eliminate the necessity for the limitlessly cumbersome machinery that would be entailed under the provisions of title II of this proposed legislation, and let us set about the task of providing medical care on a basis that is:

First, actually preferred by the people of the United States.

Second, wholly acceptable to the medical profession.

Third, that would insure the continuation and further improvement of the most effective medical service that has ever been provided.

ENDORSEMENT OF S. 191

In addition to approval, as qualified, of clauses A, B, and C of S. 1606, we are wholeheartedly in favor of the Hill-Burton bill, S. 191, which on December 11, 1945, was passed by the Senate and now is awaiting action by the House. Due largely to concentration on essential war efforts and the resulting lag in construction of health facilities, there is an urgent need for health center and hospital buildings. This need is universally recognized.

The Hill-Burton bill, S. 191, would make available Federal funds for surveys of hospital needs and grants-in-aid to States, and grants to political subdivisions and nonprofit agencies to supplement local funds to insure the building of adequate facilities. It has our unqualified approval.

OPPOSITION TO TITLE II

The PM stated that the main bulk of the National Physicians' Committee literature is filled with an all-out attack of the bill's vital provision—one establishing a national compulsory health insurance system. It is obvious that if the actual purpose of this legislation is to provide full medical care for all persons to whom payment would be a hardship, full and adequate provision will have been made by enacting into legislation the first three sections of S. 1606, with the safeguards that have been indicated, and Senate bill 191.

Our opposition to title II of S. 1606 is based on:

First, our conviction that the establishment of this kind of a system would lead to a serious deterioration in the quality of medical care for all people, rich and poor alike.

Second, it would establish a core of centralized control, applying to the most sacred and vital wants of every human being, which once established would require a miracle for free enterprise in any of its forms to survive.

HEALTH INSURANCE A REVOLUTIONARY CONCEPT

Title II of this legislation is truly and limitlessly revolutionary in its purpose and scope.

First, it would introduce an actually revolutionary concept in social security, as we know it in the United States. Under existing law, employment offices are maintained, under Federal and State control, to find jobs for the unemployed. Provisions are made for aid to the aged, the blind, and for dependent children. Payments are made in cash. To beneficiaries under the Social Security Act, compensation is paid during period of unemployment. Payments are made in cash. Retirement benefits, death benefits for surviving relatives, monthly allotments for widows and dependent children are provided. The payments are made in cash. The new Wagner-Murray-Dingell bills would place in the hands of the Federal Government responsibility for providing medical care and hospitalization for all social security beneficiaries and their dependents. Authority is given a single political appointee to hire doctors and establish rates of pay; to control and operate hospitals and actually dispense medical care to 110,000,000 people. No cash payments are involved. Assuming that at least 100,000 physicians would be needed to service the plan, then in effect the Federal Government would establish 100,000 retail medical outlets, man them, and conduct the business of providing medical care, to say nothing of dental, hospital, and nursing services provided for in the bill.

Second, such a move would represent a revolutionary change in our whole concept of the distribution of medical care and of medical care as such. It presupposes standardization and mechanization of administering medical care. Such procedure would involve making the doctor subordinate to the bureaucrat. It would mean the regimentation of the medical profession. Consummation of the plans inevitably would result in absolute regimentation of the people as far as medical care is concerned. They would be forced by law to accept such medical care as could be provided by the politically appointed administrator, or pay twice for the same service.

MEDICAL CARE WOULD DETERIORATE UNDER S. 1606

There are few people in this or any other country, even among the supporters of this revolutionary legislation, who do not acknowledge the actual superiority and effectiveness of the type of medical care that is provided by our free and independent medical profession. There are some factors in this situation that are somewhat difficult to understand, but they are vital to an intelligent solution of the problem which is generally recognized.

This vital quality of American medicine is aptly described in an editorial in a recent issue of the *Journal of the American Medical Association*, which quotes as follows from Sir Lionel Whitby in his inaugural lecture as regius professor of physics in Cambridge University:

The simple facts are that medicine is both a science and an art. It is true that medicine will never be an exact science, because the normal variations in individuals have such a wide range that automatic and mechanical treatment is prohibited, while every patient requires a different method of approach according to his psychology. But one of the attractions of the profession is the personal and individual character of its practice: the latitude with which a qualified doctor may exercise his own judgment, express his own opinions, and practice his own art. This, indeed, is one of the strongest objections to nationalization and standardization. If the profession of medicine be robbed of its scope for individuality, the soul will go out of it.

This can all be simply covered by the statement that medical care such as has been provided the American people, cannot be measured by the hour, piece, or pound. The National Physicians' Committee has been and will continue to be in vigorous and uncompromising opposition to entrusting to any centralized authority the responsibility for the distribution of medical care and hospitalization for 110,000,000 people. The proponents of this legislation attempt to make the public believe that more people would secure better medical care. On the basis of every experience, the reverse is the inevitable result.

During the course of these hearings some statements have been made which may or may not actually contribute to the factual information that should lead to a satisfactory solution of the problem of the distribution of medical care. In the course of his remarks before the committee, Senator Claude Pepper departed from the normal practice with the following statement, which I quote:

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.

I am the chairman of the board of trustees of the National Physicians Committee, and have been since the committee was organized in October 1939. I think it essential that it be known that the National Physicians Committee for the Extension of Medical Service is exactly what its name implies. It is strictly an independent committee, representing physicians throughout the United States. It has many local and State groups that support its point of view.

SUPPORT OF THE COMMITTEE BY THE DRUG MANUFACTURERS

The term "patent-medicine manufacturers," used by Senator Pepper, was apparently one of disdain, intended to discredit the institu-

tion of which I am a part. For the record, may I say that during its more than 6 years of operation, not one of these so-called patent-medicine manufacturers has endeavored to influence the policies or point of view of the committee, or exert any influence in the expenditure of its funds. Actually, these firms to which Senator Pepper has referred are almost exclusively manufacturing pharmanists. These are the institutions that gave to us for war use the sulfa drugs, atrabine, and penicillin. These are the firms which, with mass-production techniques, became a deciding factor in the saving of lives within our armed services. Of them, Col. Parren H. Long said less than a week ago:

Their genius for organization and production should receive the highest praise from a grateful people.

A bulletin recently received from the British Medical Society stated, "Their genius for mass production"—referring to atrabine, the sulfa drugs, and penicillin—"became a vital factor in the winning of the war."

I want to place myself on record as being proud of having as supporters these men of the pharmaceutical manufacturing industry, who have so valiently contributed both in times of war and peace.

We do not have to go far afield for actual examples of the results of the political distribution of medical care in the United States. Less than a year ago, the discovered abuses within the Veterans' Administration provided irrefutable evidence of nepotism and patronage dispensing, that led to carelessness and a lack of effectiveness in action that actually startled the United States. This was of such a nature and of such proportions that General Bradley, the new Administrator of Veterans' Affairs, has approached the solution of care for the veterans on a wholly different basis, decentralizing the control, and attempting in every case, as nearly as possible, to provide veterans with the type of medical care that is available to the civilian population.

In September of last year, the National Physicians Committee engaged the services of Dr. Herbert D. Simpson, professor emeritus of economics of Northwestern University, to make a study of the incidence, development, progress, and prospects of physician-sponsored medical-care plans throughout the United States. In the text of this prepared study, now in the hands of the publishers, Dr. Simpson points out that physical revolutions always follow in the wake of scientific discovery and revolution; that there must always be a lag between the scientific development and its universal application.

Approximately 150 years ago, the steam engine was invented. It led to what is now known as the industrial revolution. Fifty years ago, the internal combustion engine was developed. Certainly, it has revolutionized transportation throughout the world, making possible the automobile and the airplane. Yet nearly half a century passed before 20,000,000 automobiles dotted our highways. Scientists have discovered the principles, applied them, and invented the atomic bomb. The repercussions from this development will be visible in concentric circle form for all of the remaining generations of men.

During the last 150 years, the progress in the scientific development of medicine has been without parallel in the annals of history. During the last 50 years, the range of knowledge has so expanded and the

discoveries have been of such import, that it amounts to an actual revolution. Dr. Simpson points out that we are in the process of applying this new knowledge on a universal basis. Given time, we can, without sacrificing our birthright of independence and freedom, continue to provide the American people with the most effective medical care ever imagined in this world, made available to an ever greater and greater number of people. I, personally, am not afraid of revolutionary change, if the change represents progress. The proposals under title II of this bill represent revolutionary change that could not mean anything other than retrogression and deterioration of our medical care and the loss, eventually, of our freedom.

The CHAIRMAN. Doctor, are you a practicing physician?

Dr. CARY. Yes, sir.

The CHAIRMAN. Where do you practice?

Dr. CARY. In Dallas, Tex.

The CHAIRMAN. Dallas, Tex. Are you a member of the American Medical Association?

Dr. CARY. Yes, sir.

The CHAIRMAN. How long have you been a member of that Association?

Dr. CARY. Since 1901, I think.

The CHAIRMAN. And the American Medical Association is the important association of the medical profession of the United States, is it not?

Dr. CARY. It represents the doctors in this country.

The CHAIRMAN. It is a well-organized and well-managed organization?

Dr. CARY. The most wonderfully democratic organization you know anything about, or, we know anything about.

The CHAIRMAN. And it has among its members the ablest members of the profession?

Dr. CARY. I would feel sorry for anyone interested in the profession who did not belong to it. There is no barrier; just a question of whether he is considered eligible in his home town.

The CHAIRMAN. Now, are the members of this National Physicians' Committee members of the American Medical Association, also?

Dr. CARY. Yes, sir.

ORIGIN OF THE NATIONAL PHYSICIANS' COMMITTEE

The CHAIRMAN. Why was it necessary for the National Physicians' Committee to take on the task of opposing this legislation? Weren't the members of the American Medical Association competent to handle that task?

Dr. CARY. I can answer that, I think, to your satisfaction, Senator. I am sure you remember the President of the United States appointed in 1935 an interdepartmental committee for study of medical care. And in 1938, in July, there was a meeting in Washington, to which very few doctors were invited. A great many so-called social workers, and welfare workers, and do-gooders were there in great shape; and to our consternation, the medical profession generally throughout the United States, we woke up and recognized that the greatest propaganda organization we had ever known or heard of was attempting to change the whole practice of medicine.

Senator DONNELL. What was the date of this doctor?

Dr. CARY. July 1938. A lot of us had been interested in the welfare of the people of this country a long time, and we recognized this particular group making this particular study had a perfect right to have their own ideas and all that kind of stuff, and they were projecting something into the body politic of this country and had created all at once the greatest propaganda machine backed by the Government that any of us had ever seen or heard of.

The CHAIRMAN. That is this interdepartmental committee you have described?

Dr. CARY. When that took place. It was not a great while following that until the American Medical Association was charged with criminally violating the—

Senator DONNELL. Antitrust?

Dr. CARY. Antitrust laws. Now, we are not so dumb, we doctors. We have some smart folks, just like you Senators, and we recognized that there was a limitation to what the American Medical Association could do under its own charter. It is and was created for the purpose of education and aiding public health. Now, we are independent doctors, we belong to the organization, we know all about the organization, we know all about those purposes, we know all about the possibilities; but we felt there should be some means of combating the greatest propaganda machine that had ever become created affecting the welfare of the people of this country, and affecting us as doctors; and we proceeded to create the National Physicians' Committee, and I think, Senator, unless you pass more restrictive laws, that we have a right to our opinion and have a right to organize and combat anything we think is bad for the people of this country.

The CHAIRMAN. So the limitation imposed upon the American Medical Association by their charter made it necessary for them to carry on any opposition to this proposed legislation, and this fight against this propaganda machine—

Dr. CARY. You are attempting to say through us, that is what you mean.

The CHAIRMAN. Yes, of course.

Dr. CARY. I would say this, that they would be very simple-minded if they did not appreciate what the doctors of this country could do independently, things which they could not do themselves, by the A. M. A. going along its way of publishing many, many scientific journals and trying to do good for the people of this country and other countries without regard to this; but we are really interested in this kind of legislation. That is our legislation.

The CHAIRMAN. But you are working with the American Medical Association, and you have the endorsement of the American Medical Association?

Dr. CARY. Fortunately, when the house of delegates had a meeting I think they passed a resolution. We were gratified.

Senator DONNELL. What is the date of the resolution?

Dr. CARY. This resolution was unanimously adopted December 5, 1945.

National Physicians' Committee is governed by a board of trustees of 15, all of whom are doctors. The members are elected by the vote of physicians who have contributed to the committee.

The activities of the committee have been clearly defined and publicly announced ever since its inception. They are implemented by a paid staff under the direction of a management committee of the board of trustees.

The house of delegates of the AMA has endorsed the activities by resolution, I quote:

Whereas the members of this house of delegates as well as physicians throughout the United States are cognizant of the increasingly effective work of the National Physicians' Committee for the extension of medical service in familiarizing the public with the values, methods, and achievements of American medicine; therefore be it

Resolved that we reaffirm our approval of the activities of the National Physicians' Committee and commend the board of trustees and the management of this institution for the effectiveness of their efforts.

The CHAIRMAN. So that your organization has the approval and endorsement of the American Medical Association and its house of delegates?

Dr. CARY. I would certainly be greatly disappointed if they did not approve what we were doing.

The CHAIRMAN. They approve all of your activities in your efforts to oppose this legislation?

Dr. CARY. I think they approve our efforts in trying to enlighten the doctors of this country and trying to waken the doctors of this country and the public.

The CHAIRMAN. And the manner in which you are undertaking to accomplish that?

Dr. CARY. In the manner in which I think is very satisfactory.

The CHAIRMAN. Yes.

Dr. CARY. It seems to trouble you a little bit.

The CHAIRMAN. I do not like to have you become personal, Doctor. I am treating you courteously, and you should not be discourteous.

Dr. CARY. I do not mean to.

The CHAIRMAN. I am trying to conduct this hearing as I have all hearings with fairness. I know you are a very smart man.

Dr. CARY. Oh, no. No.

The CHAIRMAN. I am very serious about this and am trying to conduct this meeting on a high plane of dignity and fairness.

Dr. CARY. I will help you.

The CHAIRMAN. I do not want to get any ill feeling in it.

Dr. CARY. I will help you.

The CHAIRMAN. I have not said one word which should cause you any offense, have I?

Dr. CARY. Not up to the present time; I am just looking forward to it.

The CHAIRMAN. Your answer is indicative. Please answer the questions and do not fill the record with a lot of irrelevant observations that have nothing to do with the hearing.

Dr. CARY. Well, let us go.

The CHAIRMAN. It seems to me that you do not really represent the great medical profession when I consider your attitude and manner. I usually find medical men to be of fine character, men with nice personalities, and intelligent, agreeable men to talk to.

Dr. CARY. All right.

The CHAIRMAN. Please try to conduct yourself as if you were a member of the American Medical Association and in good standing in that very fine body.

Dr. CARY. That may sound good in the record, but I want to say that I think I appreciate the fine points as well as you.

Senator AIKEN. Are you an M. D., Doctor?

Dr. CARY. Yes, sir.

Senator AIKEN. All right.

The CHAIRMAN. Well, now, the American Medical Association Journal, too, has expressed approval of your organization, and I find in the Journal an article appearing for February 3, 1946, the following:

The National Physicians' Committee has been the most effective of all the organizations striving to mold public and legislative opinion in the field of medical care. Its efforts have been repeatedly endorsed by the house of delegates of the American Medical Association. This agency has used syndicated newspaper publicity and editorial opinion, newspaper advertising, pamphlets, radio, direct-by-mail solicitation, education, and every other technique of public relations in its work. Currently some thousands of representatives of medical industries are encouraging everyone whom they meet or interview to communicate directly with the Congress expressing opposition to the compulsory sickness insurance feature of the national health program and to the Wagner-Murray-Dingell bill. In many communities joint action by physicians and medical industries has been stimulated to the insertion of advertising in the press, the use of local radio, and other public relations work against state medicine. From 12 to 15 million pamphlets were circulated in the attack on the previous Wagner-Murray-Dingell bill, which passed into innocuous desuetude, and many millions of pamphlets are now being circulated through drug stores, supply houses, hospitals, and other medical agencies. Through this group, also, physicians are being educated as to the details of the proposed legislation, and they will be encouraged to make direct contact with legislators from their own States to make certain that the legislators are fully informed. The budget approximates several hundred thousand dollars, and the funds are, as nearly as I can determine, efficiently and economically used. The medical profession owes a great debt of gratitude to the distinguished physicians who serve as the directing board of the National Physicians' Committee and to the staff who carry out so effectively the policies that this board establishes.

Now, Doctor, in carrying on and conducting your work you solicit funds from the medical profession and from others, do you not?

Dr. CARY. Yes.

EXEMPTION OF CONTRIBUTIONS FROM INCOME

The CHAIRMAN. I will ask you to examine this photographic document of your organization that I pass to you, [handing document to Dr. Cary] and look at the bottom of it. It states there that these funds you are soliciting are deductible in income-tax reports.

Dr. CARY. That is true.

The CHAIRMAN. You claim they are deductible?

Dr. CARY. Yes; that is true.

The CHAIRMAN. You have had correspondence with certain people with reference to this problem, have you not?

Dr. CARY. I beg your pardon; I did not quite get that.

The CHAIRMAN. You have had correspondence with people about the subject of whether or not these funds which you solicit and expend are tax deductible?

Dr. CARY. When asked, I am sure that the general office has always answered in the affirmative.

The CHAIRMAN. Well, I have a series of letters here, Doctor.

Here is a letter from the National Physicians' Committee signed by John M. Pratt. Who is John M. Pratt?

Dr. CARY. He is our administrator.

The CHAIRMAN. This letter is addressed to Robert N. Nye, managing editor, the New England Journal of Medicine, Boston, Mass., as follows:

Answering your letter of December 9, will say that we have continuously advised physicians that payments made to the National Physicians' Committee were deductible from income-tax returns.

If this privilege is withdrawn it will be because some curious people insist upon a definition that includes the color of eyes, the length of hair, and the tilt of the nose. You will note that in your quotation the Bureau states "contributions made to that organization do not constitute allowable deductions in the Federal income-tax returns of the donors under section 23 (O) of the Internal Revenue Code."

The facts in the case are, Dr. Nye, that as far as our knowledge goes some 25,000 individual doctors who have made contributions have made these deductions and they have been allowed by the Treasury Department. It seems to us unimportant that the allowance should have to conform to any particular subsection of any section of the act.

The important thing, is deductions have not been questioned. You will understand, of course, that occupying the position that we do occupy it would be of some advantage if each and every one of the men who have some few cents involved, or even a few dollars involved, do not feel it necessary to take the matter up with the Treasury Department.

I hope this letter fully explains the position we have taken and the substantial reasons for advising that contributions are deductible. I should be pleased to have your further remarks in this connection. May I take this opportunity to wish for you and yours a merry Christmas and a more than generous share of the best that the approaching holiday season may have to offer.

Sincerely yours,

JOHN M. PRATT.

National Physicians' Committee for EMS.

The CHAIRMAN. Here is a letter from Dr. Nye, dated December 17, 1943, which reads as follows:

DEAR MR. PRATT: I must say that I fail to agree with the remarks contained in your letter of December 11, particularly the statement, "It seems to us unimportant that the allowance should have to conform to any particular subsection of any section of the act."

I do not know much about such matters, but it appears that the NPC is considered to be a nonprofit business association, such as a chamber of commerce. Organizations of this type are exempt from income taxes but are subject to social security taxes; dues paid to them are deductible as business expenses, whereas donations are not.

Under the circumstances, there appears to be no point in dodging the issue, and I believe that the NPC has no right to make the statement that contributions are deductible. Undoubtedly physicians will continue to claim deductions and will get by since the Federal inspectors are not in the habit of checking back on the correctness of the deductions in lists of small donations.

Best wishes for the Holiday Season.

Sincerely yours,

ROBERT N. NYE, M. D.,
Managing Editor.

There follows another letter from the National Physicians Committee for the Extension of Medical Service to Bernard Reis, Bernard Reis & Co., 10 East Fortieth Street, New York, N. Y., dated December 13, 1945:

DEAR MR. REIS: This will acknowledge receipt of your valued letter of November 29 in connection with tax exemption for contributions to the National Physicians Committee.

The institution has been officially granted exemption from the payment of income tax under section 23 (a) (1) (A) of the Internal Revenue Code. The Treas-

ury Department will not issue blanket authorizations for the deductions by contributors.

Over a period of 6 years approximately 200 leading drug manufacturers and members of allied industries have contributed financially to the support of this institution. Approximately 25,000 physicians have made individual contributions. As far as our information goes, all of these contributors have deducted the amounts from income tax returns, and to the best of our knowledge and belief, none has been disallowed or even questioned.

It is generally accepted that "the proof of the pudding is in the eating." On this basis, financial contributions to the National Physicians Committee are tax exempt for contributors.

Sincerely yours,

THE NATIONAL PHYSICIANS COMMITTEE,
FOR THE EXTENSION OF MEDICAL SERVICE,
JOHN M. PRATT, *Administrator*.

According to this, it appears that your organization feels that "the proof of the pudding is in the eating," and that if you can induce people to make contributions to your organization, recommending to them that they are deductible, that as long as they get by with it, it is all right?

Dr. CARY. No, Senator, this matter was taken up with the Revenue Department, and as I understand it, in 1941, we did not have the right to deduct or to say to anyone that they could deduct their donations from income tax.

The CHAIRMAN. You did not have that right?

Dr. CARY. Under 101.

The CHAIRMAN. You did not have that right?

Dr. CARY. We understood that from the Revenue Department that we did not, but under section 107, we were granted the right.

The CHAIRMAN. What is section 107?

Dr. CARY. You are the lawyer. Here it is right here. Internal Revenue Code, section 101, Exemption on Corporations. The following organizations are to be exempt from taxation under this chapter, and then No. 7, business leagues, chambers of commerce, real estate boards, or boards of trade, not organized for profit, no part of it which inures for the benefit of any private shareholder or individual. The Revenue Department in Washington has classified us under that section, and we had a perfect right to make that statement.

The CHAIRMAN. You told them that you are soliciting these funds for the purpose of carrying on this?

Dr. CARY. I did not carry on this thing with the Revenue Department, but I understand it was done in a perfectly fair legal manner, and the Revenue Department could safely say that we did not, under section 101. We did not claim so, but under section 107 we do, and they were granted that privilege.

The CHAIRMAN. Did you make a complete statement to them explaining exactly what your organization was set up to do and what it was doing?

Dr. CARY. I am not quite certain that a complete statement was made. I did not do it myself.

The CHAIRMAN. Who did it, then?

Dr. CARY. That I would have to look and find out. I am sure it was done through, possibly, our lawyer that represented us, and maybe that he went to the Revenue Department to find out exactly what our status was.

The CHAIRMAN. Have you any correspondence with the Department, the Treasury Department, on such?

Dr. CARY. I think we can furnish it. We have not got that here, but we could furnish that.

The CHAIRMAN. I would be glad to have you furnish it for the record.

Dr. CARY. We can furnish it.

Under that section we have been able to proceed and the office has been able to write letters of that character.

The CHAIRMAN. You are entitled then to make this statement now, you claim?

Dr. CARY. Right now.

The CHAIRMAN. To tell the doctors and the pharmaceutical organizations, institutions of the country, that they have a right to make contributions to your organization and to claim them as deductible?

Dr. CARY. Whatever the revenue authorities permitted us to do.

The CHAIRMAN. I am asking you a direct question, I am asking if you feel that you have a right, and that you are now making the statements to the public that the public have a right, to make contributions to your organizations and claim them as deductible?

Dr. CARY. I do not see how any one, I mean, with the decision of the revenue authorities, how they could differentiate from one to the other.

The CHAIRMAN. Well, your answer is unintelligible to me. I am trying to get you to answer this question.

You feel that you are entitled—

Dr. CARY. Yes, sir, I feel that.

The CHAIRMAN. That you are now?

Dr. CARY. That any one who donates any funds to this organization—

The CHAIRMAN. Are deductible?

Dr. CARY. Will fall within the lines of the revenue authorities' decision.

The CHAIRMAN. I took this matter up with the Treasury Department.

Dr. CARY. Well, maybe you took it up on 101.

The CHAIRMAN. Here is a letter that I received, I wrote to the Treasury Department, and this is a letter which I received back from them. I wrote to the Secretary of the Treasury, the Honorable Fred M. Vinson, on March 7, 1946.

DEAR MR. SECRETARY: I am writing with respect to the National Physicians Committee for the Extension of Medical Service, an organization operating as a corporation under the statutes of Illinois, and having its offices at the Pittsfield Building in Chicago, Ill. An investigation of this organization by the Bureau of Internal Revenue is clearly in order.

This organization, commonly known as the National Physicians Committee, engages extensively in propandaganda activities intended to influence legislation, particularly to oppose congressional enactment of national health insurance.

I have received reports that the National Physicians Committee advises prospective donors that contributions or donations may be deducted from income tax returns. Since the committee is mainly a propandaganda organization, and very actively engages in efforts to influence legislation, I believe that donations to it are subject to particular and important limitations as to deductibility from income subject to income tax. From the evidence which has come to my attention, it would appear that the National Physicians Committee has wilfully mis-

informed and misled its potential and actual contributors as to the deductibility of donations to it.

There are a number of questions, therefore, that are of particular importance.

To what extent are donations to the National Physicians Committee deductible by individual physicians? By associations of physicians? By drug manufacturers and other firms engaged in pharmaceutical business? By firms engaged in other fields of business?

To what extent have physicians, pharmaceutical firms, and other business firms making contributions to the National Physicians Committee correctly or incorrectly claimed deductions or exemptions from income tax?

May I suggest that in order to throw light on these and related questions, the Commissioner of Internal Revenue be directed to investigate the extent to which donations to the National Physicians Committee have been improperly deducted in tax returns?

It seems to me that if the National Physicians Committee has misinformed and misled its contributors as to deduction of contributions from income-tax returns, such steps should be taken and such penalties imposed as are provided by law.

For your information, I enclose several documents, pertinent to the inquiry, that have come to my attention.

Sincerely yours,

JAMES E. MURRAY.

I received a letter from the Treasury Department in this matter, from the Acting Secretary of the Treasury, which reads as follows:

TREASURY DEPARTMENT,
Washington, April 5, 1946.

MY DEAR SENATOR: Further reference is made to your letter dated March 7, 1946, and enclosures, in which you request information with respect to an organization known as the National Physicians Committee for the Extension of Medical Services which has its offices in Chicago, Ill.

You state that the committee engages extensively in propoganda activities intended to influence legislation, particularly to oppose congressional enactment of national health insurance; that you have received reports that the National Physicians Committee advised prospective donors that contributions or donations may be deducted from income-tax returns; and that you believe, from the evidence that has come to your attention, that the National Physicians Committee has willfully misinformed and misled its potential contributors as to the deductibility of donations to it.

You particularly request to be advised to what extent contributions made to the National Physicians Committee by individual physicians, by associations of physicians, by drug manufacturers and other firms engaged in pharmaceutical business, and by firms engaged in other fields of business are deductible for Federal income-tax purposes; and to what extent the above-named groups of taxpayers have correctly or incorrectly claimed deductions for contributions made to the committee.

The National Physicians Committee for the Extension of Medical Service has been held to be a business league under section 101 (7) of the Internal Revenue Code. There is no provision in the code under which contributions, as such, made to a business league are allowable as deductions in the Federal income-tax returns of the individual donors.

Contributions to business leagues may in some instances be deductible as business expenses. Section 23 (a) (1) of the Internal Revenue Code provides for the deduction in computing net income of:

"(A) * * * All the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business, * * *."

In view of what you have said about the nature of the activities carried on by this organization, it should be pointed out that the regulations of the Bureau of Internal Revenue with respect to ordinary and necessary business expenses provide, among other things, that "Sums of money expended for lobbying purposes, the promotion or defeat of legislation, the exploitation of propoganda, including advertising other than trade advertising, and contributions for campaign expenses are not deductible from gross income."

The validity of this particular portion of the Bureau regulations was upheld by the Supreme Court of the United States in the case of *Teatle Mills Corporation v. Commissioner*, (314 U. S. 326).

Accordingly, if it is determined that contributions to the National Physicians Committee for the Extension of Medical Service fall within the above-quoted provision of the regulations, such contributions would not be allowable deductions as business expenses. Claims for deductions made by taxpayers in their returns for contributions to this organization will be investigated as their returns are audited and will be determined in accordance with the principles that have been set forth.

You will appreciate, I am sure, that the information you request as to the extent to which deductions have been claimed is not available to the Bureau of Internal Revenue in any compiled form.

The information which you submitted has been carefully examined, and it appears that the matter contained in a copy of a letter from the National Physicians Committee may be misleading. Therefore, in order to clarify this situation, the Commissioner of Internal Revenue is taking this matter up direct with the committee.

Very truly yours,

JOSEPH J. O'CONNELL, Jr.,
Acting Secretary of the Treasury.

I also have a letter, that is, a further letter which I sent to Mr. O'Connell, the Assistant Secretary of the Treasury, dated April 10, 1946, which reads as follows:

DEAR MR. O'CONNELL: Thank you for your letter of April 5.

I am glad to learn that the Treasury Department is investigating—

- (1) The extent to which the National Physicians Committee has misinformed and misled its contributors as to deductibility from income tax returns; and
- (2) The extent to which contributions to the National Physicians Committee have been illegally deducted from income tax returns.

Although the National Physicians Committee has the right to lobby against the administration's health insurance program, it has no right to finance its activities at the expense of the Federal Treasury. It has no right to solicit contributions from drug companies and doctors on the ground that such contributions are deductible from tax returns.

In conducting this investigation, I am confident that the Treasury Department will obtain the full list of contributors to the National Physicians Committee and make an intensive investigation of the major contributions from large drug and patent medicine companies. It may well be found that over a period of years the Government has lost considerable money through illegal deductions by these larger corporations.

Naturally it will be important to go back over a period of years rather than to limit the investigation to tax return for 1945.

It seems to me that any violations of our revenue laws—whether by the National Physicians Committee in misinforming its contributors or by contributors to the National Physicians Committee in illegally deducting their contributions—should be dealt with through using the full penalties provided by law.

In view of the importance of this investigation, I should appreciate hearing from you within the near future as to the progress that has been made.

Sincerely yours,

JAMES E. MURRAY.

Doctor, you have sent out considerable propaganda in connection with your activities. I show you here a "bulletin."

Dr. CARY. First, Senator, I would like to deny that we have in any sense attempted to violate the revenue laws of the United States. I would like to state that this kind of thing went out to doctors, and we felt we were absolutely—and have the necessary papers in order to submit to your committee, authorizing this kind of thing. The next thing is that any contributions that have come to us have been entirely voluntary. And if anybody has sent us any contribution, they usually have, themselves.

The CHAIRMAN. When you say they are entirely voluntary, do you mean by that—

Dr. CARY. No coercion.

The CHAIRMAN. That you do not solicit any?

Dr. CARY. I would not say that this did not imply that we would not like to have them send a certain amount of money. That is all right, but it is a voluntary gift. No one is under pressure to do it.

The CHAIRMAN. But, of course, the contribution or donation is made in response to your solicitations and due to your activities, due to your publicity?

Dr. CARY. Senator, you take up a collection sometimes in church. That is voluntary, too.

The CHAIRMAN. Well, sure. I mean to say that these funds are not pouring into your organization without being prompted by your publicity and your solicitations?

Dr. CARY. We could not operate unless we had some support.

The CHAIRMAN. That is true.

Dr. CARY. That is true, but I would like to say this, that there is no gift of money to us by any drug firm who has not got well organized tax information, they have lawyers, they have everything in the world, they know exactly what they are doing, and they would also know the provisions under which we would operate, and they would also know what we have said would be proved, and they would act accordingly. There is nothing that we are trying to regulate in that.

The point is that I do not feel that you should leave an impression here that we have deliberately tried to go around the revenue laws of this country.

The CHAIRMAN. The facts speak for themselves.

Dr. CARY. I know, but the implication is there, and I do not think the implication is fair, that is all.

The CHAIRMAN. But the facts speak for themselves, and the correspondence from your agency to these people that you are seeking funds told them that "the proof of the pudding is in the eating."

Dr. CARY. All right.

The CHAIRMAN. And that if they were able to get away with it—

Dr. CARY. Whenever the Revenue Department changes its opinion about this, the literature will carry that with it, so we won't have any argument on that.

The CHAIRMAN. But the fact remains that you, when it was suggested to you that the Revenue Department might insist on these donations not being deductible, you told your prospective donors that "the proof of the pudding is in the eating," and that no one yet had been investigated, and no one yet had been compelled—

Dr. CARY. At least the revenue authorities, to our knowledge, did not change their point of view.

The CHAIRMAN. You expect the revenue authorities to change that?

Dr. CARY. No; I said that at least, so far as we were concerned, or to our knowledge, had not changed their point of view.

The CHAIRMAN. Had not changed?

Dr. CARY. Had not changed their point of view.

The CHAIRMAN. That was always the law, according to the correspondence that we have had with the Department here.

Dr. CARY. Well, we will submit the grounds under which—we will submit to your committee the grounds under which we feel that we operated under section 107.

The CHAIRMAN. Well, it is very clearly set forth in the statement from the Treasury Department there that the——

Dr. CARY. Let me make this observation——

The CHAIRMAN. Pardon me. Let me complete my question.

Dr. CARY. Yes, sir.

The CHAIRMAN. The correspondence with the Treasury Department there states very clearly that you are subject to tax on this matter, that is, the donors are, and you have no right to circulate literature in this country advising innocent donors——

Dr. CARY. That is the first time that we have heard this.

The CHAIRMAN. Let me complete my question, please.

Dr. CARY. You are not questioning me. I think you are debating.

The CHAIRMAN. I insist on you doing this, because now I do not think it is fair for you to come here and act in such an arrogant, overbearing manner, and not permit me as Chairman——

Dr. CARY. I am trying to defend what you are charging me with.

The CHAIRMAN. I want to tell you that you cannot do this. It is not fair, and you are not acting in a manner in which you are going to win any respect in this room today, either. I am trying to conduct this proceeding with fairness to you.

Dr. CARY. All right.

The CHAIRMAN. I have allowed you to make your full statement.

Dr. CARY. All right.

The CHAIRMAN. Without interrupting you once.

Dr. CARY. All right.

The CHAIRMAN. It is true, is it not, that the Revenue Department has stated very clearly that these donations are subject to taxation.

Dr. CARY. The point is that that is the first time I have heard that.

The CHAIRMAN. Well, without hearing it, and without having any knowledge of the matter.

Dr. CARY. That is what I was trying to say when you said that I was interrupting you.

The CHAIRMAN. Let me complete my question.

Without having any knowledge and direct legal advice on it, you have circulated this literature among the public in which you have undertaken to make the prospective donors believe that they are not subject to taxation on these donations.

Dr. CARY. Based upon the information that we had from the Revenue Department.

The CHAIRMAN. Well, you will answer that to the Revenue Department, of course. I do not believe other taxpayers of the United States can get away so easily as that in evading their income taxes. I have the utmost sympathy for these people who have made the contributions to your organization. I do not wish to impugn their motives or actions in any manner. They have been led into this by you and your organization in sending out literature of that kind, and I do not wish to have my remarks here construed or intended as in any manner impugning their motives or their conduct.

Dr. CARY. Senator, you do not mind, I am sure, my resenting somewhat the implication that we deliberately did so and so, and operating under the decisions which we had ourselves, we thought we were operating correctly and within the law.

The CHAIRMAN. You thought so?

Dr. CARY. And I would like to leave it there.

The CHAIRMAN. The taxpayers of the United States, generally, find that they must know what they are doing when they are making their income-tax returns, and that they have no right to assume things that do not justify them in evading their taxes. So I am sure that when you take this matter up with the Treasury Department you can have that matter adjusted.

In your statement here, Doctor, you tell about the funds that you collected up to October 31, 1945, making a total, you say of \$905,359.23.

What collections have you made since that time?

Dr. CARY. There has been, I think, over \$125,000 from the medical profession. For the 5 months up to April 1, 1946, it has expanded \$246,222.82, and for the same period \$162,000 was in voluntary contributions from the doctors.

The CHAIRMAN. Can you segregate and give us the contributions that you received from business firms?

Dr. CARY. 90 percent of that, the remainder, was from business firms.

The CHAIRMAN. 90 percent?

Dr. CARY. Yes.

The CHAIRMAN. And 10 percent came from the medical profession?

Dr. CARY. No, no, no. The medical profession was 54.3 percent.

The CHAIRMAN. I mean this subsequent collection.

Dr. CARY. This subsequent collection is \$162,000 from the medical profession against \$246,000.

The CHAIRMAN. How much from the business concerns?

Dr. CARY. Well, in all probability the same ratio would apply.

The CHAIRMAN. In addition to the collections that you have taken up, how much money was spent in addition to what you have accounted for by advertising that was paid by individuals, physicians, dentists, and drug stores?

Dr. CARY. Well, now, Senator, the medical profession has been disturbed very deeply about this type of legislation and they have carried on in their own way throughout the United States, not stimulated by us, but separately through the general desire to meet the situation. They have carried on advertisements of their own. In other words, county medical societies, with some of their friends, have paid for page advertisements, and that would happen in different parts of the country. I think many millions of people have read literature that was brought out in that kind of manner.

The CHAIRMAN. In other words, you prepare literature in your office and send it out to various parts of the country?

Dr. CARY. You would be surprised to know how many other people are doing the same kind of thing.

The CHAIRMAN. I am not disputing that. I am merely talking about your organization.

Dr. CARY. Well, I think they used some of our literature, because it is pretty good.

The CHAIRMAN. Well, yes. You send it out to them and they think it is pretty good.

Dr. CARY. They ask for it.

The CHAIRMAN. And they pay for publishing in in the newspapers across the country?

Dr. CARY. Not wholly our literature. They utilize that in writing their own literature and things of that kind.

The CHAIRMAN. Here is an ad appearing in the Daily Sun, Goose Creek, Tex., Saturday, March 2, 1946, which has the signature of a great number of doctors at the bottom of it.

Is that literature that you have prepared?

Dr. CARY. I have never seen it; never saw it in my life, but I do know that that has happened time and again in various parts of the country, and it is an awfully little town, too, don't you know, you can hardly find it.

The CHAIRMAN. You supply this literature to the medical profession, and in your statement that you gave here this morning, you say that you have carried on this educational campaign?

Dr. CARY. We think so.

The CHAIRMAN. You call it an educational campaign?

Dr. CARY. We think so.

The CHAIRMAN. And you have gotten out pamphlets and sent them across the country to the medical profession and to every one that could be reached?

Dr. CARY. Every one we hope will read it.

The CHAIRMAN. I have here some samples of your literature which I would like to submit for the record.

Dr. CARY. If you do not mind, Mr. Senator, we would just submit the whole file here. We have lots of them. Maybe you have not seen them. We will submit the whole file.

The CHAIRMAN. Let me look at them. This literature goes to the medical profession and others that receive it, as you say. Here is one pamphlet that you have that says, "Show-down on Political Medicine." You refer to this bill S. 1606 as political medicine?

Dr. CARY. That is, at least, our conception of what it leads to.

The CHAIRMAN. And you also refer to it as socialized medicine?

Dr. CARY. We think it is, if enacted.

The CHAIRMAN. This literature, generally, is along that line, entitled "Political Medicine" and other names, such as that. "State Medicine" is another name you give it.

Dr. CARY. We are not the only ones who coin names, you know, and terms.

The CHAIRMAN. That is right. That seems to be a prevalent habit in this country, but I do not think that it is the right way to have important legislation considered. It seems to me that if your organization wishes to conduct a campaign of education over the country, it should refrain from misrepresenting or distorting the provisions of the bill and should confine itself to presenting legitimate objections and criticisms of it.

Dr. CARY. Senator, we have presented here a statement which I think has a lot of constructive ideas in it. We may differ very materially in the application of the suggestions, but unquestionably, after very great consideration on our part, knowing something about this situation, we have offered in this address, which I hope you will take occasion to read, at least, some suggestions which we think will be very vital in the welfare of the people of this country.

The CHAIRMAN. I would like to ask you—

Dr. CARY. And I think those constructive points that we have tried to raise put us in a position of trying to be helpful rather than trying to be obstructive.

The CHAIRMAN. Well, the American Medical Association appeared here the other day with several very competent witnesses who testified on this subject, and we are willing to listen to their recommendations, and they were given a very——

Dr. CARY. I was here.

The CHAIRMAN. Satisfactory hearing.

Dr. CARY. You were very courteous to them and everything was lovely, and I have offered this——

The CHAIRMAN. We have been very courteous to you.

Dr. CARY. You have.

The CHAIRMAN. And you have appeared here and given your testimony without any objection or interference in any manner, and we hope that you will feel free to express yourself on this legislation, even though your testimony seems sometimes somewhat slightly biased.

Dr. CARY. Well, I would not speak of you, Senator, at all.

The CHAIRMAN. I would like to ask you this question: How many business organizations have contributed \$10,000 to your organization?

Dr. CARY. I really would not be able to say. I know that there has been 97 business organizations, as my record shows, about 97 business organizations who have been deeply interested in this whole effort of ours, and out of this effort, many of them have become very beautifully educated and have put into their own industrial plans very advanced social programs. It has been remarkable to me how the businessman who, apparently, knew so little of what could be done, have really adapted programs and plans in which they are now, many of them, covered in the most elaborate manner, much to the satisfaction of their employees.

The CHAIRMAN. Yes. Well, now, you have not told me——

Dr. CARY. They did not have any conception of how they should do it. We do not tell them how. And that is not the point, but we are trying to encourage in every way in all industry that they will do the same thing that is being done, we will say, by the Abbott Chemical Co., and the Eli Lilly Co., and any number of companies that have really the most comprehensive plans for the care of their employees, and it has been a very encouraging thing to me, as a doctor interested in this whole plan, the whole situation, to see industry fall into line, and industry was so backward about all of this thing. Industry is doing that now and they are doing it very willingly as they see other plants operate.

The CHAIRMAN. That is all very interesting, but you have not answered my question.

Dr. CARY. What is your question?

The CHAIRMAN. I asked you how many people have contributed \$10,000 to your organization.

Dr. CARY. I would not be able to tell you offhand, but I think we can furnish it.

The CHAIRMAN. Will you furnish that for the record?

Dr. CARY. We will be glad to furnish that.

The CHAIRMAN. Will you also furnish for the record the other donations that you have received in sums of \$1,000 or more?

Dr. CARY. I do not know, Senator, whether you have attempted to find out from any other group that has come before you information of this kind. We have bared our expenditures here.

The CHAIRMAN. Yes, sir.

Dr. CARY. And we have told you what we have collected.

The CHAIRMAN. I am not asking you that.

Dr. CARY. So and so, but do you not think that you had better treat all of us alike?

The CHAIRMAN. Yes, sir.

Dr. CARY. I do not know of any other group that has come before you that has even been asked whether they got their money, what they were doing with it.

The CHAIRMAN. I suggested yesterday—

Dr. CARY. But when you do that, I think we ought to be all treated alike. We have bared this thing. We have given you the facts there, and I think that is all right.

The CHAIRMAN. Nevertheless, Doctor, I have asked you to do this. I want you to submit for the record here the donations that you have received. Will you or will you not do that.

Dr. CARY. I do not know whether that is the thing that we should do or not.

The CHAIRMAN. Well, all right, I just want you to go on record as declining to give us that information.

Dr. CARY. I am not declining. I am just—

The CHAIRMAN. You do not know whether you will or not?

Dr. CARY. That is the point. I think we have been very liberal about this whole thing.

The CHAIRMAN. You have been very liberal and generous in every way, I am sure. I appreciate your great generosity.

I noticed in your statement here, Doctor, on page 11, you said:

We do not have to go far afield for actual examples of the results of the political distribution of medical care in the United States. Less than a year ago, the discovered abuses within the Veterans' Administration provided irrefutable evidence of nepotism and patronage dispensing,"

and so forth and so on.

Did your organization uncover that situation, Doctor?

Dr. CARY. I can say this, that as an individual, if you will allow me to discuss it as an individual, talking to General Hines some years ago, he asked me why it was that he could not get internes in his hospital. And I said, "General, what do you pay them?"

He said, "I pay them \$150 a month," but he said, "I do not get the ones I want, I do not get the kind I want."

"Well," I said, "General, as a young doctor graduating, in Bellevue in New York, I fought for the opportunity of becoming an interne, in that hospital. That hospital did not pay any of us anything. That hospital offered an educational opportunity for the young man. It offered something that young men were willing to put their time into and to devote their lives to, and money could not buy that." "Now," I said, "General, if you will build your hospitals somewhere where you can get the best medical talent and can have an educational program in your hospital, you will get good internes and you will give the veterans a better service."

Now, that was not done. I do not mean to say that that conversation was one that I expected to have any bearing upon the question. It was purely a conversation between General Hines and myself, but I had some knowledge of educational affairs and what constituted making a good doctor, and so on, and so on.

Now, to my delight, and to the delight of the American medicine, General Hawley came out to the House of Delegates in December with a program which was one that General Bradley had endorsed and understood and made that kind of an appeal, in which he expected to get from the medical profession that kind of help which would change the whole setup as regards how these patients would be treated. And he said, "We will build hospitals as close to medical centers, and not out here in the country, and we will expect you doctors to cooperate to give these men the kind of talent that we need, and we do not want just paid men in the hospital. We want to use the doctors. And I am opposed," he said, "to state medicine." It was very inspiring address and the medical profession responded immediately to it, and over the United States today the doctors are cooperating in every way in the world.

Down in my own town, for instance, my own school, we are asking to provide the proper doctors for Ashborn Hospital. It could not be opened without it.

Congressman Rayburn can tell you about it. That is at Lisbon Hospital. It has been there for a long time, a veterans' hospital, and is now being manned by men who go there, not necessarily living there, but go there and help in giving to these veterans service. And the whole picture has changed, and they can get residents, and they can get young doctors to come and stay, because it is an educational program where these people get service, and that is what we are talking about.

The CHAIRMAN. So you claim then that you were the one, or your organization—

Dr. CARY. Oh, no.

The CHAIRMAN. That discovered these abuses?

Dr. CARY. Oh, no, no, no. This is a recital of the general attitude that has been supplied by many members of the veterans.

The CHAIRMAN. Do you not know that the exposé that started that situation was made by a reporter here in the Congress, a reporter named Albert Deutsch who wrote the article which made the exposure, and which started the investigation which led to these improvements?

Dr. CARY. There was a man named Maser, I think, that preceded him in writing a very interesting article about this whole thing in one of the magazines. I cannot say that definitely. That can be supplied.

The CHAIRMAN. The Treasurer's report of your organization, presented at the National Physicians Committee meeting in December, 1944, in New York, showed the following information, that 75 percent were registered from the pharmaceutical trade, 20 percent from the medical profession, and 5 percent from insurance men.

Dr. CARY. You mean at that meeting?

The CHAIRMAN. That is the report of your Treasurer of your organization.

Dr. CARY. You mean the meeting?

The CHAIRMAN. Yes, at that meeting.

Dr. CARY. Well, those meetings of that kind have been held, really, for us to see and know these gentlemen a little better and for them to know what we have done. They do not offer any suggestions. They do not tell us what to do, but do like to know how it is done. And

that is not a meeting called for doctors. Doctors in New York come to them.

The CHAIRMAN. I have another document here that I want to introduce, a "Bulletin" from the National Physicians Committee. The "Bulletin" is the one I just showed you a little while ago. You recognize this "Bulletin" issued from your concern?

Dr. CARY. Those informational, or those are informational bulletins. I think this is a photostatic copy.

The CHAIRMAN. I ask that be incorporated in the record.

Dr. CARY. That is a photostatic copy of that.

(The Bulletin referred to is as follows:)

BULLETIN

NATIONAL PHYSICIANS COMMITTEE

DEDICATED IN THE PUBLIC INTEREST TO PRESERVING FOR DOCTORS OF MEDICINE
THE DISTRIBUTION OF MEDICAL SERVICE IN THE UNITED STATES

The Pittsfield Building, Chicago, Ill.

NOVEMBER 26, 1943.

To Contributors and Friends:

REPORT MAILED

On the following pages of this Bulletin is reproduced a confidential report that is being mailed to all physicians in continental United States. It is deserving of careful consideration by all interested in preserving the framework of private medical practice and the free enterprise system in the production and distribution of drugs and medical supplies.

PROGRAM OFFICIALLY ADOPTED

At the annual meeting of the National Physicians Committee board of trustees (Chicago, November 20, 21) a greatly expanded program of educational efforts was formulated and officially confirmed. With unanimous approval the following resolution was adopted:

"Whereas, the preservation of the principles fundamental to maintaining the quality of American medicine requires the development and encouragement of plans for meeting the cost of unusual or prolonged illness; and

"Whereas, a survey of methods already available for prepayment costs indicates that facilities are in existence to provide for at least the most pressing demands: therefore be it

Resolved, That the management committee is authorized and the administrator is authorized and instructed, to proceed with efforts designed to:

"(a) Encourage the medical profession to active participation in the development of plans and the more general use of existing facilities to provide for easy payment of insurance against unusual or prolonged illness;

"(b) Educate the people to the importance, nature and value of prepayment facilities, within the framework of principles approved by the medical profession, now available for meeting the costs of unusual illness;

(c) Investigate conditions relating to and inform industry concerning the principles underlying sound participation with employees in prepayment plans for meeting the cost of unusual or prolonged illness and hospitalization;

"(d) Inform private insurance underwriters of the opportunity that is being offered through cooperation in Nation-wide efforts to provide group insurance policies for those needing or desiring insurance against the hazards of unusual illness;

"(e) Encourage contributors and friends to a greater degree of participation in the efforts of the National Physicians' Committee in this constructive program."

This resolution was approved on the understanding that the activities outlined, if undertaken on a scale adequate to the need, would necessitate expenditures of approximately \$500,000 annually.

CONFIDENTIAL REPORT—12 MONTHS NATIONAL PHYSICIANS COMMITTEE OPERATIONS,
NOVEMBER 1, 1942—OCTOBER 31, 1943

The National Physicians' Committee for Extension of Medical Service was formally established in October, 1939. Its operations are based on a fiscal year beginning November 1 and extending to October 31.

For the 12 months period ending October 31, 1943:

Income and expenditures were—	
Income from physicians and physicians groups.....	\$103,493.81
Income from all other sources.....	94,012.16
Total revenue.....	197,505.97
Expenditures (current operating).....	¹ 154,545.28
Receipts over expenditures.....	42,960.69
Contract Commitments—Printing & Research.....	40,724.00

ADMINISTRATION—SALARIES

National Physicians Committee is administered by a board of 14 physician trustees. The executive officer in charge of management and operations is John M. Pratt. Since July Mr. Pratt, in addition to necessary stenographic and clerical employees, has had one office and one field assistant.

Salaries—Executive and assistants.....	\$22,983.33
Salaries and wages—Clerical.....	7,304.00
Rent, light, heat.....	1,861.32

Total operations overhead (16.3 percent of income)..... 32,148.35

¹ Major items of expenditure are printing, \$53,997.09; letter processing and mailing costs, \$17,606.09; postage, \$14,972.43; editorial service and research, \$10,404.67.

Tabulations, by States, of number of civilian physicians, number NPC contributors, total contributions of individual physicians, average contribution, number of 28-page booklets mailed, and number of 8-page pamphlets mailed to doctors, Nov. 1, 1942, to Oct. 31, 1943

	Number civilian physicians	Number N. P. C. contributors	Total contributions of individual physicians	Average contribution	Number of booklets	
					28-page	8-page
Alabama.....	1,554	39	\$607.00	\$15.56	2,113	8,514
Arizona.....	373	25	385.00	15.40	487	5,065
Arkansas.....	1,257	44	728.00	16.54	1,881	7,152
California.....	7,600	412	5,712.00	13.09	14,285	93,187
Colorado.....	1,253	72	833.00	11.57	3,453	14,091
Connecticut.....	2,005	74	995.00	13.44	4,323	11,613
Delaware.....	248	12	136.00	11.63	621	1,647
District of Columbia.....	1,253	35	442.00	12.63	1,562	4,145
Florida.....	1,456	83	1,114.00	13.42	2,565	25,006
Georgia.....	2,080	56	1,030.00	18.39	3,279	15,121
Idaho.....	285	49	535.00	10.92	1,033	8,640
Illinois.....	8,320	530	9,044.00	17.06	17,306	156,265
Indiana.....	2,812	134	1,783.00	13.30	4,316	29,396
Iowa.....	2,080	73	722.60	9.89	3,566	22,115
Kansas.....	1,388	68	1,048.00	15.41	4,627	13,800
Kentucky.....	1,927	55	739.00	13.44	3,035	11,700
Louisiana.....	1,808	96	1,555.00	16.37	6,019	46,190
Maine.....	681	24	311.00	12.96	1,345	4,635
Maryland.....	2,262	272	4,875.00	17.92	5,373	85,474
Massachusetts.....	5,761	152	1,900.00	12.50	7,096	43,357
Michigan.....	4,468	246	6,797.00	27.63	8,812	67,530
Minnesota.....	2,523	284	2,620.00	9.23	4,071	23,637
Mississippi.....	1,095	39	468.00	12.00	1,753	4,872
Missouri.....	3,855	173	2,276.00	13.15	7,694	80,680
Montana.....	383	33	440.00	13.33	3,675	13,970
Nebraska.....	1,178	85	1,184.00	13.92	1,872	13,352
Nevada.....	105	4	125.00	31.25	337	825
New Hampshire.....	486	22	244.00	11.08	921	7,165
New Jersey.....	3,655	167	1,967.00	11.77	7,211	27,197
New Mexico.....	268	18	257.00	14.27	415	3,590
New York.....	18,528	719	8,907.00	12.38	29,683	91,478
North Carolina.....	2,107	113	1,545.00	13.67	3,854	35,327
North Dakota.....	390	20	267.00	13.35	662	4,401
Ohio.....	6,489	309	3,980.00	12.88	10,435	104,273
Oklahoma.....	1,635	78	1,026.00	13.15	2,841	15,976

Tabulations, by States, of number of civilian physicians, number NPC contributors, total contributions of individual physicians, average contribution, number of 28-page booklets mailed, and number of 8-page pamphlets mailed to doctors, Nov. 1, 1942, to Oct. 31, 1943—Continued

	Number civilian physicians	Number N. P. C. contributors	Total contributions of individual physicians	Average contribution.	Number of booklets	
					28-page	8-page
Oregon.....	1,002	54	\$843.30	15.62	\$3,029	14,645
Pennsylvania.....	9,604	560	7,458.50	13.32	18,677	83,474
Rhode Island.....	690	29	308.00	10.62	921	6,355
South Carolina.....	1,039	63	849.00	13.47	1,901	28,499
South Dakota.....	357	30	478.00	15.93	580	7,693
Tennessee.....	2,126	116	1,978.00	17.05	5,535	34,101
Texas.....	4,796	320	4,967.00	15.52	17,165	66,473
Utah.....	455	26	330.00	12.69	615	7,375
Vermont.....	369	12	84.30	7.02	448	1,320
Virginia.....	2,148	96	1,203.00	12.53	3,254	18,269
Washington.....	1,409	115	1,800.00	15.65	2,067	40,745
West Virginia.....	1,314	95	1,194.00	12.56	3,466	34,458
Wisconsin.....	2,657	89	1,113.00	12.50	3,809	21,190
Wyoming.....	154	8	140.00	17.50	283	2,625
	121,718	6,227	89,343.70	\$14.35	234,271	1,468,308

	<i>Average</i>
Total contributions involving physicians.....	\$89,343.70 \$14.35
From 132 medical societies.....	9,636.11 73.00
From 38 hospitals, clinics, etc.....	4,514.00 118.79

Total income from physician services..... 103,493.81

Number of booklets

	<i>28-page</i>	<i>8-page</i>
Distributed through physicians.....	234,271	1,468,308
Distributed through drug stores, insurance companies, and others.....	321,895	8,185,584
	556,166	9,653,892

FOUR YEARS

During its 4 years of operation approximately 25,000 individual physicians have contributed to the support of NPC.

During the 12 months' period—November 1, 1942, to October 31, 1943—approximately 12,000 physicians, individually and through groups, have made possible the effective beginnings of the most comprehensive and broad-scale educational and research efforts ever undertaken in the United States by any professional group. Details are published on adjoining pages and in the literature accompanying this report.

Nation-wide research survey

The NPC has employed the largest research institution of its kind in the United States to make a Nation-wide survey of public opinion in relation to:

1. The status of physicians in the community.
2. The adequacy of medical care.
3. Medical service plans.
4. Compulsory health insurance.

The survey has been under way since July 1. A preliminary report was made on September 28. Final reports will be available on or about January 15, 1944.

Preliminary findings

On the basis of "pilot survey" data, it has been determined that:

- (a) The doctor holds a high—the highest—place in the esteem of the public;
- (b) The public is satisfied with the quality and availability of medical care; but
- (c) The preponderant majority of the public state that it is essential to provide a method for meeting the costs of prolonged or unusual illness.

The task ahead

If the medical profession refuses or fails to meet the demands of the public—a method or methods for meeting the costs of unusual illness—government will assume, gladly assume, the responsibility. The independence of the profession will be sacrificed. The quality of medical care and our highest level of health will be jeopardized.

Facilities are available

It has been determined that—through prepayment plans under physician sponsorship, industrial medical plans, industry cooperation with employees to provide group insurance, private companies providing health insurance policies and other methods—adequate facilities are available to meet every demand.

Nature of task indicated

The need—the essential—in the situation is for a gigantic, truly Nation-wide educational effort to enlighten the public as to the nature, the value, the availability of these facilities and how to use them most effectively.

The nature and the scope of the problem has been determined. A broad and solid foundation on which to build has been laid. The "know how" has been acquired.

NOW

It is apparent that necessities are indicated of many times the extent and scope of previous efforts. The future of every practicing physician and every medical student is involved. A question is posed:

Will the profession accept the challenge, acknowledge the essentials, and take steps to meet the realities on a scale adequate to the need?

NPC FUNCTION, METHODS, AND STATUS

The functions of NPC are—

(a) To aid, without qualification, in all-out efforts to win the war—and the peace;

(b) To preserve during a period of revolutionary changes the framework of private medical practice in the United States;

(c) Through the encouragement of prepayment medical service plans and informing the public of the nature and value of facilities available—to seek the most widespread distribution of the most effective methods and equipment in medicine and surgery.

Methods of NPC—NPC holds that: The only real security for the profession and the only real safeguard for the public lies in an understanding by the people—130,000,000 people—of the methods, the achievements, and the values that have resulted through our system of the private distribution of medical care. Its program is one of public education—informing the public.

The status of NPC—Actively working with NPC in effective and truly nation-wide efforts are individual representatives of drug and surgical instrument manufacturing societies; wholesale, retail, and chain drug-store associations, and some insurance groups.

AMA HOUSE OF DELEGATES ENDORSEMENT

On June 9, in Atlantic City, the house of delegates of the American Medical Association adopted a resolution of endorsement of the National Physicians Committee. The resolution reads:

"Be it resolved, That we register our approval of the activities of the National Physicians Committee for the Extension of Medical Service, commend the board of trustees and the management of this institution for the efforts they have made to enlighten the general public in connection with American medicine's methods, progress, and achievements and in pointing out that the public has a vital interest in the final result; and be it further

"Resolved, That it be declared the policy of this house of delegates to encourage this effort and similar efforts with identical purposes."

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS ENDORSES

The annual meeting of the AMA house of delegates (Chicago, June 7-10, 1943), by formal action established a council on medical service and public relations.

Subsequently the council defined general policies. Clause 7 of A Statement of General Policies (of the council) reads:

"There is no official affiliation between the American Medical Association and the National Physicians Committee. However, since it is the purpose of the National Physicians Committee to enlighten the public concerning contributions which American medicine has made and is making in behalf of the individual and the Nation as a whole, it is the opinion of the council that the medical profession may well support the activities of the National Physicians Committee and other organizations of like aims."

The NPC has a record of effective effort. To adequately meet the developing crisis it urgently needs the support of every medical group and every practicing physician in the United States.

Senator DONNELL. Doctor, you were born in Alabama, were you not?

Dr. CARY. Yes, sir.

Senator DONNELL. And your early educational training was in the Union Springs Academy; is that right?

Dr. CARY. Yes, sir.

Senator DONNELL. And then you went to New York City and received your medical degree from Bellevue Hospital Medical College; is that right?

Dr. CARY. Yes, sir.

Senator DONNELL. You interned at Bellevue and at the New York Eye and Ear Infirmary; is that correct?

Dr. CARY. Yes, sir.

Senator DONNELL. You live now in Dallas, Tex.; is that right?

Dr. CARY. Yes, sir.

Senator DONNELL. How long have you lived there, Doctor?

Dr. CARY. Since 1901.

Senator DONNELL. And did you start immediately after you got back to practicing your profession?

Dr. CARY. Well, within a very few months. The death of my brother took me back to Texas. My brother lived there, and his family, and I was guardian for his children. I tried to go back to New York but that became such a serious matter with the family that I went back and opened my office in the Linz Building, and I think, in maybe October or September, or October, of that year.

Senator DONNELL. Is the Linz name quite a well-known name in Dallas?

Dr. CARY. They have been leading jewelers there for 77 years, something like that.

Senator DONNELL. Is that the way the Linz Building acquired its name, from that family?

Dr. CARY. Yes, sir.

Senator DONNELL. You have been practicing continuously in Dallas, have you, ever since 1901, or thereabouts?

Dr. CARY. Yes, sir.

Senator DONNELL. Approximately 45 years?

Dr. CARY. Yes, sir.

Senator DONNELL. Do you know Senator Tom Connally?

Dr. CARY. Very well.

Senator DONNELL. I call attention, Mr. Chairman, at this point, to this portion of the Appendix of the Congressional Record of day before yesterday, April 17, 1946. This is an extension of the remarks of Hon. Tom Connally of Texas, in the Senate of the United

States, Wednesday, April 17 (legislative day of Tuesday, March 5), 1946.

Mr. CONNALLY. Mr. President, I ask unanimous consent to have printed in the Appendix of the Record some newspaper clippings respecting Dr. E. H. Cary, of Dallas, Tex., a very famous and outstanding physician and surgeon of my State.

There being no objection, the clippings were ordered to be printed in the Record, as follows:

[From the Dallas (Tex.) Daily Times-Herald of February 21, 1946]

"DR. E. H. CARY ACCORDED 1945 LINZ AWARD HONOR—PHYSICIAN CHOSEN FOR LEADERSHIP IN MEDIC CENTER

"Dr. Edward Henry Cary,"—is that yourself?

Dr. CARY. Edward Henry Cary, yes.

Senator DONNELL (reading):

"Dr. Edward Henry Cary, outstanding Dallas eye surgeon and medical educator for nearly half a century, was acclaimed Thursday as the outstanding citizen of Dallas during 1945 for his work as founder and guiding genius of the great medical center of the Southwestern Medical Foundation."

How large a city is Dallas, Tex?

Dr. CARY. Well, we claim quite a few, I think it is 400,000.

Senator DONNELL. Somewhere between 300,000 and 400,000?

Dr. CARY. Maybe more than that. We have what we call a metropolitan Dallas; that is, Highland Park; we have a number of very lovely cities that won't come in. It is around 450,000.

Senator DONNELL. Somewhere in the neighborhood of 400,000 or 450,000 people?

Dr. CARY. Yes, sir.

Senator DONNELL. This articles states that you were acclaimed "as the outstanding citizen of Dallas during 1945" for your work as founder and guiding genius of the great medical center of the Southwestern Medical Foundation. (Reading:)

"At a luncheon at noon Thursday at the Baker Hotel Texas Room, Dr. Cary was presented with the annual Linz award, a plaque presented by Linz Bros. That award was presented by Frank McNeny, chairman of the committee which selected Dr. Cary over a field of nominees that included outstanding leaders in many fields of endeavor.

"Mr. McNeny extended his appreciation to Linz Bros., donors of the award, and the Times-Herald, sponsors, declaring the two were 'dominant factors in the development of Dallas to its high state of civic consciousness.'

"In accepting the award, Dr. Cary expressed thanks to Linz Bros., and 'the community of Dallas'.

"So many magnificent men have done their duty in Dallas that to be selected as one of those honored is very gratifying,' he said. 'But I could have accomplished nothing without the support of the newspapers, the Foundation trustees, and the citizenship of Dallas.'

"The award was a silver shield on a mahogany base. On the shield were inscribed the words: 'For the high ideals and noble aims, from which your splendid work has resulted in greatest benefit to the community of Dallas, this presentation is made by Linz Bros.' "

You were presented, as indicated in this article, with a plaque on the shield of which were inscribed the words:

"For the high ideals and noble aims, from which your splendid work has resulted in greatest benefit to the community of Dallas, this presentation is made by Linz Bros."

Is that right?

Dr. CARY. Yes, sir.

Senator DONNELL (reading):

Albert Linz, president of Linz Bros., opened the meeting.

“ONE HUNDRED NINETY-FIVE NOMINATIONS

“The committee had a difficult task in reaching the final decision, Mr. McNeny said, reporting that more than 50 persons were presented in some 195 nominations.

“‘It is a moving thing to read as in a great volume a record of the good deeds of one’s fellowmen,’ Mr. McNeny said of the nominations.

“Among the nominations, those that impressed the committee most were for servicemen, Mr. McNeny said. ‘Their gallantry is not to be compared with mere civic duty.’ But, he pointed out, the rules of the award as set down over many years require that the service be rendered directly to the community.

“Moreover, he said, when all nominations were in, one name led all the rest. In presenting the award, Mr. McNeny said to Dr. Cary:

“DR. CARY’S WORK CITED

“‘The highest achievement of any calling is the character and devotion of the men who give it leadership. It is given to few men to excel in their chosen profession and at the same time to retain the good will and friendship of apparently all of those engaged in the profession.

“‘And it is given to fewer still to rise to the highest national office within the gift of the members of the profession, and to few indeed is given the capacity to combine these accomplishments with that of outstanding civic achievement.

“‘Dallas is deeply conscious of and deeply appreciative also of the great humanitarian institution which is emerging under your fine leadership. If we have properly appraised the sentiments of the community, Dallas expects you to heal its hurts.

“‘On behalf of Linz Bros., the Times-Herald and the Linz award committee, and, too, I presume to speak for the entire community, I esteem it the highest privilege to present to you the Linz award for crowning civic achievement. And by the authority vested in me by these groups, I designate you Dallas Citizen No. 1 for 1946.’

“AIDS MEDICAL CENTER

“As president of the board of trustees of Southwestern Medical Foundation, Dr. Cary saw the dream on which he worked for many years expand into a full-fledged reality during the year just past. Opening in 1943, a war year, the medical school operated by the foundation immediately gained favor of the medical profession.

“During that same year the citizens of Dallas made known their whole-hearted support by contributing \$1,500,000 of which \$1,000,000 was set aside as a building fund. During 1945 the school prospered, gained in student body and faculty and established a strong position in the community. Under Dr. Cary’s leadership, the institution’s future was insured when Dallas again came across with the cash, \$1,315,000 for a 5-year operating fund.

“Throughout the yet short service of the foundation, its driving force has been the Dallas physician, who will be 74 years old next Thursday. Despite his advanced years, a busy medical practice, far-reaching civic leadership and business affairs far beyond the realm of the average medical man, Dr. Cary gave heavily of his time and money to insure the future of Dallas as the medical center of the Southwest.

“COLLEGE GROWS RAPIDLY

“Under Dr. Cary’s leadership the foundation and its college have made rapid strides since opening 32 months ago. The Dallas Venereal Clinic has won national recognition for its work on syphilis. The clinic was selected as one of the five in the Nation to receive grants from the National Research Council. The Buchanan Blood and Plasma Center at Baylor Hospital continued on its program of research and humanitarian work. There are many other outstanding achievements.

"The college already has been ranked class A by the Council on Medical Education of the American Medical Association. During the early months of 1945 plans were begun for the medical school buildings.

"Edward Henry Cary was born February 28, 1872, in Union Springs, Ala., the son of James Milton Cary and Lucy Powell Cary, solid southerners of English descent. He grew up in Union Springs, attending preparatory school at Union Springs Academy. In 1898 Dr. Cary received his medical degree from Bellevue Hospital Medical College, New York University, and interned at Bellevue and at the New York Eye and Ear Infirmary.

"ACTIVE CIVIC LEADER

"Dr. Cary came to Dallas on completion of his internship and immediately went into medical practice and teaching. From 1902 until 1943, when it moved to Houston, he was professor of ophthalmology and otolaryngology and head of that department at Baylor, Dean of Baylor Medical School from 1902 to 1922, he has been dean emeritus since 1929. Other positions at Baylor include chairman of the department of surgery from 1921 to 1929; chairman of the faculty from 1909 to 1920; chairman of the staff of Baylor Hospital during the same period; and chairman of the advisory board of the school and hospital.

"In business affairs, Dr. Cary is president of the Cary-Schneider Investment Co., president of the Medical Arts Hospital, and a director of Republic National Bank. He heads the Cary clinic.

"Other positions include president and chairman of the board of the National Physicians Committee, president of the old Kessler Plan Association, chairman of the district medical examiners board in World War I and member of the Selective Service Appeals Board in World War II, organizer of the Baylor Hospital unit which served in France during World War I, past president of the Texas Philosophical Society, fellow of the American College of Surgeons, member and past trustee of the American Medical Association; and president of a number of medical groups, including the American Medical Association.

Club and lodge affiliations include Critics Club, Dallas Athletic Club, Dallas Country Club, Brookhollow Country Club, thirty-second-degree Mason and a Shriner, and member of the Order of the First Families of Virginia.

I will ask you to state also whether or not this statement in the concluding paragraph of this article in the Dallas Times-Herald is true:

The Linz award is presented annually to the Dallasite who is selected by a committee of judges as having rendered the greatest service to the community during the past year. The award is sponsored by the Times-Herald, which received nominations for a period of several weeks during January and February.

Is that correct, to your knowledge?

Dr. CARY. Yes; it is.

Senator DONNELL. And I call attention also to the fact that this clipping from the Times-Herald is supplemented in the Congressional Record of day before yesterday by another clipping from the Dallas (Tex.) Morning News of February 23, 1946, in which the opening sentence is:

The designation of Dr. Edward H. Cary as the recipient of the Linz award was peculiarly appropriate as viewed against several different backgrounds of civic affairs and development. He clearly deserved the award on the basis of the merit for which it is specifically given: "High ideals and noble aims * * * resulting in greatest benefit to the community of Dallas" during the last year.

Then I read further in the article:

But in winning the award on this basis, Dr. Cary exemplified also the special and increasing need of, and opportunity for, broad service to humanity in a day of specialization. He is a specialist in his own profession, but it was not as a professional that he won the award, even though it was through his profession that he entered the field of civic service in which the choice is made.

Doctor, what is this Southwestern Medical Foundation that is referred to here in this article, of which you are stated here to be the founder and guiding genius?

Dr. CARY. Well, the Southwestern Medical Foundation was created in 1938 for the purpose of raising funds to carry on medical education and scientific research in the Southwest, supported by nonsectarian groups. I have been the head of it for 17 years—the dean—and many, many years more or less in the forefront of it. It is a denominational school which never was able to get any money.

Senator DONNELL. That is Baylor University?

Dr. CARY. Yes, sir.

Senator DONNELL. That is located in Dallas, is it?

Dr. CARY. I attempted to develop this foundation for the purpose of segregating funds so that Baylor would get the full benefit of it.

Senator DONNELL. Pardon me. Baylor was located in Dallas until about 1943, is that right, and then moved to Houston; is that right?

Dr. CARY. Yes. I was going to tell just how that happened, in this sense, in a few words. We have never been able, although we made several campaigns, to get funds to carry on the medical education and research work and things of that kind in the school. All over with a magnificent faculty we have been able to educate and to send out into the world a fine group of young doctors who made marvelous records. They have made marvelous records, but we did not have the funds for research and the funds to carry on, and I have attempted to create this foundation and to gather around men of money and talent and leadership, so that we could accumulate the necessary millions to do this job properly.

While going on with this and having the backing of the medical profession and all of the people, why, Houston was able to offer Baylor some \$2,000,000, and the Baylor board decided that they would go down to Houston, because they would have control of that money, and with us it was a nonsectarian foundation which would not necessarily be controlled by anyone but the foundation group, although the administrative group would have been part Baylor and part ourselves. That necessitated then, as soon as Baylor accepted this fund, which was during the war, and they decided to move. The faculty lived in Dallas. Their student body did not want to leave Dallas. They liked their teachers and all of that kind of stuff. And the appeal of the medical men came to the foundation to go on and develop a medical school to take the place of this situation which had arisen, and so we have proceeded to do that.

Senator DONNELL. Did the people of Dallas make contributions?

Dr. CARY. We amended our charter and were able to carry on this thing, so in 1943, we took over the student body, the faculty, practically all of the faculty, all of the clinical faculty and, practically all of the full time faculty, and employed new men, brought new talent in, and so on and so on, and to cut the story short, I will say that in the last 2½ years, or over a period of 2½, nearly 3 years, we have been able to raise in Dallas, through bond money and through contributions, \$11,500,000, and we have today a medical school down there which I think educators would say is one of the 25 medical schools of this country.

Senator DONNELL. You are president of the board of trustees of the Southwestern Medical Foundation?

Dr. CARY. Chairman of the board of trustees.

Senator DONNELL. I will just read, in concluding these articles: The Dallas Morning News of February 23, 1946, concludes with this language:

There are men who devote themselves exclusively to their specialized fields and, by doing so, greatly benefit humanity. This has been peculiarly true of the field of medicine. But there must always be the Dr. Carys to take the general as well as the specialized view. Otherwise, our social development would fall apart for lack of something to knit it together.

In passing it should be noted that, while Dr. Cary wins the award for 1945, the achievement of the year is really the accumulation of a quarter of a century of untiring effort toward an end. For many years, he has dreamed of a great medical center here, not merely because he aspired to build such a center for his home city, but because he saw the logical need of one for the service of city, of the surrounding region, and—through medical research—service to humanity throughout the world.

The Linz award is fittingly given. The people of the community should follow through with the kind of recognition and support that will fully materialize Dr. Cary's quarter-century vision.

The CHAIRMAN. I am sure, Doctor, that you feel that you are well entitled to that award?

Dr. CARY. Well, I would not make any claims as to that, Senator. Whatever I have done in my community stands for itself. I think you can find out about it from any citizen in my section of the country.

The CHAIRMAN. You are well acquainted, I am sure, with Senator Connally?

Dr. CARY. I know Senator Connally. He frequently comes into Dallas. I know very well the Honorable Sam Rayburn, who, I think, would tell you quite a bit. I know my friend Mr. Sumners, who is retiring from Congress, but who is a magnificent Representative from our State. I happen to know a number of other Congressmen, and I think they know me, and so on. So I won't have to worry about what you find out.

The CHAIRMAN. Are you living in Texas now, or are you spending your time up here; where do you spend most of your time?

Dr. CARY. I came from Dallas up here, and I will go back to Dallas.

The CHAIRMAN. So you live in Dallas?

Dr. CARY. I am about as active, Senator, today as ever, except this, I practice medicine for about 4 hours, and I spend the rest of my time engaged in various and sundry things that are of civic importance, which I am glad to do.

The CHAIRMAN. The activities of this Physicians Committee up here is being conducted by some other officials in the office in your headquarters?

Dr. CARY. We have monthly meetings of the management committee. I do not think anything is done in the National Physicians Committee that is contrary to the views of the board of trustees. We never make a decision, so far as the management committee is concerned, of any importance without asking the board of trustees to pass on it, so that there is perfect harmony of action in that regard.

The CHAIRMAN. You actually participate in the management of the Physicians Committee?

Dr. CARY. I am a nonpaid gentleman.

The CHAIRMAN. Just a philanthropic movement on your part?

Dr. CARY. With me it is a part of the general movement, public welfare. I look at it, possibly, a little different from you. I have been engaged in medical education for all of these years, and I have watched all of this thing. I have been part of the evolution of medical education. I have seen what the doctors have been able to accomplish in raising themselves by their own boot straps. I remember so well when we used to have visitation from English educators and German educators at the Council of Medical Education, and we deplored the lack of educational standards on our own part, and we gradually lifted the medical standard to such a point until we now can point with pride to them and say that the medical schools of this country are better than any medical schools on earth. And it is the kind of doctors that we are trying to turn out.

I want to say another thing. I would like to say that in fundamental—

The CHAIRMAN. Before you leave the subject that you have just been discussing there, you feel that it would be of great benefit to the American people if you could succeed in defeating this effort to make available to the American people, to the fullest degree, modern medical care upon reasonable terms.

Dr. CARY. Senator, we have a far better plan, a far better method, and less expensive one, and we think a more correct one, and we have offered what we might call suggestions here that would modify certain things that would take care of that mass of people that I think you are interested in, those who cannot pay.

The CHAIRMAN. When was this plan prepared that you have in mind?

THE BLUE CROSS PLAN

Dr. CARY. Oh, we have been struggling, in fact, I was a part of the development of the Blue Cross, and the Blue Cross has developed in my town, it started there, it was given credit for it, and, as I say, it started there, and I happen, among my other many things, I do not want to be boastful of what I am interested in, is the very thing that you are interested in, except in a little different way. There is possibly one of the most expansive programs of hospital service.

The CHAIRMAN. The Blue Cross?

Dr. CARY. Yes, sir.

The CHAIRMAN. We have gone into the Blue Cross.

Dr. CARY. This is the State of Texas.

The CHAIRMAN. We have had that.

Dr. CARY. And a parallel organization for medical-surgical service in which \$49.20 will buy all of the essential medical and hospital services for a family regardless of size.

The CHAIRMAN. The Blue Cross?

Dr. CARY. And a man by himself, the single man, would have only to pay \$19.80 for the same thing. And if you do not mind, I will put that in the record.

The CHAIRMAN. That is all right.

(The Blue Cross pamphlet referred to is as follows:)

BLUE CROSS

COMPREHENSIVE SERVICE FOR THE WHOLE FAMILY—COMPANION NONPROFIT PLANS

GROUP HOSPITAL SERVICE

GROUP MEDICAL AND SURGICAL SERVICE, DALLAS, TEX.

Double protection is available to the people of Texas. Group Medical and Surgical Service and Group Hospital Service, the Blue Cross Plan, are companion organizations, both operating without profit.

These plans neither substitute nor conflict with other insurance.

No waiting.—Benefits are given immediately upon acceptance of the group. Red tape is eliminated. When the doctor sends you to the hospital, merely present your membership card. No need to notify anyone but the hospital. Payments on surgical or medical cases are handled immediately and direct with your doctor.

Keep your membership.—When you change or leave employment, merely notify the office of this plan and arrange to pay quarterly, semiannually, or annually at no increase in rates. A service charge of 25 cents is required with each payment.

Millions protected.—More than 20,000,000 Americans have protected their savings and provided for their hospital care through 84 Blue Cross Plans in the United States and Canada, all operating on a nonprofit basis, and the majority supplying surgical service through affiliated nonprofit organizations.

THE MEDICAL AND SURGICAL PLAN

Group medical and surgical service provides:

1. Payments on surgical procedures performed in a hospital. (See schedule at right.)
2. Up to \$3 per day for doctors' services in medical hospital cases after the first 7 days and for a period of 28 days each year.
3. Maternity care after first 12 months (not included under individual contracts).
4. The same protection to all members of the family.

Benefits available to employee, husband or wife, and all unmarried children under 19. Unmarried children between the ages of 19 and 25 may be included as sponsored dependents.

Group requirements: (1) Blue Cross groups with 60 percent of employees; (2) minimum group is 25; (3) monthly payments to be handled through pay roll.

Monthly cost:

Individual	\$0.75
Member and one or more dependents	2.00
Each sponsored dependent75

Non cancelable membership.—Repeated use of services, increasing age, change, or resignation of employment do not cancel membership or increase its cost. The plan is designed to render a service when most needed.

Not included.—The plan includes all general surgical procedures and medical care, but does not include benefits where care is received under State or Federal laws, or for pre-existing conditions, dental or oral surgery, X-ray services, physiotherapy or diathermy, removal of tonsils and adenoids during first 6 months.

Surgical benefits (including obstetrical)

The following schedule designates the payments to be made to apply as credits against the charges of the physician and does not fix the value of his services. When more than one operative procedure takes place at one time, only the maximum allowable benefit will be paid for the major surgery.

Abdomen:

Appendectomy	\$75
Gastrectomy	150
Other cutting into abdominal cavity for diagnosis or treatment of organs therein (unless specified below)	100

Amputation of—	
Thigh -----	\$100
Leg, entire foot, arm, forearm, or entire hand-----	75
Fingers or toes—one-----	15
Each subsequent amputation from same injury-----	5
Anesthesia: Not to exceed -----	10
Breast:	
Simple amputation-----	75
Radical removal-----	150
Removal of cysts or benign tumors-----	25
Abscess, deep—furuncles excepted-----	25
Chest:	
Complete thoracoplasty, or removal of portion of lung-----	150
Other cutting into thoracic cavity for diagnosis or treatment (tapping excepted)-----	50
Initial induction of artificial pneumothorax-----	10
Refills-----	5
Maximum-----	25
Dislocation, reduction of—	
Knee (patella excepted)-----	35
Hip-----	35
Shoulder-----	35
Elbow-----	25
Ankle-----	25
Lower jaw-----	15
Collar bone-----	10
Wrist-----	10
For dislocation requiring open operation the maximum benefits shall not exceed twice the corresponding amount shown above.	
Ear, nose and throat:	
Mastoidectomy: One side-----	75
Both sides-----	100
Tonsilectomy and adenoidectomy-----	35
Under 12 years-----	25
Sinus operation by cutting, including submucous resection (puncture of antrum excepted)-----	50
Submucous resection of nasal septum-----	35
Bronchoscopy for drainage, biopsy, or removal of foreign body or obstruction-----	50
Cutting into trachea-----	25
Other cutting operation (puncture of antrum and tapping excepted)-----	10
Eye:	
Removal of cataract-----	75
Needling of cataract-----	35
Any cutting operation into the eyeball (through the cornea or sclera)-----	50
Cutting of extrinsic eye muscle-----	50
Removal of eyeball-----	75
Other cutting operation on eyeball or eye muscle-----	20
Fracture, treatment of:	
Hip, skeletal traction of internal fixation-----	100
Upper arm-----	75
Kneecap-----	50
Vertebrae (one or more) (coccyx and vertebral processes excepted)-----	100
Legs—	
Tibia-----	50
Fibula-----	35
Femur-----	75
Jaw-----	50
Shoulder blade-----	50
Forearm-----	50
Wrist-----	25
Ankle (both bones)-----	75
Single bones-----	35

Fracture, treatment of—Continued

Finger (metacarpals phalanges)-----	\$25
Toes-----	10
Nose, rib, or ribs-----	25

NOTE.—The amounts shown are for simple fractures—single or multiple. For compound fractures the maximum amount of reimbursement will be one and one-half times the corresponding amount shown. For fracture requiring open operations the maximum amount of reimbursement will be twice the corresponding amount shown but in no event to exceed an aggregate of \$150.

Genito-urinary tract:

Removal of kidney-----	\$125
Cutting into or fixation of kidney (other than removal of tumors or stones)-----	100
Removal of tumors or stones in kidney, ureter or bladder:	
By open operation-----	100
By crushing, cauterization, or endoscopic means-----	35
Removal of entire prostate by open operation (complete procedure)---	100
Removal of part of prostate by endoscopic means-----	50
Circumcision:	
New born-----	5
Child up to 12 years of age-----	10
Adult-----	15
Varicocele, cutting operation in hydrocele, excision, or incision and treatment of sac (tapping excepted)-----	25
Stricture of urethra—open operation-----	50
Intra-urethral cutting operation-----	25
Goitre: Thyroidectomy (complete procedures, including ligation of thyroid arteries, to be treated as one operation)-----	150
Hernia, cutting operation for radical cure:	
Single hernia-----	75
More than one hernia-----	100
Joints:	
Opening or cutting into for repair of internal derangement of shoulder, hip, or sacroiliac joint-----	75
Knee joint-----	75
Elbow, wrist, or ankle joint-----	50
Ligaments or tendons:	
Cutting operation-----	25
Suturing of tendons: Single-----	25
Multiple-----	50
Obstetrics and gynecology:	
Normal delivery with pre- and post-natal care-----	50
Caesarian section-----	100
Miscarriage—abortion-----	25
Extra-uterine pregnancy-----	100
Hysterectomy-----	75
Dilation and curettage (nonpuerperal)-----	25
Trachelorrhaphy and Perineorrhaphy-----	50
Paracentesis, tapping of:	
Abdomen, chest, bladder, spine-----	10
For each subsequent paracentesis-----	5
Maximum in any one case-----	25
Ear drum-----	5
Hydrocele-----	5
Joint-----	5
Rectum:	
Abdomino-perineal resection-----	150
Cutting operation for radical cure of hemorrhoids (complete procedure)-----	50
Cutting operation for prolapsed rectum-----	50
Cutting operation for fissure-----	20
Fistula in ano-----	20
Skull:	
Cutting into cranial cavity ("drill taps" excepted)-----	150
"Drill taps"-----	25

Spine or spinal cord:

Operation with removal of portion of vertebra or vertebrae (coccyx and vertebral processes excepted)-----	\$100
Removal of part or all coccyx-----	50

Tumors (Removal by cutting operations):

Malignant skin tumors (not including the lip)-----	15
Malignant tumors of lip-----	25
Malignant tumor necessitating resection of head and neck-----	100
Malignancy of tongue-----	50
Benign tumors, one or more-----	10
Maximum multiple-----	25

Varicose veins:

Cutting operation-----	25
Injection treatment-----	5
Not to exceed-----	25

The benefits of the medical and surgical plan are available for care received in any hospital registered with the American Medical Association.

See the enclosed list of "member hospitals" in which the guaranteed service benefits of the hospital service plan are provided.

The common-sense, American way to pay for health care.

THE HOSPITAL SERVICE PLAN

MEMBER HOSPITAL BENEFITS

1. Room accommodations: An allowance of up to \$5 per day for member, excepting obstretical cases, and up to \$4 per day for dependents, sponsored dependents, and all obstretical cases.
2. Meals, including special diets and infant feedings.
3. General nursing service.
4. Anesthetics and anesthesia up to \$10 each admission.
5. X-ray examinations, up to \$15 each admission.
6. All drugs and medicines, except blood and plasma.
7. Emergency Room Service (see below).
8. All delivery and nursery room service (10 days).
9. Operating room—No limit.
10. Laboratory examinations—No limit.
11. Dressings—No limit.
12. Plaster casts—No limit.
13. Use of Cystoscopic room—No limit.
14. Use of cardiographic equipment—No limit.
15. Basal metabolism examinations—No limit.
16. Use of physiotherapeutic equipment—No limit.
17. Oxygen therapy—No limit.

Maternity care.—Maternity care, including any condition of pregnancy, is available under membership agreements effective and including a husband and wife for a continuous period of not less than 1 year next preceding the date of such care. Maternity care is limited to a total of 10 days during any contract year or period of pregnancy.

Emergency room service.—Accident cases not requiring bed care may receive all emergency room service required within 24 hours after the accident, not including laboratory, X-ray, and physiotherapy procedures.

All illnesses covered.—All illnesses for which members receive care in any registered hospital are covered. No exclusions on illnesses not common to both sexes. Women members pay same rate and receive same benefits as men, except for obstretical care which is provided on dependent coverage basis.

30 DAYS PLUS

The benefits listed for both member and nonmember hospitals are available to each person for 30 days, and one-half the benefits are available for an additional 90 days in each contract year.

Exception.—Maternity care is limited to 10 days.

FAMILY SERVICE

Benefits for dependents are identical with those for members, except room allowance.

BENEFITS IN OTHER HOSPITALS

The cash allowance for services in nonmember hospitals is \$6 per patient day for members for all care except maternity, and \$5 per patient day for dependents, sponsored dependents, and maternity cases. This allowance in maternity cases is limited to 10 days in each contract year.

Reciprocity services.—When through agreements between this plan and other Blue Cross plans, member hospital benefits of other plans are available, any person entitled to and receiving care under this plan may elect to receive member hospitals benefits of another Blue Cross plan instead of the cash allowance for services in nonmember hospitals. This plan has such an agreement with the majority of the Blue Cross plans.

MONTHLY COSTS

Individual	\$0.90
Member and one or more dependents.....	2.10
Each sponsored dependent.....	.60
Enrollment charge (paid by employee only).....	1.00
(There is no enrollment charge for dependents)	

WHO MAY JOIN

Enrollment is open only to members of employed groups, plus the following members of the employee's family:

Dependents.—Wife or husband and all unmarried children between the ages of 30 days and 18 years.

Sponsored dependents.—Unmarried children between the ages of 19 and 25.

NOTE.—Mothers, fathers, brothers, and sisters are not eligible either as dependents or sponsored dependents of the employee.

Group requirements

If the total number of employees is:	The enrollment number required is
5 (minimum group eligible).....	5
6-10.....	All but one
11-30.....	Minimum of 10
31 or more.....	Minimum of $\frac{1}{3}$

No medical examination is necessary—just the word of a Texas worker that he or she knows of no need for hospital care.

SERVICES NOT INCLUDED

The benefits of the plan are not available for:

A. Obstetrical (maternity) care for individual members unless such members apply for and pay the monthly rate applicable to a family group comprised of a member and one or more dependents.

B. Any medical or surgical treatment of any nature received or rendered through or in Veterans' Administration facilities; any services rendered under any other present or future laws enacted by the Congress of the United States or by the legislature of any State, including workmen's compensation; or any services that are available to the patient under any other nonprofit hospital service plan.

C. Hospital admission solely for X-ray, laboratory, electrocardiographic and basal metabolism examinations, or physical therapy not incidental to necessary hospital bed care otherwise required at the time of admission.

D. Care in a health resort or rest home.

E. Provision of special braces, appliances, apparatus, and radium treatments.

F. Treatment for physical conditions existing at the time the patient became a subscriber of the plan.

G. Plastic surgery for conditions existing before the effective date of the agreement.

H. Any care unless, on the effective date of this agreement, the member was an employee of the employer or a member of the group through which the application for this agreement was made.

I. Services in ambulatory (out-patient) cases, (except emergency room service as herein outlined).

OFFICERS

E. H. Cary, M. D., president; president, Southwestern Medical Foundation, Dallas.
 Robert Jolly, vice president; superintendent, Memorial Hospital, Houston.
 L. N. Markham, M. D., vice president; Markham Hospital, Longview.
 Lawrence Payne, secretary, administrator, Baylor University Hospital.
 J. Howard Payne, treasurer; postmaster, Dallas.
 Walter R. McBee, executive director
 Philip H. Overton, general counsel.

OFFICES

Home office: 2022 Bryan Street, Dallas, Riverside 9508.

Area offices:

Abilene: 310 Citizens National Bank Building.
 Amarillo: 510 Amarillo Building.
 Austin: 514 Capitol National Bank Building.
 Corpus Christi: 422 Medical Professional Building.
 El Paso: 401 Roberts-Banner Building.
 Fort Worth: 609 Commercial Standard Building.
 Houston: 1515 Second National Bank Building.
 Lubbock: 421 Lubbock National Bank Building.
 San Angelo: 511 San Angelo National Bank Building.
 San Antonio: 722 Milam Building.
 Tyler.
 Waco: 810 Professional Building.
 Wichita Falls: 716 Staley Building.

DIRECTORS

Chas. F. Ashcroft, president, Sulphur Spring State Bank, Sulfur Springs.
 John H. Burlison, M. D., past president, State Medical Association of Texas, San Antonio.
 Earl M. Collier, superintendent, Hendrick Memorial Hospital, Abilene.
 H. F. Connally, M. D., president, State Medical Association of Texas, Waco.
 J. Chas. Dickson, M. D., Houston.
 George R. Enloe, Fort Worth.
 J. Anderson Fitzgerald, Ph. D., dean, School of Business Administration, University of Texas, Austin.
 Mrs. Alfreda P. Hassel, superintendent, Medical and Surgical Memorial Hospital, San Antonio.
 Harry G. Hatch, superintendent, Northwest Texas Hospital, Amarillo.
 C. J. Hollingsworth, superintendent, West Texas Hospital, Lubbock.
 Wayne J. Holmes, administrator, Wichita Clinic Hospital, Wichita Falls.
 W. E. Justin, H. J. Justin & Sons, Fort Worth.
 Chauncey D. Leake, Ph. D., dean, Medical Branch University of Texas, Galveston.
 F. T. McIntyre, M. D., San Angelo.
 M. J. Norrell, secretary, Magnolia Petroleum Co., Dallas.
 B. E. Pickett, M. D., Carrizo Springs.
 Mrs. Josie Roberts, superintendent, Methodist Hospital, Houston.
 E. A. Rowley, M. D., Amarillo.
 Ben Taub, J. N. Taub & Sons, Houston.
 Tol Terrell, president, Texas Hospital Association, Fort Worth.
 Sister Mary Vincent, superintendent, Providence Hospital, Waco.
 Eva M. Wallace, administrator, All Saints Episcopal Hospital, Fort Worth.

TEXAS MEMBER HOSPITALS—THE BLUE CROSS PLAN

TEXAS MEMBER HOSPITALS

- Abilene:**
 Hendrick Memorial Hospital
 St. Ann Hospital
Alice: Physicians and Surgeons Hospital, Inc.
Amarillo:
 Northwest Texas Hospital
 St. Anthony's Hospital
Atlanta: Ellington Memorial Hospital
Austin:
 Brackenridge Hospital
 St. David's Hospital
 Seton Hospital
Baird: Callahan County Hospital
Ballinger: Bailey Clinic Hospital
Bay City: Matagorda General Hospital
Beaumont:
 Hotel Dieu Hospital
 St. Therese Hospital
 Sprott Hospital
Beeville:
 Beeville Hospital
 Thomas Memorial Hospital, Inc.
Bellville: Bellville Hospital
Belton: Belton Hospital
Big Spring:
 Big Spring Hospital Corp.
 Cowper Clinic and Hospital
 Malone & Hogan Clinic Hospital
Balanco: Hospital in the Hills
Bonham: S. B. Allen Memorial Hospital
Borger: North Plains Hospital
Bowie: Bowie Clinic Hospital, Inc.
Brady: Brady Sanitarium
Breckenridge: Westside Hospital
Brownfield: Treadway-Daniell Hospital
Brownsville: Mercy Hospital
Brownwood: Brownwood Memorial Hospital, Inc.
Bryan:
 Bryan Hospital
 Hammond Memorial Hospital
 St. Joseph's Hospital
Burkburnett:
 Burkburnett Clinic Hospital
 Russell Clinic Hospital
Burnet: Shepperd-Allen Hospital
Burton: Burton Hospital
Cameron:
 Cameron Hospital
 Newton Memorial Hospital
Canadian: Canadian Hospital
Canyon: Neblett Hospital
Center:
 Center Sanitarium
 Warren Hospital
Childress: Jeter Townsend Hospital
Clarksville: Red River County Hospital
Cleburne: Cleburne Sanitarium
Clifton: Goodall-Witchter Clinic Hospital
Colorado City: C. L. Root Memorial Hospital
Columbus: Columbus Hospital
Commerce:
 Allen Hospital
 Leberman Hospital
Conroe: Montgomery County Hospital
Cooper: Janes Clinic and Hospital
Corpus Christi:
 Fred Roberts Memorial Hospital
 Memorial Hospital
 Spohn Hospital
Corsicana:
 Corsicana Hospital
 Navarro Clinic Hospital
 Physicians Surgeons Hospital
Crockett:
 Butler Memorial Hospital
 Jim Smith Memorial Hospital
 Stokes-Dean Hospital and Clinic
Crowell: Foard County Hospital
Cuero:
 Burns Hospital
 Lutheran Hospital
Dalhart: Loretto Hospital
Dallas:
 Baylor University Hospital
 (Florence Nightingale Hospital)
 Bradford Memorial Hospital for Babies
 Children's Hospital of Texas
 Gaston Hospital
 Good Samaritan Hospital
 Jones Eye, Ear, Nose and Throat Hospital
 Medical Arts Hospital
 Methodist Hospital of Dallas
 Pinkston Clinic Hospital
 St. Paul's Hospital
Decatur:
 Decatur Clinic Hospital
 Rogers Hospital
Denison: Madonna Hospital
Denton: Denton Hospital and Clinic
Deport: Stephen H. Grant Hospital
Dublin: Guy Hospital
Eagle Lake: Laughlin Hospital
East Bernard: Albert Schuhmann Hospital
Eden: Eden Clinic
Edinburg: Grandview Hospital
Electra: Electra Hospital
El Paso:
 Hotel Dieu Hospital
 Masonic Hospital
 Providence Hospital
 Southwestern General Hospital
Floresville:
 Blake Hospital
 Oxford Hospital

- Floydada :**
 Floydada Hospital
 Pitts Hospital and Clinic
- Fort Worth :**
 All Saints Episcopal Hospital
 W. I. Cook Memorial Hospital
 Harris Memorial Methodist Hospital
 Pennsylvania Avenue Hospital
 St. Joseph's Hospital
- Fredericksburg :**
 Fredericksburg Hospital and Clinic
 Keidel Memorial Hospital
- Gainesville :**
 Gainesville Sanitarium
 Medical and Surgical Hospital
- Galveston :**
 John Sealy Hospital
 St. Mary's Infirmary
- Gatesville :** Coryell Memorial Hospital
- Georgetown :** Martin Hospital
- Gilmer :**
 Oak Lawn Sanitarium
 Ragland Clinic Hospital
- Gladewater :**
 Hancock Hospital
 McKean Clinic Hospital
 Leake Clinic Hospital
- Goose Creek :**
 Goose Creek Hospital
 Lillie Duke Hospital
- Gorman :** Blackwell Sanitarium
- Graham :** Graham Hospital, Inc.
- Greenville :**
 Dr. Joe Becton's Hospital
 Goode-Looney Clinic Hospital
 Phillips Clinic and Hospital
- Groesbeck :** Dr. Cox's Hospital
- Hallettsville :** Ranger Hospital
- Harlingen :**
 Medical Arts Clinic Hospital
 Valley Baptist Hospital
- Haskell :** Haskell County Hospital
- Hereford :** Deaf Smith County Hospital
- Houston :**
 Heights Hospital
 Hermann Hospital
 Houston Negro Hospital
 Jefferson Davis Hospital
 Memorial Hospital
 Methodist Hospital
 Parkview Hospital
 St. Joseph's Infirmary
 Turner Urological Institute
 Wright Clinic and Hospital
- Huntsville :** Huntsville Memorial Hospital
- Iowa Park :** Park Clinic Hospital
- Iraan :** Iraan Hospital
- Jacksboro :** Jacksboro Hospital
- Jacksonville :** Nan Travis Memorial Hospital
- Kaufman :** Rowe Clinic and Hospital
- Kenedy :** Kenedy Clinic and Hospital
- Keerville :** Keerville General Hospital
- Knox City :** Knox County Hospital
- La Grange :** La Grange Hospital
- Lamesa :**
 Dunn Clinic Hospital
 Price Hospital
 Lamesa General Hospital
- Lampassas :** Rollins-Brook Hospital
- Laredo :** Mercy Hospital
- Liberty :** Mercy Hospital
- Littlefield :**
 Littlefield Hospital
 Payne-Shotwell Hospital
- Livingston :** Livingston Hospital
- Lockhart :** Lockhart Sanitarium, Inc.
- Longview :**
 Hurst Eye, Ear, Nose, and Throat Hospital
 Markham Hospital
- Loraine :** Johnson Hospital
- Lubbock :**
 Lubbock Memorial Hospital
 West Texas Hospital
- Lufkin :** Angelina County Hospital
- McAllen :** McAllen Municipal Hospital
- McKinney :** McKinney City Hospital
- Marlin :**
 Buie-Allen Hospital
 Hunter Clinic Hospital
 Torbett Clinic and Hospital, Inc.
- Marshall :** Kahn Memorial Memorial
- Memphis :**
 Clark Hospital
 Memphis Hospital
 Goodall Hospital
- Mercedes :** Mercedes General Hospital
- Meridian :** Holt Hospital and Clinic
- Merkel :** Sadler Clinic Hospital
- Mexia :**
 Brown Memorial Hospital
 Christoffer-Edgar Hospital
 Midland : Western Clinic Hospital
 Mineral Wells : Nazareth Hospital
 Mount Pleasant : Taylor Hospital and Clinic
 Mount Vernon : Crutcher Hospital
 Muleshoe : Green Hospital and Clinic
 Nacogdoches : City Memorial Hospital
 New Braunfels : New Braunfels Hospital
 Nixon : Crest View Hospital
 Olney : Hamilton Hospital
 Paducah : W. Q. Richards Memorial Hospital
- Pampa :**
 Pampa Hospital
 Worley Hospital
- Paris :**
 Sanitarium of Paris
 St. Joseph's Hospital
- Pasadena :** Pasadena Hospital and Clinic
- Pearsall :**
 Goodnight Clinic Hospital
 Dr. Beall's Hospital

- Pecos: Camp and Camp Hospital
 Pittsburg: Pittsburg Medical and Surgical Hospital
 Plainview: Plainview Sanitarium
 Port Arthur: St. Mary's Hospital
 Poteet: Shott's Memorial Hospital
 Quanah: Memorial Hospital
 Ralls: McGuire Hospital
 Roscoe: Young Hospital
 Rosenberg: Fort Bend Hospital
 Rotan: Callan Hospital
 San Angelo:
 Clinic Hospital of San Angelo
 St. John's Hospital
 Shannon West Texas Memorial Hospital
 San Antonio:
 Central Clinic
 Medical and Surgical Memorial Hospital
 Nix Hospital, Inc.
 Physicians and Surgeons Hospital, Inc.
 Santa Rosa Hospital
 San Marcos: Memorial Hospital
 San Saba: San Saba Hospital
 Santa Anna: Sealy Hospital
 Sealy: Sealy Hospital
 Seguin: Seguin Hospital, Inc.
 Seminole:
 Gaines County Hospital
 Andrew S. Tomb Clinic-Hospital
 Seymour: Baylor County Hospital
 Shamrock:
 Shamrock General Hospital
 St. Mary's Hospital
 Sherman:
 Wilson N. Jones Hospital
 St. Vincent Hospital
 Slaton: Mercy Hospital
 Stephenville: Stephenville Hospital
 Sulphur Springs:
 Longino Hospital
 McConnell Hospital
 Taylor:
 Stromberg Clinic Hospital
 Wedemeyer Hospital
 Teague: Davidson Memorial Hospital
 Terrell:
 Friddell Hospital
 Holton Johnston Hospital
 Lane Clinic Hospital
 Texas City:
 Danforth Clinic and Hospital
 Beeler-Manske Clinic Hospital
 Tyler:
 Bryant Clinic and Hospital
 Mother Frances Hospital
 Uvalde: Merritt Hospital
 Vernon:
 Christ the King Hospital
 Moore Hospital and Clinic
 Vernon Hospital
 Victoria: Victoria Hospital
 Waco:
 Hillcrest Memorial Hospital
 Providence Hospital
 Waxahachie: Waxahachie Sanitarium
 Weatherford: Medical and Surgical Hospital
 Wellington: St. Joseph's Hospital
 Weslaco: McCalip Ivy Hospital
 Wharton:
 Caney Valley Hospital
 Rugeley-Biasingame Hospital
 Wheeler: Wheeler Hospital
 Wichita Falls:
 Bethania Hospital
 Wichita Falls Clinic Hospital
 Wichita General Hospital
 Winters: Winters Municipal Hospital
 Yoakum: Huth Memorial Hospital

A current "member hospital list" may be had at any time upon request to

GROUP HOSPITAL SERVICE, INC.

2202 Bryan Street, Dallas 1, Tex.

The CHAIRMAN. Have you anything else that you would like to offer?

Dr. CARY. That, seems to me, might be pertinent.

The CHAIRMAN. Anyway, Doctor, the subject of Blue Cross, of course, has been already discussed by other witnesses.

Dr. CARY. This is an enlargement of the program. These things grow.

The CHAIRMAN. The whole subject has been very carefully gone over.

Dr. CARY. These things grow.

The CHAIRMAN. That has been gone into by the committee. I would like to have you tell me when you first became interested in suggesting a cure for the problem in this country of the inability of great masses of the people to secure medical care at reasonable cost?

Dr. CARY. I can tell you something that possibly gets right back to that. When I was president of the Southern Medical Society——

The CHAIRMAN. I want you to tell me——

Dr. CARY. I am going to tell you.

The CHAIRMAN. To answer my question. When did you?

Dr. CARY. I am answering.

The CHAIRMAN. When did you propose a program to meet that problem?

Dr. CARY. I am going to tell you right now.

The CHAIRMAN. I wish you would not take too long a time. Can you not condense it a little?

Dr. CARY. All right, I will condense it. I hope I make it intelligible.

I was president of the Southern Medical Society. I recognized that the redistribution of doctors was a very important thing in the care of people. We were educating young men so well that when they went out into the country, they would not stay but a year or two and come back. I would say "Why in the world do you come here? Why don't you go back where you are needed, where you belong?"

"I am not going to practice medicine in the country where I have no facilities."

In that thesis which I delivered in 1920, and that is getting back a little bit, I advocated the very things that the Hill-Burton bill is doing today. I have advocated it as a solution of the redistribution of doctors. It is in the files of the libraries, I am sure, but it is practically the same, identical thing, that the Hill-Burton bill comes along now to do. It was an effort on my part to fix it, so that in every community, certainly a community of 10,000 people, there would be hospital facilities, there would be clinical facilities, and there would be a desire on the part of the well-educated young man to stay and practice medicine where he was really needed, and I am still for that, and I have been for it all of these years.

The CHAIRMAN. And that is your contribution to the solution?

Dr. CARY. That is just one.

The CHAIRMAN. Just one of them?

Dr. CARY. Yes.

The CHAIRMAN. If you have some more, I wish you would furnish us a list of them and we will incorporate them in the record, because we want to give you full credit for everything you have done.

Dr. CARY. I am not seeking full credit.

The CHAIRMAN. If you wish to make any supplemental statement, telling us what other efforts you have made in the past to meet this problem, we will be glad to have you submit it.

Senator DONNELL. May I proceed with the examination, if the chairman has finished his examination?

The CHAIRMAN. Yes, sir.

Senator DONNELL. Doctor, you spoke of having been president of the Southern Medical Society. Have you served as the president of the American Medical Association?

Dr. CARY. Yes, sir.

Senator DONNELL. What year or years?

Dr. CARY. 1932, I think, and 1933.

Senator DONNELL. I will ask you, Doctor, just boiling it down—and I am taking this from one of these newspaper articles, and if it is

in error, you correct me—that from 1902 to 1943 you were professor of ophthalmology and otolaryngology; is that right?

Dr. CARY. Yes, sir.

Senator DONNELL. And the head of that department in Baylor University, dean of Baylor Medical School from 1902 to 1922, dean emeritus since 1929, chairman of the faculty from 1909 to 1929, chairman of the department of surgery from 1921 to 1929, chairman of the staff of Baylor Hospital during the same period, and chairman of the advisory board of the school and hospital. Is that all true up to this point?

Dr. CARY. Yes, sir.

Senator DONNELL (reading:)

In business affairs, Dr. Cary is president of the Cary-Schneider Investment Co., president of the Medical Arts Hospital, and a director of Republic National Bank. He heads the Cary Clinic.

Is that all true?

Dr. CARY. Yes, sir.

Senator AIKEN. What is that, Republican Bank in Texas?

Senator DONNELL. It is Republic.

Senator AIKEN. Does that refer to the politics of the bank or what?

Senator DONNELL. I am sorry to say, Mr. Chairman, that this is Republic rather than Republican.

Senator AIKEN. You said Republican. [Laughter.]

I knew there was a mistake somewhere.

I might say, Mr. Chairman, that the principles of the Republic and of the Republican Party are identical.

Doctor, have you, also, served as chairman of the board of the National Physicians Committee, president of the Kessler Plan Association, chairman of the District Medical Examiners Board in World War I, and member of the Selective Service Appeals Board in World War II, organizer of the Baylor Hospital Unit which served in France during World War I, past president of the Texas Philosophical Society, fellow of the American College of Surgeons, member and past trustee of the American Medical Association, and president of a number of medical groups, including the American Medical Association?

Is all of that true?

Dr. CARY. Yes, sir.

Senator DONNELL. Doctor, the chairman presented to you or referred to several documents, and you placed in the record here quite a number that I have not seen at all, but I saw one which was handed to me here this morning marked "Showdown on Political Medicine." I observed that that is the document which contains some of this language which has been mentioned by the chairman previously; namely, at page 8, where you say that the proposals that have been embodied in the Wagner-Murray-Dingell bill would provide political distribution of medical care in its most vicious and most dangerous form, and then you go farther and make other statements along the line of this being socialized medicine.

I refer particularly to page 15, also in which you discuss the authority granted to the Surgeon General with the approval and under the direction of the Federal Security Administrator.

Doctor, without going into the merits, pro or con, I will ask you to state whether or not you regard it to be true that the Wagner-Murray-

Dingell bill would provide political distribution of medical care in its most vicious and most dangerous form. Do you think that is true?

Dr. CARY. I do not see how on God's earth you can avoid it in this country.

Senator DONNELL. Do you think this is socialized medicine?

Dr. CARY. I know it is.

Senator DONNELL. I notice that President Truman's definition of "socialized medicine" is set forth in this pamphlet at page 19, where he says: "Socialized medicine means that all countries work as employees of government." And then I observe that you point out; that is, your booklet does, that the President's proposals anticipate that the Surgeon General, under the direction, I take it, of the Federal Security Administrator, would hire doctors and establish rates of pay, et cetera. I am quoting from the booklet.

Do you believe those statements to be true; is that your interpretation of the bill?

Dr. CARY. That is my interpretation of the bill.

Senator DONNELL. And you understand, then, I take it, that the Surgeon General, inasmuch as he will hire doctors and establish rates of pay, is employing those doctors to work for the Government; is that true?

Dr. CARY. Absolutely.

Senator DONNELL. That is your argument?

Dr. CARY. Yes, sir.

Senator DONNELL. Maybe you are wrong or right, you are sincere in your belief to that effect?

Dr. CARY. We believe it.

Senator DONNELL. Let me ask you, without going into all of the detail of this, and I have not seen all of that bundle over there except as you handed it in, I am going to ask you to tell this committee right now; and I want you to do it with due reflection: Is there a single statement that you know of in any of this literature that you do not believe, honestly believe, to be true?

Dr. CARY. Not one.

Senator DONNELL. You may be mistaken, but you believe it to be true; is that right?

Dr. CARY. Absolutely.

Senator DONNELL. You referred to the fact that back here in July 1938 there was a national health conference called by President Roosevelt, was it not?

Dr. CARY. Well, I know that it was called. I think Miss Roach was the chairman. She may have called it.

Senator DONNELL. I might be mistaken myself. It was what was called the national health conference.

Dr. CARY. Miss Roach was the chairman, and she may have called it technically. I do not know.

Senator DONNELL. Did you come in contact with a gentleman named Isadore Falk?

Dr. CARY. I have seen him, afterwards, when a member of a committee of seven, representing the American Medical Association, trying to discuss that departmental committee report, the things which we disagreed with, which was at that time leading to compulsory sickness insurance, and which, in a very large way, was denied, not by

Mr. Falk but denied by the gentleman who is the head of the public health, and all of that kind of stuff, but we could not reach any very definite agreement about it, and we came back to have another meeting and came back later and had the pleasure of seeing him again.

Senator DONNELL. He has been quite active in these matters relating to compulsory health insurance, has he not?

Dr. CARY. I understand he is the gentleman that writes the bill.

Senator DONNELL. Have you read Dr. Altmeyer's testimony with reference to the participation of Mr. Falk in the preparation of this proposed legislation?

Dr. CARY. I think he has always been very frank, and I have a great deal of admiration for him.

Senator DONNELL. Did you read his testimony on that particular point?

Dr. CARY. I saw something.

Senator DONNELL. I am not going to take but a moment of your time, or the time of the committee.

This article in PM that you introduced, I think, in evidence, "AMA-Drug Trust Axis Sponsors Campaign * * * of Lies Against Wagner-Murray Health Bill," that seems to be written by Albert Deutsch, and goes on: "Peddle Propaganda Pills to Drug American Public."

Do you know anything about the origin of this article, or anything about PM, that would induce it to enter into a campaign of this kind?

Dr. CARY. Well, all I know is that a very, very rich man seems to have a quirk in his mind and is the publisher of all of this stuff, and he does not mind going in debt with it. He may get a little tax deduction. [Laughter.]

And all of that. And we have this man, Albert Deutsch, whom I do not know, I do not know him, maybe he is in the audience. I understand he is a little fellow with shocked hair, but he is a vicious little rascal, from my standpoint. He says we are vicious. My God, I think we are temperate.

Senator DONNELL. At any rate—

Dr. CARY. He is vicious, the most vicious little devil I ever heard of.

Senator DONNELL. The point about the matter that I desired to emphasize at this point was that although you get out some literature that looks to me like it is at least typographically well gotten out, seems to be circulated, as I understand, over the country in advocacy to opposition to this bill, it appears that somebody, for some reason, is coming out pretty strong in this PM with all of this alliteration about peddling propaganda pills, "sponsors campaign of lies against Wagner-Murray health bill, although I realize that, as I have indicated, maybe you made mistakes, are you conscious, I am going to ask you again, of anything in your literature, I mean by that the literature of the National Physicians' Committee, that has not been what you thought to be true, whether you are mistaken or not?

Dr. CARY. Absolutely, it is true, everything we say.

Senator DONNELL. Doctor, do you know Dr. Butler of Harvard, who testified here the other day?

Dr. CARY. I do not know him personally, but I understand he is a most charming gentleman.

Senator DONNELL. He is an able man, and testified here, has shown great ability.

Dr. CARY. The man has inherited a great deal of wealth and has a good deal of time. He has no practice. He is on the staff of the Massachusetts General Hospital. I understand he said he practiced night and day. Well, somebody in the office, on the staff, might call him down to General Massachusetts, I do not know, but he is a very interesting character, because I heard him mentioned here quite a bit, and he made a statement down here which I think is important.

Senator DONNELL. Where did he make this statement?

Dr. CARY. Before this committee.

Senator DONNELL. Before this committee?

Dr. CARY. Yes; that the members of this board of trustees were intellectually dishonest. I think that statement is important, because he is such an interesting man.

Senator DONNELL. May I interrupt you just a moment?

I observe on that board of trustees an old school friend of mine, Dr. William J. Carrington of Atlantic City, who is the son of the former State superintendent of public schools in Missouri. He is a colonel in the United States Army at this time and I know that man, and I know him to be an honorable man.

Dr. CARY. I was just going to say that in December, on December 5, when we were meeting out in Chicago, that one of the fine doctors in Boston, Dr. Leland S. McKittrick—

Senator DONNELL. He is one of your Board of Trustees, is he not?

Dr. CARY. A member of the board of trustees; was chairman of the committee. Dr. Allan M. Butler was on the Massachusetts General.

Senator DONNELL. Is that the same Dr. Butler I was asking about?

Dr. CARY. Yes, and Dr. Vlado A. Getting, Massachusetts State commissioner of health, Dr. Merrill C. Sosman, clinical professor of roentgenology, Harvard Medical School, and Dr. Elmer S. Bagnall, 281 Main Street, Groveland, Mass., who were members of the Subcommittee on Medical Economics, Postwar Planning Committee.

Senator DONNELL. This was last December, 1945?

Dr. CARY. This committee came into existence before that, but the result of their findings was signed by all of them.

Senator DONNELL. That is, including Dr. Butler?

Dr. CARY. Including him.

Senator DONNELL. Would you read whatever you think is appropriate of the results?

Dr. CARY. Dr. McKittrick told me that Dr. Butler, who is a distinguished doctor and a very fine character, and all of that, aided very materially in bringing about the resolutions which they were able to offer to the Massachusetts Medical Society, and the thing, which it seems to me, is most important in this thing—

Senator DONNELL. That is in this resolution that was prepared in which Dr. Butler concurred; is that right?

Dr. CARY. Absolutely concurred in every way.

Senator DONNELL. What does it say?

Dr. CARY. I will not read the whole thing. You can put it in the Record if you wish. I have reference to this particular section:

Provision of adequate medical care for those unable to obtain it by voluntary prepayment plans or by direct payment is the responsibility of the local or State

government. Part of the burden of this responsibility may be assumed by charitable agencies. Federal grants-in-aid to State programs administered by State boards of health are an acceptable method of helping to meet this responsibility.

Senator DONNELL. Let me see that.

Dr. CARY. And with the resolutions that Dr. McKittrick had out in Chicago, after we had spent a day in trying to see how we could help this legislation without being obstructive or without trying to be over-critical, or this or that, we spent over a day working as hard as we could, and we went downstairs, Dr. McKittrick and I, we went downstairs, and we tried to apply what we had done up to that time, and I did not know about these principles that they had accepted up there, but we tried to apply to what we had done all of the principles which they had accepted, and it was our opinion that we were entirely within those principles to present at this meeting a paper which contains the facts which I have tried to bring forth. Afterwards I think that was accepted. This was sent to me, Massachusetts Medical Society. They accepted those principles, and it was the Massachusetts Medical Society itself that accepted the principles which were there.

Senator DONNELL. Its acceptance of those principles is in this document.

Dr. CARY. I have not read it. I think it is in there.

Senator DONNELL. For the purpose of saving time, may I offer for the record, at least, in the files of the committee, not necessarily to be printed in full, these two documents; namely, what I understand to be a document addressed to the Massachusetts Medical Society, Subcommittee on Medical Economics, Postwar Planning Committee—is that a committee of the society, Doctor?

Dr. CARY. Yes, sir.

Senator DONNELL. Signed Leland S. McKittrick, chairman.

Dr. CARY. He was the chairman.

Senator DONNELL. Dr. Butler, you say, was on that committee? That is the committee—

Dr. CAREY. They worked a long time trying to find the solution of some of these problems that have been discussed here, and we thought that these principles which he had signed, and all of that kind of stuff, was in complete accord with his own principles, because he signed them and had led in the discussion of them.

Senator DONNELL. I observe in this printed document here, which I will offer here, the first three words of which are: "Massachusetts Medical Society," that only the name "Leland S. McKittrick, chairman," appears at the bottom.

Dr. CAREY. Here are the others.

Senator DONNELL. That you read before. And your information is that Dr. Butler cooperated in this preparation of this report, was derived in what manner?

Dr. CARY. Derived after repeated discussions of every phase of medical care and every phase of that.

(The two documents referred to are as follows:)

MASSACHUSETTS MEDICAL SOCIETY PRESENTS BASIC PRINCIPLES WHICH SHOULD GOVERN MEDICAL-CARE PLANS

The objective of adequate medical care in our free society is to make available to everyone—regardless of race, color, creed, financial status, or place of resi-

dence—every known essential preventive, diagnostic, and curative medical service of high quality. The attainment of such medical care must necessarily be an evolutionary process which will require the cooperation of all concerned over a period of years.

The success of any plan for medical care is dependent on the mutual cooperation of the public, those rendering professional services and the administrative agencies. This cooperation can be obtained only if those rendering the services are convinced that they will have a continuing authoritative voice in the formulation and execution of policies and plans, thereby assuming their proper share of responsibility.

Provision of adequate medical care for those unable to obtain it by voluntary prepayment plans or by direct payment is the responsibility of the local or State government. Part of the burden of this responsibility may be assumed by charitable agencies. Federal grant-in-aid to State programs administered by State boards of health is an acceptable method of helping to meet this responsibility.

The medical care of those who are able to purchase it by voluntary prepayment plans or by direct payment is the responsibility of the individual.

Eligibility for receiving benefits under a program aided by Federal grants should be determined by the individual States.

The patient shall have free choice of his physician, group of physicians, clinic, or hospital from among those participating in any plan, provided that the physician, group of physicians, clinic, or hospital shall have the right to refuse or to accept the patient.

Physicians and other qualified persons rendering medical care shall receive adequate remuneration for their services.

The physicians shall be free to elect or reject without prejudice participation in a medical-care plan. The rights of the physician as to the choice of methods by which he is to be paid shall be fully protected.

The Massachusetts Medical Society looks upon these basic principles as essential to the development of any successful medical-care plan and, as guides by which to evaluate medical-care plans that may be proposed in the future, with the understanding that changing conditions may require their later revision.

THE SOCIETY LOOKS AT THE WAGNER-MURRAY-DINGELL BILL (S. 1606) AND THE MATERNITY AND CHILD WELFARE ACT OF 1945 (S. 1318)

Senators Wagner and Murray introduced the National Health Act of 1945—Senate 1606—in the United States Senate, on November 19, 1945, the day on which the President's message dealing with this subject was read to the Congress.

The interest of the Massachusetts Medical Society is largely centered in titles 1 and 2 of the act.

Title 1 authorizes grants-in-aid to States to extend the public health services, to increase maternal and child-health services, and to provide medical care for the needy.

Title 2 makes provisions for full medical, dental, nursing, and laboratory care and hospitalization for those able to pay for such services.

The Massachusetts Medical Society with regard to title 1, part A, cites the progressive leadership that the physicians of New England have always shown in the development of public-health enterprises, and its adoption as a principle the making available to everyone, every known essential, preventive, diagnostic, and curative medical service of high quality. We do approve in general this part of the bill as written, with the following exceptions:

The responsibility for the training of personnel should be the duty of the States and not that of the Federal Government, as designated in section 314A.

Provision should be made which would insure proper representation of the professional organizations on the advisory council—section 314F.

Responsible private agencies, such as the Blue Cross and the Blue Shield, should be included among those with whom the State health agency may make working agreements—section 314H.

The State administrative agency should be required to consult with professional advisory committees before issuing regulations, which in turn should be issued only after due notice—section 314H.

The society believes that the objective of title 1, part B is more clearly covered in Senate bill 1318.

With respect to title 1, part C, the society approves of Federal grant to aid the several States in assuming their responsibility of providing medical care for those unable to pay for such services. It approves, in general, of this part of the bill as written with the following exceptions:

Federal grants-in-aid for the medical care of needy persons should be made by the United States Public Health Service to State departments of public health.

It disapproves of the provision that places the responsibility in the Social Security Board on the Federal level and in the department of welfare on a State level—section 131.

The society through its Blue Shield having approved of the service principle rather than the payment to patients of cash benefits for medical care, disapproves of the provision in the bill which makes cash payments to individuals for this purpose.

Title 2 is compulsory health insurance. It would be very costly to carry out the provision of this section of the bill, and there is nothing to intimate what this will add to the burden of the taxpayer or how the money will be raised. Since the society believes that the payment for medical care of those able to pay for such services by direct payment or on a prepayment basis is the responsibility of the individual and that with the extension and development of voluntary or other plans particularly adapted to certain areas, medical care of the highest quality can be obtained at a reasonable cost, it disapproves of this section.

The Maternal and Child Welfare Act of 1945—Senate 1318—is designated as an act "to provide for the general welfare by enabling the several States to make adequate provision for the health and welfare of mothers and children and for services to crippled children."

The society finds serious objections to this bill as written. Some of the more important of these are as follows:

The bill makes no adequate provision for general public-health programs that are more fundamental than this specialized legislation.

Services and facilities are available to all who elect to participate, regardless of economic status. (This violates basic principles 4 and 5.)

The public deserves a reasonable estimate concerning the ultimate cost of this proposed legislation. Experience and such factual data as are available indicate an ultimate annual budget approximating \$1,000,000,000. This should be clearly recognized in any consideration of the bill.

Fee-for-service method of payment is restricted to consultation or emergency visits and is not ordinarily available to practitioners or specialists.

The bill does not make clear just who is to decide the fee for a given service that would be considered adequate remuneration in an individual State, nor does it make provision for variable fees to meet the differing costs in the several States.

The bill does not prohibit professional personnel, groups, or institutions rendering service under the program from accepting supplemental payment from or on behalf of patients.

The bill does not provide for payment to groups of physicians, clinics, or hospitals providing professional services.

The bill does not emphasize the desirability of full utilization and further development of existing services and facilities.

The bill does not emphasize the necessity of restricting the development and expansion of a State program to the capacity of available administrative and professional resources.

The bill does not provide the professions with a continuing authoritative voice in the formulation of policies and plans. Such committees as are selected under the provisions of the bill may represent the attitude of the administrator rather than that of a given profession or group. (This violates Basic Principle 2.)

The bill does not provide the facilities whereby the opinions of both the Federal and State advisory committees are made available to the public.

Designation of the Children's Bureau as the administrative agency does not adequately assure proper integration of the health activities of the Federal Government.

For these reasons the society believes that this proposed act does not represent the best form of legislation for the purposes for which it was written.

MASSACHUSETTS MEDICAL SOCIETY, SUBCOMMITTEE ON MEDICAL ECONOMICS, POSTWAR
PLANNING COMMITTEE

INFORMATION CONCERNING RECENT DELIBERATIONS

The Subcommittee on Medical Economics met on September 13, 1945, to study Senate bill 1050, the so-called Wagner-Murray-Dingell amendment to the Social Security Act.

It was soon obvious that before any critical study of this or any proposed legislation could be made, certain guiding principles on which all could agree should be formulated.

It was also pointed out that Senate bill 1318, the so-called Pepper Material and Child Welfare Act of 1945, might soon come up in committee and that a study of this bill should take precedence over that of Senate bill 1050.

It was, therefore, agreed that the committee should:

(1) Outline the important basic principles that were considered essential to a successful medical-care plan.

(2) Prepare a brief discussion of the various methods of payment for medical services.

(3) Study and prepare a critical report on Senate bill 1318.

Subsequent meetings were held on September 27, October 18, November 1, 2, 4, and 19, and December 10, for periods varying from 5 to 7½ hours. Drs. Humphrey McCarthy, chairman of the committee on legislation, Joseph O'Connor, of Worcester, Stewart Clifford, of Boston, and Caroline Chandler of the State department of public health took an active part in the discussions that followed and were most helpful to the subcommittee. What at times appeared to be widely divergent attitudes were, after free discussion, molded into this report.

The following basic principles were evolved as being essential to a medical-care plan in a free society:

(1) The objective of adequate medical care in our free society is to make available to everyone—regardless of race, color, creed, financial status, or place of residence—every known essential preventive, diagnostic, and curative medical service of high quality. The attainment of such medical care must necessarily be an evolutionary process that will require the cooperation of all concerned over a period of years.

(2) The success of any plan for medical care is dependent on the mutual cooperation of the public, those rendering professional services and the administrative agencies. This cooperation can be obtained only if those rendering the services are convinced that they will have a continuing authoritative voice in the formulation and execution of policies and plans, thereby assuming their proper share of responsibility.

(3) Provision of adequate medical care for those unable to obtain it by voluntary prepayment plans or by direct payment is the responsibility of the local or State government. Part of the burden of this responsibility may be assumed by charitable agencies. Federal grants-in-aid to State programs administered by State boards of health are an acceptable method of helping to meet this responsibility.

(4) The medical care of those who are able to purchase it by voluntary prepayment plans or by direct payment is the responsibility of the individual.

(5) Eligibility for receiving benefits under a program aided by Federal grants should be determined by the individual States.

(6) The patient shall have free choice of his physician, group of physicians, clinic, or hospital from among those participating in any plan, provided that the physician, group of physicians, clinic, or hospital selected shall have the right to refuse to accept the patient.

(7) Physicians and other qualified persons rendering medical care should receive adequate remuneration for their services. Eventually this should include payment for services rendered to needy patients both in and out of hospitals.

(8) The physician shall be free to elect or reject without prejudice participation in a medical-care plan. The rights of the physician as to the choice of methods by which he is to be paid shall be fully protected.

Methods of paying physicians under medical-care plans

In considering the various methods of paying physicians under such plans, several points must be kept clearly in mind to avoid drawing misleading conclusions from the experience of private practice.

First, in private practice, where the patient pays the bill, there is a deterrent to either excessive demands by the patient or excessive services by the doctor. In any plan where a third party pays the bill, this deterrent is largely removed regardless of the method of payment. Under medical-care plans, provisions against excessive demands should be made by specific clauses in the contracts or by establishing regulatory measures.

Second, under a medical-care program where patients are free to choose their physicians and doctors are free to accept or refuse individuals as patients, the stimulus to the patient and the doctor for establishing a satisfactory relationship is almost independent of the method of payment.

Third, the same opportunity for group practice pertains under any method of payment.

Incidentally, the subcommittee reaffirmed its approval of the Blue Shield prepayment plan sponsored by the Massachusetts Medical Society, as stated in the September 20 issue of the *New England Journal of Medicine*.

Fee-for-service.—Under a fee-for-service system, practitioners, specialists and consultants are paid a stated value for each unit of service rendered.

In current plans the physician is required to submit to the administrative agency a clinical report and a bill or voucher for each service rendered. This entails the administrative costs of handling such reports and vouchers and may require the administrative agency to set up a system of cross indexes concerning the practices of each physician and the health of each patient.

When a doctor cares for few patients under a medical-care plan, fee-for-service provides a remuneration that is proportional to the service rendered and thus covers the uneven incidence of illness among such patients.

Under any system of payment, fee-for-service is an appropriate way to pay for consultant or for emergency services not rendered by the patient's family doctor.

Under medical-care plans, experience shows that this method of payment is susceptible to abuse by a small percentage of physicians and patients. If the total budget of the medical-care plan is limited and demands are in excess of the funds the payment per unit of service may be reduced.

Per capita.—The per-capita system applies primarily to general practitioners. Under this system, practitioners are paid a certain sum per patient per year for each patient who elects him and whom he accepts. This payment is made regardless of the amount of care given to different patients or the fact that some patients will receive no service. A doctor being paid on this basis may be paid in addition for consultant or unusual services on a fee-for-service or per-case basis.

The practitioner is required to notify the administrative agency when he first becomes the practitioner of a given person. This provides the administrative agency with the necessary information for remuneration of physicians. The administrative agency may from time to time request additional information from the doctor for study or other informative purposes. Physicians are usually given the choice of receiving remuneration quarterly, semiannually or annually.

When a doctor cares for enough patients under a medical-care program to provide an actuarially sound distribution of risk due to the uneven incidence of illness among his patients, the per capita method of payment permits economy in administrative burden with equity to the doctor.

This method of payment is not susceptible to excessive care by the practitioner but is susceptible to excessive demands by the patient.

Salary.—Under the salary method, a stipulated compensation for services rendered is regularly paid a physician, usually per week or per month.

For certain physicians practicing as members of well-organized groups or institutions, this form of payment provides a graded and predictable remuneration. It may provide the means of attracting a physician to a rural community to which he otherwise would not go because of irregularity of income.

If groups of physicians or institutions contract to provide medical care either as consultants, specialists or practitioners, salary may in certain instances be a desirable form of paying for the medical care so provided.

If provision is made on a merit basis for advancement and increased salary, the competition for high-salaried positions provides the incentive to a high quality of endeavor on the part of physicians, just as it does in other professions and occupations.

This method of payment necessitates but little administrative paper work.

Per case.—Under the per-case method a physician is paid a stipulated sum for the total service he renders a patient during a particular illness or because of a particular condition, usually within a stated time.

It is particularly applicable to consultant or specialist services rendered to certain types of cases.

Under the per-case basis a single clinical report and a bill are usually required to be submitted only at the termination of the services rendered.

Per session.—The per-session method applies a flat rate of payment for the services rendered per stipulated session.

Payment on this basis is particularly applicable to services rendered intermittently in group clinics.

It usually requires the submission of a report of the physician's presence at the session.

Cash indemnity.—Under the cash-indemnity system, payments are made by the administrative agency to the patient, not to the doctor. It provides for payment of a flat sum for wages for time lost because of illness, cash payments toward the cost of medical care according to a fee schedule, or both. Each person is free to make his own arrangements with those who furnish medical services as to both the amount of service and the charge for it.

It provides no assurance that the money paid to the patient will be expended on medical care, and little control over quality or cost. Such supervision as would check on the expenditure of the funds for the medical care for which they were allotted and on the cost and quality of the care provided would entail an almost insurmountable task.

Physicians might be obliged to spend time on examination for certification of illness to permit the patient's collection of a cash indemnity rather than for the treatment of illness.

Although the amount of administrative paper work concerning medical care would be small, that required by the professional certification of illness might be great.

The Maternal and Child Welfare Act of 1945

The Maternal and Child Welfare Act of 1945 (Senate bill 1318) has been carefully studied by this subcommittee. Although this subcommittee is in complete agreement with the objectives stated in the introduction to the bill.—“To provide for the general welfare by enabling the several States to make adequate provision for health and welfare of mothers and children and for services to crippled children”—it finds serious objections to the bill as written. Some of the more important of these are as follows:

(1) The bill makes no adequate provision for general public-health programs that are more fundamental than this specialized legislation.

(2) Services and facilities are available to all who elect to participate, regardless of economic status. This violates Basic Principles 4 and 5.

(3) The public deserves a reasonable estimate concerning the ultimate cost of this proposed legislation. Experience and such factual data as are available indicate an ultimate annual budget of approximately \$1,000,000,000. This should be clearly recognized in any consideration of the bill.

(4) Fee-for-service method of payment is restricted to consultation of emergency visits and is not ordinarily available to practitioners or specialists.

(5) The bill does not make clear just who is to decide the fee for a given service that would be considered adequate remuneration in an individual State, nor does it make provision for variable fees to meet the differing costs in the several States.

(6) The bill does not prohibit professional personnel, groups, or institutions rendering service under the program from accepting supplemental payment from or on behalf of patients.

(7) The bill does not provide for payment to groups of physicians, clinics or hospitals providing professional services.

(8) The bill does not emphasize the desirability of full utilization and further development of existing services and facilities.

(9) The bill does not emphasize the necessity of restricting the development and expansion of a State program to the capacity of available administrative and professional resources.

(10) The bill does not provide the professions rendering service a continuing and authoritative voice in the formulation of policies and plans. Such committees as are selected under the provisions of the bill may represent the attitude of the administrator rather than that of a given profession or group. This violates basic principle 2.

(11) The bill does not provide the facilities whereby the opinions of both the Federal and State advisory committees are made available to the public.

(12) Designation of the Children's Bureau as the administrative agency does not adequately assure proper integration of the health activities of the Federal Government.

For these reasons we believe that the Maternal and Child Welfare Act of 1945 (Senate bill 1318) does not represent the best form of legislation for the purpose for which it was written.

LELAND S. MCKITTRICK,
Chairman.

JANUARY 9, 1946.

Senator DONNELL. How did you know that Dr. Butler approved this report which is headed: "Massachusetts Medical Society"?

Dr. CARY. He is on our board and Dr. McKittrick is on our board, and he was out in Chicago, and after we had tried to help this legislation, Dr. McKittrick divulged that he had a group of principles in which he was the chairman of the committee. He said:

Come to my room and let us see if we can apply these principles to this type of what we have decided.

Senator DONNELL. Did Dr. Butler say that he had concurred in these principles or did Dr. McKittrick?

Dr. CARY. He had signed that, Dr. McKittrick told me.

Senator DONNELL. How do you know Dr. Butler had signed it; had agreed to it?

Dr. CARY. McKittrick said so.

Senator DONNELL. He said so?

Dr. CARY. It was a unanimous report, and I am sure that that Massachusetts acceptance will show that it was a unanimous report.

Senator DONNELL. I take it that that is—

Dr. CARY. My interest in the matter is not in any sense to discuss Dr. Butler, except that Dr. Butler made this statement.

Senator DONNELL. I think that is clearly hearsay.

The CHAIRMAN. I do not raise the question that it is hearsay. You can put it in the record.

Senator DONNELL. It is hearsay, and I want to concede that. However, I observe in this document, "What at times appeared to be widely divergent attitudes were, after free discussion, molded into this report."

I am confident that the Doctor is giving us what he thinks is correct information.

The CHAIRMAN. I have no objection.

I do not know whether he took that position at one time or another; that is, I mean, Doctor Butler.

Dr. CARY. Not so long ago.

The CHAIRMAN. Apparently, from the record that we have here, the American Medical Association, at least, a branch of it, at one time thought that compulsory systems of insurance were better than voluntary. So we are entitled to change our views as we study problems.

Senator DONNELL. The date of this document is January 9 of this year, 1946, this one headed: "Massachusetts Medical Society Subcommittee on Medical Economics, Postwar Planning Committee," and the other document, while I have not read this at all, never saw it until it was handed out here, is marked on the outside, in printing, "February 6, 1946."

I offer the two for whatever they contribute to the matter at hand.

The CHAIRMAN. All right.

Senator DONNELL. I think that is all.

The CHAIRMAN. I thank you for your testimony here. You stated that in your opposition to this legislation, you are not conscious of any

wrongful motives, either in your direct testimony or the matters pertaining to the national income tax question which was raised here?

Dr. CARY. You are right, sir.

The CHAIRMAN. All right.

Dr. CARY. I would like to conclude with this paper.

Mr. Chairman, in my prepared statement I indicated that it would require the lengthy testimony of several witnesses in order to express adequately the point of view of the vast majority of doctors on the radical and revolutionary proposals contained in S. 1606, and to illustrate what I mean I should like to conclude my testimony by pointing out very briefly some of the points which I believe may be passed over during the course of these hearings; for example:

1. I am sure, Mr. Chairman, that should this legislation approach enactment, there will be a mighty rush of the groups who desire to be excluded from its provisions. The rush to get out of the bill will become so widespread that the whole compulsory health insurance program will degenerate into a simple tax on the unorganized who are unable to support and finance a lobby here in Washington to protect their interests.

2. I should also like to allay, once and for all, the specious argument of inevitability that is being used by the proponents in an effort to stampede the Congress and the people into accepting the principle of compulsory health insurance. That is the same argument which Hitler made for his "new order." When he was warning France and Great Britain and the United States to keep hands off—and permit him to have his way with the small nations of Europe. There are some today who argue that free enterprise is old-fashioned and outmoded, that a government-controlled economy, of which political medicine is a part, must be accepted because it is "inevitable." That type of defeatism doesn't impress me in the slightest, and I don't think it impresses any American who has the gumption to fight for his grand heritage. There is no change in our American form of government which is "inevitable" unless the American people, in their wisdom, determine that that change is desirable and beneficial.

3. And, finally, I believe that if this legislation was submitted to the people in a referendum, with full knowledge of its implications, the voters of this country would finally and forever reject the meddling and the presumption of the bureaucrat to interfere in the sacred relationship of patient and physician, and would cast against this kind of revolutionary legislation the everlasting scorn of a free-born and freedom-loving people.

Mr. Chairman, I wish to express my gratitude for the privilege of coming before your committee as a representative of the point of view of my organization, the National Physicians Committee for the Extension of Medical Service, which I sincerely believe to be the best point of view of the vast majority of physicians.

The CHAIRMAN. We will call the next witness, Mr. Becker.

Is Mr. Becker here?

(No response.)

The CHAIRMAN. Senator, this witness will not appear today. He will appear on some subsequent hearing. So we will adjourn now until Monday morning at 10 o'clock in room 318.

(Thereupon, at 12:30 p. m., Friday, April 19, 1946, the committee recessed to reconvene in room 318, Monday, April 22, 1946, at 10 a. m.)

NATIONAL HEALTH PROGRAM

MONDAY, APRIL 22, 1946

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

The committee met at 10:15 a. m., pursuant to adjournment, the Honorable James E. Murray (chairman), presiding.

Present: Senators Murray, Ball, Ellender, and Donnell.

The CHAIRMAN. Will the hearing come to order.

The first witness this morning is Mr. C. Rufus Rorem, director of the Blue Cross Commission, American Hospital Association.

Mr. ROREM. Here, sir.

The CHAIRMAN. Mr. Rorem, you may proceed.

Mr. ROREM. Senator, I would like to ask if in the discussion Mr. John R. Mannix, who is the chairman of our commission, might also participate.

The CHAIRMAN. He may. Mr. Mannix, do you wish to sit up here?

STATEMENT OF C. RUFUS ROREM, PH. D., C. P. A., DIRECTOR, THE BLUE CROSS COMMISSION OF THE AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY JOHN R. MANNIX, CHAIRMAN, THE BLUE CROSS COMMISSION OF THE AMERICAN HOSPITAL ASSOCIATION

The CHAIRMAN. First, then, Mr. Rorem. Will you give your name, and your connection with this organization, and anything in connection with your background you wish to put in the record; and following you Mr. Mannix will give his name and his biographical sketch.

Mr. ROREM. My name is C. Rufus Rorem. I am director of the Blue Cross Commission of the American Hospital Association. I was formerly a member of the faculty of the University of Chicago. I am a certified public accountant. My work is serving as a coordinating agency for Blue Cross plans. I am the salaried director of the commission which does this work.

The CHAIRMAN. Mr. Mannix is associated with you. And, Mr. Mannix, will you give your full name?

Mr. MANNIX. My name is John R. Mannix. I am chairman of the Blue Cross Commission. I am also director of the Blue Cross Plan for Hospital Care in Chicago. I was formerly director of the Michigan Hospital Service. And prior to that time I was in hospital administration with the University Hospitals of Cleveland.

The CHAIRMAN. Thank you, Mr. Mannix. Mr. Rorem, you may proceed with your statement.

Mr. ROREM. I have a prepared statement which I would prefer not to read. I would like to summarize the substance of the prepared statement which I have here, first by saying that this testimony might in some respects differ from the others. Instead of talking primarily about Senate bill 1606, we would like to talk about Blue Cross as a significant factor and trend that will influence the Senate, we hope, in its planning for a national health program.

So we are following the spirit of your opening statement, that facts rather than slogans will really contribute to this movement.

We are here, frankly, to espouse the cause and the interests of voluntary prepayment programs. Any statement less than that would not be entirely frank.

We feel that the movement has tremendous opportunities that are just now beginning to be realized.

Seventeen years ago I was engaged in research in medical economics, particularly, and I participated in developing some of the statistics that have been mentioned here as the basis for the need for a coordinated program.

I still have the same conviction that such a program is necessary. Any variation in viewpoint would arise out of experience we have had in this field during the past several years. For we have been spending full time to try to make a prepayment program work.

There are three parts of this testimony.

DESCRIPTION OF THE BLUE CROSS SYSTEM

First, I would like to describe just what a Blue Cross plan is—its character and its significance, something of its history.

Second, some recent developments that I believe are especially significant at this time.

And, third, specific suggestions which the Blue Cross Commission offers, in which we believe you might have interest.

A Blue Cross plan is a nonprofit community organization sponsored by the medical profession, the hospitals, representatives of industry, labor, welfare, Government, the population.

The ordinary Blue Cross plan, which is, of course, a prepayment plan for health service, costs for hospital protection about 75 cents a month per person, or \$2 per family. Medical and surgical protection for hospitalized illness costs about the same.

Typical benefits are 3 or 4 weeks' hospitalization at full coverage, with discounts beyond that period.

The governing body serves on a nonprofit basis, as are the trustees of any nonprofit organization. All that these men get for their work is the satisfaction of having participated in a community program.

The benefits are available in services rather than cash allowances. This is a very important contrast with commercial insurance.

The benefits are guaranteed under contractual arrangements with member hospitals, approximately 3,500 in the United States.

There are 86 Blue Cross plans in the country at the present time. They are supervised through an approval program by the American Hospital Association. This approval program includes various standards such as nonprofit sponsorship, free choice of hospital and doctor, guaranty by the hospitals of the service, financial solvency, and other standards of good business practice.

It is not accidental that prepayment for hospital care has run so far ahead of other types of payment. The basic success of a prepayment plan for hospital care arises from several factors.

In the first place, the hospital system of the country is itself a public system. Of the \$4,000,000,000 invested in hospitals more than 95 percent has been provided on a nonprofit basis either through philanthropy or through taxation, the investors not expecting to get either their money back or the interest on their capital.

In addition to that, the role of the hospital in the community is unique. The hospital itself, as an institution, is held responsible for care of the public. There is not only moral, but in some cases legal, responsibility for the hospital to give care regardless of ability to pay. A situation where a hospital refuses to do this is so rare that it is "news." In our town it happens about twice a year. It is actually in the headlines when some hospital refuses a case because of inability to pay.

A hospital bill combines a high emotional crisis, a severe physical shock, and a large economic expenditure. This explains why people are especially anxious about budgeting hospital bills and why they talk about their operations.

Blue Cross plans now protect approximately 21½ million persons. Growth during the first quarter of this year exceeded our expectations—approximately 1,400,000 in the 3 months just ended—right in the face of the strike situation. This is particularly significant because some of the largest growth during this time was in areas where we were not able to enroll in the strike-bound industries. The State of Massachusetts added 200,000 participants alone.

We might refer to two tables at the end of this testimony which show the percentage of enrollment by State population, in case anyone wishes to look up the State from which he comes.

The percentage of enrolled population is highest in the East and industrial centers, but it is interesting that out of 12 States that have 20 percent or more of their people in Blue Cross, at least 4 States can be classified as rural.

Our statistics show also that even in the industrial States that have a high percentage, such as Michigan, the percentage of enrolled population is just as high in the smaller towns and county-seat cities—throughout the State as it is in the metropolitan centers.

Senator ELLENDER. Might not this low percentage be also due to the fact that many of the States provide facilities for charity patients as is the case in Louisiana?

Mr. ROREM. That is right.

Senator ELLENDER. We have six hospitals in Louisiana entirely maintained by the State and all of the sick people who are unable to pay may obtain hospital services free of charge.

Mr. ROREM. That is one of the factors, of course.

Two factors hold down enrollment on a State level. One is the sheer difficulty of reaching the rural areas and the other is the point you mentioned, namely, it is hard to get people in the habit of paying for something they used to get for nothing.

That is present in any program, voluntary or governmental.

Senator ELLENDER. You say the number of people enrolled aggregate 21½ million. Is that exclusively Blue Cross?

Mr. ROREM. That is exclusively Blue Cross alone.

Senator ELLENDER. For what period of time has the membership been that high? In other words, what has been your progress from year to year in recent years?

Mr. ROREM. This last year a little less than 4,036,000, in the calendar year 1945.

Senator ELLENDER. Has that been your greatest advance?

Mr. ROREM. The last 3 months' enrollment was the largest in our history. They are larger than the last year during the war, which we feel is significant. It surprised us all. We are doing better than we expected.

Apparently the net enrollment is growing more rapidly than ever. Some of the points I mention explain why.

COSTS UNDER THE BLUE CROSS

Senator ELLENDER. I presume in your statement you will tell us what the charges are and what services are made available for those charges?

Mr. ROREM. Yes.

Senator ELLENDER. And how you operate?

Mr. ROREM. Just before you came in I referred to that, but take Louisiana as a fairly reasonable sample. The cost is approximately 75 cents per month for the employed person and approximately \$2 per month per family for complete hospitalization.

The CHAIRMAN. Would you explain what does complete-hospitalization comprise of?

Mr. ROREM. Board and room service, typically in semiprivate accommodations, which is broadly defined according to the community, as meaning rooms with more than one bed. And various special services, operating room, laboratory, anesthesia, basal metabolism.

The CHAIRMAN. Does it include the operating room?

Mr. ROREM. Benefits always include the operating room. We find, in our tabulations, that there is a variation. For example, X-ray is a very controversial feature. It is included in about 50 of the 86 plans which cover about 16,000,000 of the 21,000,000 people. Two of the large plans that exclude X-rays are coordinated with medical plans which do include X-rays. In general, Blue Cross covers pretty nearly the complete service within the hospital.

Senator ELLENDER. What about the doctors' fees?

Mr. ROREM. As to the doctors' fees, that is one of our points in the general development, which I would be glad to mention there.

The CHAIRMAN. Does it include all possible laboratory services that might be required in the case where a person is taken to a hospital?

Mr. ROREM. That is the general principle; yes.

The CHAIRMAN. But they do not all cover that; there is a variation?

Mr. ROREM. There is some variation in the plans.

The CHAIRMAN. Do some plans require extra payment in connection with the use of the operating room?

Mr. ROREM. I know of no plan that has extra payment in connection with the use of the operating room. There are a few types of services that are always included, regardless.

Mr. Mannix can tell you of that.

The typical trend at the present time is to extend rather than reduce the type of illness covered, the type of service, and the length of stay.

The CHAIRMAN. They do not include any medical care prior to entering the hospital?

Mr. ROREM. The Blue Cross plan, as such, does not. But many Blue Cross plans provide emergency care which does not require admission to a bed. A person may come to the out-patient department and receive whatever is necessary and go home. In the past it was not that way.

The CHAIRMAN. Of course, only a person that is eligible for hospital care would be taken into the hospital?

Mr. ROREM. That is right.

The CHAIRMAN. If they were sick and did not require to go to a hospital, and it was not necessary for them to go to a hospital for an operation, of course, they would not be covered?

Mr. ROREM. That is right. This is for hospitalized illnesses or services of the hospital.

I have some comments on the inadequacy of such protection as a part of my testimony. We try to face all these things frankly.

The CHAIRMAN. What we are searching for is the best possible plan whereby the American people can get the modern medical care that is necessary for protecting the health of the American people. If that can be done by a voluntary system, why, of course, no one would want to oppose it. But the feeling is that these voluntary systems, while they are all right as far as they go, they do not go far enough.

Mr. ROREM. We have some suggestions as to how we think they can go further and faster.

The CHAIRMAN. All right.

Senator ELLENDER. Is there any time element in your contract; that is, is this length of time fixed in which a person can have services for the pay that is made each year or each month?

Mr. ROREM. Ordinarily there is a limit, either per illness or per year. But it starts again each year.

The typical contract at the present time is 3 or 4 weeks per year per person of full coverage, plus 60 to 90 days or more at some partial discount, usually about 50 percent of the hospital bill.

Senator ELLENDER. In the event a patient should exceed the time fixed, how is that person taken care of?

Mr. ROREM. He is on his own until the next year starts.

The CHAIRMAN. After an operation is completed and he is dismissed from the hospital, does he continue to get medical care at his home?

Mr. ROREM. Not under the Blue Cross contract.

The CHAIRMAN. So that if he remained ill for some months following that and required medical care, that would be outside the plan?

Mr. ROREM. That is right.

I would like to read the next four paragraphs, because they pertain to what we are discussing. This is page 3, the second full paragraph:

The complete costs of medical care for hospitalized illness (including physicians' services) represent approximately 50 percent of the average family budget for health services. Only one-tenth of the people are hospitalized in the course of a year. Yet, 10 percent of the individuals bear 50 percent of the load for the costs of medical care to the employed population and their dependents.

Which is the more important in the first instance, to cover the 50 percent of the sickness costs which represent the small bills paid by 90 percent of the popu-

lation, or to cover the 50 percent of the costs loaded upon the 10 percent who suffer a serious illness requiring hospitalization? There is no clear-cut answer in principle, but administrative considerations are important.

Access to the facilities and personnel of a good hospital is itself a form of prevention. It removes the economic barrier and encourages the subscriber to seek early treatment and attention.

It is desirable, of course, that patients have early and easy contact with general practitioners and specialists. Yet, it has proved very difficult to initiate and administer such benefits unless both subscribers and practitioners are thoroughly familiar with their rights and responsibilities. The problems of administering the benefits for a minor illness are more complex than for a catastrophic illness. Legislation alone will not remove the practical administration difficulties, nor will it provide the facilities essential to a comprehensive prepayment program of health service.

Now, I regard that as the introduction to the discussion and not as the end of the discussion. Maybe we Blue Cross people are too much occupied with the administrative practicalities of a prepayment program. But we live with them every day and are inclined to judge proposals in terms of whether or not they will work. Maybe we get pessimistic, but we know that administration is difficult. It is easy to demand that somebody else do something, but sometimes it is difficult to follow through. I suppose a Member of Congress knows that better than we.

Senator ELLENDER. Under your plan, who determines whether or not a person is entitled to hospitalization?

Mr. ROREM. The doctor.

Senator ELLENDER. What influence have you over that doctor, if any?

Mr. ROREM. Moral influence only.

Senator ELLENDER. Is he paid by you or by the patient?

Mr. ROREM. Neither. The hospital is paid by the Blue Cross plan. The doctor directly by the medical plan.

Senator ELLENDER. So that your plan is to have hospitalization as one service and then—

Mr. ROREM. Medical care for hospitalized illness for the next; and the third, comprehensive care in the home and in the office.

Senator ELLENDER. All of that could be combined into one policy?

Mr. ROREM. That is right; in a single program.

Senator ELLENDER. Or take either of these three plans.

Mr. ROREM. Yes. It might be done, but ordinarily the public demand starts with the hospitalization. Second, medical care for the catastrophic illness, and third, home and office service.

PAYMENT OF DOCTORS

Senator ELLENDER. Do you propose to cover that phase of the service dealing with the payment of doctors' bills?

Mr. ROREM. Over half of the 86 plans are now coordinated with such a program for doctors. Louisiana happens to be one.

Senator ELLENDER. Who selects the doctors?

Mr. ROREM. The patient.

Senator ELLENDER. The patient. Are they paid on a regular stipulated fee fixed by you or whatever they choose to charge?

Mr. ROREM. There are two kinds of prepayment plans for medical care, which are really modifications of one type. In either the doctors are paid by the plan, not by the patient. The benefits which are paid to the doctor are stated amounts—a fee schedule. For people below

certain income groups in some of the plans the doctors agree that they will not charge more.

Other plans are on an indemnity basis, and do not protect the patient against the doctor charging more. Either the doctor does or does not. In discussing the indemnity basis of paying physicians, many people ask: "How do I know that the doctor will not charge any more?" The simple and straight forward reply to that question is: "Ask him." When they ask the physician if he is going to charge him more, it is amazing how many physicians take the position that the plan's payment is a reasonable amount, in view of the fact that they receive it regularly from every person.

Senator ELLENDER. In fixing these fees, do you have a regular fee rate applicable to all communities, or does it vary in localities?

Mr. ROREM. On the State-wide plans they operate throughout the State as a standard set of fees. There may be as many as 100 different items on the list. For local plans, within a State, they may be different. New York City has four different plans which are slightly different in the payments.

Senator ELLENDER. Do you have any method of employing certain groups of physicians to treat members of your organization.

Mr. ROREM. No.

Senator ELLENDER. It is left entirely to the patient?

Mr. ROREM. That is right.

Senator ELLENDER. However, the doctor must abide by whatever fee system you establish and which is agreed to?

Mr. ROREM. That is right.

Senator BALL. I have to leave in a few minutes.

Mr. ROREM. Yes, sir.

Senator BALL. I would like to ask a couple of questions.

I have been a member of the Blue Cross since it was first organized in Minnesota, and it has done a marvelous job there. Could you tell us what percentage of hospital beds in the country are participating in the Blue Cross plan?

Mr. ROREM. About 80 percent of the general hospital beds under nongovernment auspices. That is a low estimate. I thought you were going to ask this: What percentage of hospital beds are occupied by Blue Cross patients? This ties in very closely with the whole question of need for hospital facilities. Plans are not filling the hospitals. In your State and in Buffalo, Cincinnati and St. Louis, where spot checks have been made, the number of Blue Cross subscribers in the beds of those towns on any given day is smaller in number, percentage-wise than the percentage of the people enrolled. The people arrive earlier and leave earlier. More people go, but they do not stay so long.

Senator BALL. I would like to ask one more question before I leave. I have to go to an Appropriations Committee meeting.

ADMINISTRATIVE EXPENSE

That is, what percentage of your subscription funds goes for administration expense?

Mr. ROREM. On the average, in the United States, 12 percent goes for all types of overhead cost, administrative expense.

In some of the plans it is considerably lower. In Baltimore, for example, 9 percent. In Cleveland, less than 8 percent. It is higher

in the areas where the population is more widely scattered, and it is higher during the early days of organization.

Of this 12 percent, on the average, 3 percent is used for consumer education and what we might call promotion, the entire salaries of the field representatives.

The other 9 percent is for accounting, for keeping track of eligible persons, paying hospital bills.

One out of three Blue Cross families involves a case each year, which means a lot of record keeping.

Senator BALL. A lot of bookkeeping?

Mr. ROREM. A lot of bookkeeping. But, nevertheless, it is approximately 12 percent. About 7 percent this past year went to a reserve for the payment of date bills, and 81 percent was paid out in cash, currently for hospital payments.

Approximately 129 million revenue, 105 million hospital payments, and it would be about 8 million to reserve this year.

Senator BALL. This 21 million, I take it, that are covered, includes the family?

Mr. ROREM. Yes; it does include the family.

Senator BALL. And that is growing pretty fast?

Mr. ROREM. There is no evidence of any slowing up at all. Some of the plans had net deductions following VJ-day, but are now increasing very rapidly.

Senator ELLENDER. Reverting to your method of fixing fees, do you have much difficulty among the doctors of a community as to the schedule of fees you agree to pay?

Mr. ROREM. It is their committee that sets these up.

Senator ELLENDER. So that the fees agreed upon are about what the current ones are, am I right in that?

Mr. ROREM. I am not sure that they would be what the current ones are alleged to be, or what the doctors would like to have them, but they certainly equal what the doctors collect.

Senator ELLENDER. Well, would you say that because of the fact that these prospective sick people belong to your association and that doctors are treated on a large scale, as it were, that the fees are much smaller than they otherwise would be?

Mr. ROREM. I do not believe that the fees are any smaller than the doctors are actually collecting. They are somewhat smaller than the doctors frequently charge, but not smaller than they collect. The fees of a practitioner are not the amount that actually reaches the cash drawer.

Senator ELLENDER. In other words, the average patient is unable to pay as much as the traffic might bear?

Mr. ROREM. That was one of the factors that led to the Committee on the Cost of Medical Care, with which I was employed for a couple of years. Also, one of the factors which leads to public interest in prepayment plans for health service.

The CHAIRMAN. You say that the doctors in the community set up these Blue Cross plans?

Mr. ROREM. No; they set up the fee schedules for the payment to the doctors.

ADMINISTRATION OF BLUE CROSS

The CHAIRMAN. How are these plans managed? Is there a board of directors? What is the system?

Mr. ROREM. You mean the Blue Cross?

The CHAIRMAN. The Blue Cross.

Mr. ROREM. There are several paragraphs that cover the point.

The CHAIRMAN. Will you reach that?

Mr. ROREM. Yes. I have been talking generally about it, but I have actually a statement here.

Senator DONNELL. Mr. Chairman, I think it would be helpful if Mr. Rorem would be kind enough to give us some information before he goes forward.

May I ask you this, the sense in which you use the term "plan" is that it is an organization as defined on your first page as a nonprofit community organization?

Mr. ROREM. That is right.

Senator DONNELL. I am not clear as to just the arrangement existing with respect to it being either a corporate or non-corporate organization. May I ask you a few questions along that line?

Mr. ROREM. Suppose we just take this subject that Senator Murray mentioned and deal with it now?

Senator DONNELL. Might I ask you this question—

Mr. ROREM. I am prepared to go into that now.

Senator DONNELL. If you do not mind, let us take this up now. Suppose in St. Louis, you decide to organize a plan. I understand you have one there.

Mr. ROREM. That is right.

Senator DONNELL. Does the person organizing the plan organize it in a corporate form or a noncorporate form, or, what is done, actually?

Mr. ROREM. You are right in your statement that a plan is the association.

Senator DONNELL. Yes.

Mr. ROREM. In every instance it is a corporation—a nonprofit corporation organized under the laws of the State.

Senator DONNELL. Of the State where it is located?

Mr. ROREM. Of the State where it is located. In most areas it is organized under special enabling legislation, which brings it under the supervision of the Department of Insurance for purposes of determining subscription rates, benefits, payment to hospitals, other administrative and financial features of the program.

Senator DONNELL. Take that plan for instance. Suppose that public-spirited citizens in the city of St. Louis decide to organize a plan and they organize it under the corporate laws of the State of Missouri as the St. Louis Plan No. 1. Does the St. Louis Plan No. 1 become affiliated with some other plans, either in the State of Missouri or elsewhere?

Mr. ROREM. Each plan is a separate legal and administrative entity, but under the Blue Cross Commission, of which I am director, we now have administrative arrangements by which transfers of membership can be made from one plan to another with a minimum of

administrative routine. Also we have arrangements for providing out-of-town benefits when a person is traveling.

Let us take St. Louis as an illustration. Suppose a St. Louis hospital had a subscriber from Chicago. That subscriber would contact the St. Louis hospital, where he needed to be cared for. The hospital would contact the St. Louis Blue Cross plan, which would handle that subscriber just as if he lived there. They would handle the arrangements and collect from Chicago. These are administrative arrangements.

Senator DONNELL. If the chairman will bear with me a moment, I would like to get this a little more clear in my own mind.

Say the St. Louis Plan No. 1 is organized under the corporate laws of St. Louis. It operates itself.

Mr. ROREM. That is right.

Senator DONNELL. And determines what fees it is going to charge to the members.

Mr. ROREM. Within the regulation of the State body.

Senator DONNELL. What do you mean by that?

Mr. ROREM. The State regulatory bodies, departments of insurance or welfare.

Senator DONNELL. Say the insurance department or the State welfare department.

Mr. ROREM. It so happens that Missouri is one of the few where it is not under the insurance department, but in many States it is.

Senator DONNELL. Suppose we take a State where it is. Give me one of those.

Mr. ROREM. Iowa.

Senator DONNELL. Iowa. Just transfer it to Des Moines, Iowa, from St. Louis, Mo. They organize the Des Moines, Iowa, No. 1 plan. That Des Moines No. 1 plan is under the supervision of the State Insurance Department.

Mr. ROREM. That is right.

Senator DONNELL. And then I will call it the "Des Moines" for short. Des Moines decides its own rates it charges those members. Is that right?

Mr. ROREM. That is right.

Senator DONNELL. And it collects its own fees?

Mr. ROREM. That is right.

Senator DONNELL. And disburses its own expenditures?

Mr. ROREM. That is right.

Senator DONNELL. Does it make any contribution to any central organization anywhere under the control of the American Hospital Association?

Mr. ROREM. It does. It makes a contribution to my office.

Senator DONNELL. That is located in Chicago?

Mr. ROREM. That is right.

Senator DONNELL. And that is under the operation of the—

Mr. ROREM. That is a self-contained, self-administered body, but a subdivision of the American Hospital Association.

Senator DONNELL. Is that a corporation or just a Bureau?

Mr. ROREM. It is a trust fund within the corporate structure of the American Hospital Association.

Senator DONNELL. I see. We will take the Des Moines plan. Does it make a contract with the branch up in Chicago of the American Hospital Association, by which it, the Des Moines plan, pays a certain proportion of its receipts into the Chicago office for service of some kind or other?

Mr. ROREM. You mean the Chicago office of the Blue Cross?

Senator DONNELL. Of the American Hospital Association.

Mr. ROREM. Yes; it does. The contract, however, is evidenced by its continuance to pay the dues, and I would like, for the record, to explain how much that is.

Senator DONNELL. It pays an annual dues. How is that determined?

Mr. ROREM. It is determined on the basis of one and one-quarter mills per person a month, or one and one-half cents per year per family, with a maximum which is established.

Senator DONNELL. It pays that into the branch of the American Hospital Association in Chicago?

Mr. ROREM. That is right.

Senator DONNELL. What service does that branch in Chicago render to the Des Moines plan in return for this contribution?

Mr. ROREM. That is a very interesting opportunity to tell you what we do in our office.

Senator DONNELL. Just generally speaking.

Mr. ROREM. First of all, the collection and distribution of the statistical data both as to service and finances.

Senator DONNELL. Yes.

Mr. ROREM. Second, a very extensive type of administrative counsel. Our staff is not large. We have total employees of 16 people. Administrative counsel means conferring with local boards of trustees as to possible changes of rate, methods of enrollment programs for enrolling individuals, or farm groups, which have proved to be effective one place and might be adopted in another. The consumer education program is conducted through our office. We serve primarily as a clearing house rather than a power house.

Senator DONNELL. Does your office suggest to the local office the form of contract to be issued by the Des Moines plan?

Mr. ROREM. Yes. We have a part in the organization. Of course, new plans are very rare now.

Senator DONNELL. Yes.

Mr. ROREM. In the beginning, my office started in an informal way when I was not in the employ of the Blue Cross plan. It started out as a consulting agency. I did not know much, but others knew less. And they say "in the realm of the blind, a one-eyed man is king."

Senator DONNELL. A matter of relativity.

Mr. ROREM. Yes. Now, the situation is reversed and the plans actually support my office.

Senator DONNELL. Then the other plans all over the United States, these 86, they have the same corresponding relation to your office?

Mr. ROREM. Yes.

Senator DONNELL. As does the Des Moines plan I have hypothesized?

Mr. ROREM. That is right.

Senator DONNELL. And I presume that that has a tendency toward uniformity of procedure, subject only to local variations and needs?

Mr. ROREM. Their own self-interest is forcing that. One of the problems in democratic action is to get simplicity, uniformity, and coordination. We spend most of our time on that.

I might digress, because it is not in our testimony, to say this. At present the problem is not to arouse public interest. The problem is to take care of the public. Current emphasis is upon simple administrative designs by which the public can be enrolled just as fast as they want to be enrolled. We do not have to sell them, but we have to take care of them.

Senator DONNELL. Just one further question. These 21,359,258 members on April 1, 1946, belong respectively to some of these 86 plans. I mean by a plan a local organization, each of which has a relationship substantially as you have indicated between the Des Moines plan and the Chicago office?

Mr. ROREM. That is right.

Senator DONNELL. Is that correct?

Mr. ROREM. That is correct.

Senator DONNELL. Yes, sir. I said one more question, but may I ask you just one more. That is, what is the approximate annual income that comes into the Chicago office from these various 86 plans?

Mr. ROREM. Our budget for this year is \$124,000.

Senator DONNELL. I see.

Mr. ROREM. About one-tenth of 1 percent.

Senator DONNELL. The reserve you spoke of, that is a reserve created back in the local plans?

Mr. ROREM. That is right.

Senator DONNELL. It is not a reserve that comes into the American Hospital Association office?

Mr. ROREM. No part of it comes in.

Senator DONNELL. Thank you.

The CHAIRMAN. Doctor, you indicated that a group of public-spirited citizens in any part of the country could get together and organize one of these Blue Cross plans?

Mr. ROREM. That is right.

The CHAIRMAN. After they organized it, then they are in control of it. Do they manage it and determine the manner in which it shall operate or how is that handled?

Mr. ROREM. That is true.

The CHAIRMAN. They do?

Mr. ROREM. They do. Some of the plans have arrangement by which the general public may elect such people, or the subscribers. It has not been administratively so very practical. Usually when the vote is taken, very few come to the meeting. The nominees presented by a nominating committee of subscribers are usually elected. The boards attempt to represent the subscriber interest, the public interest. That is important in the judicious and equitable selection of the people for the boards.

The CHAIRMAN. How are they selected; by the members?

Mr. ROREM. Typically by the board. They are what are commonly called self-perpetuating boards.

Senator DONNELL. How do they start? Who determines the initial membership of them?

Mr. ROREM. It is determined, I suppose, by the strength of the personalities in the organizing committee. In some States it is deter-

mined by law. Colorado, for example, requires that it shall be one-third general public, one-third representatives of hospitals, and if there is a medical plan involved, one-third representative of the medical profession.

The CHAIRMAN. As a practical matter, in the 86 plans developed, are the boards that manage those plans made up of members largely representative of the hospital and the medical profession?

Mr. ROREM. On the arithmetic of that, and depending on the use in which you define the terms, I would say that a large percentage have some direct connection with hospitals, as trustees or for that matter, as administrators.

The CHAIRMAN. Well, the movement to expand the Blue Cross system, as I understand it, has largely come from the hospitals?

Mr. ROREM. In this testimony, the movement has been spoken of as a producer co-op, in contrast to a consumer co-op. That analogy is not quite complete. It has certain elements of completeness. It is not complete in this: That the set-up of the distribution of funds is such that reserves resulting from subscriber's payments can be used only to reduce subscription rates or expand benefits. The payments to the institution are not determined exclusively by the institutions themselves. They are determined through negotiation. And the board of trustees thinks of itself as a channel or a link between two types of public agencies.

On the one hand, the Blue Cross plan represents the public as consumers; on the other hand, the hospitals represent the public as producers.

So it is a link between the hospitals which produce the care and the consumers who receive it.

The CHAIRMAN. In any of the 86 plans that are in existence, is there a board of directors that is made up exclusively of consumers?

Mr. ROREM. Well, if you mean by consumers elected on some sort of a majority vote by the subscribers—

The CHAIRMAN. No; I mean exclusively people who do not belong to the medical or hospital professions.

A VOICE. Connecticut.

Mr. ROREM. I beg your pardon?

The VOICE. Connecticut.

Mr. ROREM. One plan, Cleveland, Ohio, which has the highest percentage of enrollment, has no hospital superintendents on the board. It has hospital trustees; no hospital administrators.

The same thing was true until recently in the State of Connecticut.

The same thing is true of a small plan in Decatur, Ill., in which the dominating factor is the local credit union.

The CHAIRMAN. I believe everyone recognizes the value of the Blue Cross system. The hospitals of the country, as I understand it, found they had great difficulty in maintaining their hospitals, and that the Blue Cross system was of great assistance to them in maintaining regular income. The development of these plans has been of considerable benefit to the hospitals, has it not?

Mr. ROREM. That is right.

The CHAIRMAN. As well as to the public?

Mr. ROREM. That is right.

The CHAIRMAN. To those who belong to the organizations. The only criticism I know of against them is that they do not provide complete coverage, and that they do not represent a sufficient number of the people to bring down the cost as they would with a much wider coverage.

Mr. ROREM. I am interested that you finished your sentence that way. I thought you were going to say "do not have enough consumers on the board of trustees." We feel that the proof of the pudding is not in the recipe but in the cake. The general fact has been that the board of trustees, although they may not be elected representatives of organized labor or of agriculture, have the interest of the subscriber in mind as their dominant concern.

Now, as far as expansion is concerned, I am interested to hear you say that the criticism is that Blue Cross plans have not done more, which is exactly the criticism we make ourselves.

The CHAIRMAN. The great problem we have in this country is to make medical care available to the great masses of the people who have heretofore felt they could not afford to consult a doctor.

Mr. ROREM. That is right.

The CHAIRMAN. If we had a system of that kind in operation in this country, it seems to me we would have less hospital cases.

Mr. ROREM. I agree.

The CHAIRMAN. Because it is neglect that builds up the ill health of the country and makes it necessary for hospital operations in the final end.

Mr. ROREM. That is right.

The CHAIRMAN. So it seems to me that the Blue Cross plan is not effective in that respect, because it does not at the present time cover that situation.

Mr. ROREM. Well, I am interested to hear you say that, because among our suggestions are ways in which we believe the Federal Government can be of genuine help to volunteer programs.

Seven years ago we were very proud, and critics and friends were proud, when we had 1,000,000 members. Now we are apologetic for having only 21½ million, and our critics and friends are apologetic that we have not done more.

We are definitely concerned in anything that will make the present service expand both in its coverage of the type of care and the number of people.

The CHAIRMAN. In these communities where they have established these Blue Cross systems, are all of the medical profession, all the surgeons and specialists, in that community, available for service to the people who belong to these plans, these Blue Cross plans?

Mr. ROREM. For all practical purposes, yes. Probably 90 percent.

The CHAIRMAN. So that a person who belongs to the plan, for instance, over here in Baltimore, who belongs to the Blue Cross plan, could select as the surgeon they wish to have any of the well-known surgeons in Baltimore?

Mr. ROREM. That is right.

The CHAIRMAN. And the same way with other specialists?

Mr. ROREM. Yes.

The CHAIRMAN. They could select any one of them?

Mr. ROREM. Yes.

The CHAIRMAN. And would get that care from that surgeon and specialist under the terms and conditions set forth?

Mr. ROREM. Yes.

The CHAIRMAN. In the Blue Cross plan without any extra fees or otherwise?

Mr. ROREM. Well, not necessarily without any extra fees.

The CHAIRMAN. Oh.

Mr. ROREM. Because that is one of the practical problems with which we are wrestling at the present time, and some members of the medical profession say they do not wish to become participants on that basis. Others say that they will. That is one of the practical problems of obtaining complete medical care cooperation which has to be faced.

The CHAIRMAN. So that in many communities, many doctors of high reputations and good practice do not feel inclined to join the system?

Mr. ROREM. I would say some, not many.

The CHAIRMAN. Some.

Mr. ROREM. Most do participate.

The CHAIRMAN. I see. But there are always some in every community that are very high up in the profession and make a very high income, and of course it would not be to their financial advantage to give their time to a system of that kind?

Mr. ROREM. I do not know whether the "hold-outs" if I may use that term, are primarily the most eminent doctors. I think they have other characteristics, such as just unwillingness to participate even in a plan sponsored by their own profession.

The CHAIRMAN. Rugged individualists.

Mr. ROREM. That is right. I do not think they are necessarily the leading clinicians of the community. They might be; but not necessarily.

The CHAIRMAN. Not necessarily?

Mr. ROREM. No.

The CHAIRMAN. Do not let me interrupt you further.

Mr. ROREM. May I run through these points here?

The CHAIRMAN. Yes.

Senator DONNELL. Do you mind if I interrupt again, Mr. Chairman? I would like to get the organizational basis very clear in my own mind, at any rate, and I think it has importance, particularly as tending to show how practicable it is to have uniform coverage over the country, or, if not uniform, at least wide-spread coverage.

In the first place, let me ask you, Mr. Rorem, is the term "Blue Cross" applied only to those plans supervised by the American Hospital Association?

Mr. ROREM. We apply the term "Blue Cross" only to such plans.

Senator DONNELL. Are there other plans in existence not embraced in what you term "Blue Cross plans"?

Mr. ROREM. Just using that term? Or do you mean in existence?

Senator DONNELL. Are there any others in existence?

Mr. ROREM. There are many.

Senator DONNELL. There are many?

Mr. ROREM. Many.

Senator DONNELL. So the 86 you are referring to here which have 21,300,000 members, those are only the ones that are under the supervision of the American Hospital Association?

Mr. ROREM. That is right.

Senator DONNELL. There are numerous others, too?

Mr. ROREM. That is right. Some of them are very good.

Senator DONNELL. Some of them are very good.

Mr. ROREM. Some are not so good.

Senator DONNELL. And some of them are not so good.

Do you have any idea of what the total number of members is of the ones not under the jurisdiction of the American Hospital Association?

Mr. ROREM. Approximately. We do not know exactly, but a conservative estimate would be more than 10,000,000, unduplicated in count.

Senator DONNELL. I see. Yes, sir. If we would set up, we will say, this Blue Cross plan in Des Moines, Iowa, the Des Moines Plan, and it affiliates with the American Hospital Association, who determines the form of the contract which it issues to those members? Does the local organization do that?

Mr. ROREM. The local organization.

Senator DONNELL. The local organization decides that?

Mr. ROREM. We try to influence its subject matter and form, and its charges to the public.

Senator DONNELL. Has, in practice, the thing worked out so that in these 86 plans there is practically a uniform contract used in all of them between the association and the members?

Mr. ROREM. I would say it is increasingly a uniform contract.

Senator DONNELL. About what proportion of the 86 plans use the same contract or substantially the same contract with their members?

Mr. ROREM. Most of the plans give 3 or 4 weeks of hospitalization per illness or per year plus a substantial discount. All of the plans cover the operating room. All of the plans cover the delivery room. The variation comes in the 10 percent of the cost on such specialized items as basal metabolism tests. Some plans have this, and others do not.

All plans pay the item which comprise 85 percent of the hospital bill, representing room charge, laboratory, and anesthesia, and factors of that type. Others give 86, 87, 95, 100 percent of the bill.

Senator DONNELL. Would this be a fair statement: That the board of trustees of the Des Moines plan would determine its own fees which it would charge the members.

Mr. ROREM. That is right.

Senator DONNELL. And it would issue contracts, which contracts had been decided upon by the trustees?

Mr. ROREM. Yes.

Senator DONNELL. Acting perhaps under the advice of the American Hospital Association, but with the ultimate decision in the board itself?

Mr. ROREM. That is correct.

Senator DONNELL. Then, in addition, the board of trustees has the function of making contracts with the hospitals?

Mr. ROREM. That is exactly true.

Senator DONNELL. Who are going to furnish the services?

Mr. ROREM. That is right.

Senator DONNELL. Does it make contracts with the doctors?

Mr. ROREM. If there is a medical plan involved, it does so.

Senator DONNELL. In the first place, it makes a contract and he gets a doctor, the form of which was determined by the board of trustees. That is the incoming side of it.

Mr. ROREM. That is right.

Senator DONNELL. On the outgoing side of it, the contract is made by the board of trustees with the hospitals, and in some instances, with the doctors?

Mr. ROREM. Yes.

Senator DONNELL. Somebody has to run the office of this local Des Moines Blue Cross. The board of trustees sets up that office and determines who shall be the personnel?

Mr. ROREM. That is right.

Senator DONNELL. And in the States where it is under the supervision of the insurance department, there is perhaps governmental assurance that there will be supervision of the reasonableness of salaries paid and expenditures?

Mr. ROREM. That is correct.

Senator DONNELL. Where there is no governmental supervision, that rests in the integrity and good judgment of the board of trustees; is that right?

Mr. ROREM. That is right. I might say, all employees of Blue Cross work on salaries or for nothing.

Senator DONNELL. I see. One other thing you spoke about was these reciprocal arrangements between the Blue Cross groups.

Mr. ROREM. Yes.

Senator DONNELL. For instance, suppose Des Moines started a Blue Cross and wants the reciprocal arrangement with the other 85. What does it do?

Mr. ROREM. We clear that through our office.

Senator DONNELL. They send it into your office and you take it up with the other 85, and if all 85 agree, it goes into effect.

Mr. ROREM. And if not with all, with some of the plans.

Senator DONNELL. I was going to add that. If only part agree it goes in effect with the part that makes the agreement?

Mr. ROREM. That is right.

Senator DONNELL. Is the reserve you speak of set up in the case of Des Moines by the Des Moines plan as the excess of income over expenditure; that is placed in a reserve?

Mr. ROREM. That is right.

Senator DONNELL. Well, I presume in Iowa, as you have indicated, being under the insurance department, there is some actuarial supervision to determine that they are not going to have a successful history the first 10 years and not go into the hole the next 10 years.

Mr. ROREM. That is a very difficult problem.

Senator DONNELL. And you are assisting on what you regard as a sound actuarial basis; is that right?

Mr. ROREM. That is right.

The CHAIRMAN. Let me ask a few questions.

Mr. ROREM. Yes, sir.

The CHAIRMAN. You have attached to your statement exhibit No. 1, which gives a list of the States of the Union that have these plans.

Mr. ROREM. Yes.

The CHAIRMAN. The plans mount up to 86 plans.

Mr. ROREM. Eighty-six in the United States and Canada, 80 in the United States, and 1 in Puerto Rico.

The CHAIRMAN. And Canada.

Could you furnish the committee with a break-down of that showing the various kinds of plans and the number of groups in each different kind?

Mr. ROREM. You mean the number—

The CHAIRMAN. These plans are not identical, as I understand it.

Mr. ROREM. That is right.

The CHAIRMAN. Some of them cover only certain things.

Mr. ROREM. These are hospitalization plans only.

The CHAIRMAN. These are hospitalization plans only?

Mr. ROREM. Any figures with respect to medical and surgical protection do not appear here at all.

The CHAIRMAN. Are these plans uniform?

Mr. ROREM. For all practical purposes.

The CHAIRMAN. For all practical purposes. Do they omit some of these things?

Mr. ROREM. Some do. We have those tabulations and can supply them to your committee.

The CHAIRMAN. I think it would be a good thing if you did supply them to the committee.

Mr. ROREM. For example, we can tell you how many plans cover X-ray and how many do not, and the total number of people.

The CHAIRMAN. Is there any variation in the methods of management in these plans?

Mr. ROREM. The boards of trustees are the management. The employees are on a salary basis. I am not quite sure what you mean.

The CHAIRMAN. I mean the variations and how the plans are managed. Each plan has a board of directors?

Mr. ROREM. Yes.

The CHAIRMAN. Set up to direct the activities and to see that they get the best possible service at the lowest possible rate.

Mr. ROREM. That is the objective.

The CHAIRMAN. If they can reduce the rate, they are anxious to do so?

Mr. ROREM. That is right.

The CHAIRMAN. And if there is any variation in the methods of management—

Mr. ROREM. They are not basic.

The CHAIRMAN. And in the kind of management, whether it is wholly consumer management or whether it is partly professional management, management of a part of the medical profession or hospitals.

Mr. ROREM. There is no Blue Cross plan that is solely managed by the hospitals.

The CHAIRMAN. No.

Mr. ROREM. That I know of.

The CHAIRMAN. But they have representation?

Mr. ROREM. They have representation on the board.

Mr. ROREM. They have representation on the board dominating influence or merely advisory?

Mr. ROREM. I am glad you asked the question that way, because I know of one plan—and I wish Senator Ball were here, because I would like to have him know about that—in which there is a rather high percentage of hospital administrators on the board of trustees.

We will say, out of a board of 20, there are as many as 7 or 8 hospital administrators, but other hospital managers around state: "The trouble with you hospital superintendents is that when you get on that Blue Cross board you forget about the hospitals. Your mind is always on the subscriber. You forget you are supposed to protect our interest." Apparently there is—

The CHAIRMAN. There is a tendency on the part of those people to lean backward?

Mr. ROREM. That is right.

The CHAIRMAN. In the protection of the consumer?

Mr. ROREM. Yes; even though not appointed by them and even though one might think they were there to represent their own interests. Yet when they face an entire community, looking to them for representation, the tendency appears to be the other way.

I have heard it said many times, "He is not a hospital man any more; he has gone over to Blue Cross." It is very interesting.

The CHAIRMAN. I am very glad to hear that, but I think it would be well if you could, in giving us this break-down, give us the personnel on the board of directors.

Mr. ROREM. We can also give you that, and you will be interested as to the Blue Cross plans which had official representatives of many special groups, particularly agriculture and organized labor.

The CHAIRMAN. Yes.

Mr. ROREM. At the present time only 15 of the plans have actually official appointees of organized labor on their boards of trustees. A number more include people who are members of unions in their personal capacity. It is about the same for agriculture.

The CHAIRMAN. And in giving us this break-down you will also tell where these Blue Cross plans are located?

Mr. ROREM. Oh, yes.

The CHAIRMAN. And the States they are located in and also the communities.

Mr. ROREM. Yes; we have all of that.

Senator DONNELL. What about a State in which there is no governmental supervision over the plan?

Mr. ROREM. There are no such; it is just that it is not always the insurance department.

Senator DONNELL. You take, for instance, in my own State, Missouri, what is it there?

Mr. ROREM. The secretary of state handles that direct.

Senator DONNELL. The secretary of state?

Mr. ROREM. So-called; there is a special type of legislation in your State called the pro forma decree,

Senator DONNELL. Pro forma decree?

Mr. ROREM. It is one of those.

Senator DONNELL. I do not think there is any particular relation attaches, though. A pro forma decree corporation in our State is simply a corporation that is formed under a decree of a certain court.

Mr. ROREM. That is what it is.

Senator DONNELL. And there is no particular supervision thereof by the State, unless there has been some statute passed that I am not familiar with. The thought I have in mind is this: Take, for instance, right in my own city of St. Louis, there will be organized Blue Cross plan No. 6, and that Blue Cross plan, we will say, is not under supervision of the State insurance department. It accumulates a considerable sum of money in the reserve. Is there any effort being made by your organization to induce all of these various voluntary organizations that are in that category, if there are any, to give protection by bonding their employees or otherwise protecting them?

Mr. ROREM. That is taken for granted; all employers are bonded. We would not think of anything less than that.

Senator DONNELL. Has there been any unfortunate experience with any of these Blue Cross plans where there have been defalcations or bad judgment, and money all used up, and the concern ultimately proved unable to meet its obligations?

Mr. ROREM. Oh, no. There have been a few petty defalcations. But it is interesting that a special study by the bonding companies, undertaken because Blue Cross had thought that they were paying too much for personal bonds, revealed the fact that it was possible to write bonds on Blue Cross subscribers at about 50 percent of what had been charged up to that time.

Senator DONNELL. Do you not think that if there had been any States in which there is not governmental supervision guaranteeing proper bonding and other protection for the subscribers, it is important that legislation of that kind be had in the States?

Mr. ROREM. Oh, very much so.

Senator DONNELL. To guarantee local supervision, and along the lines that I have indicated.

Mr. ROREM. The interesting thing, however, is that the local boards of trustees routinely impose much stricter standards upon themselves, because of their own local reputation, than the State regulatory bodies have done.

Senator DONNELL. I can see that likelihood.

Mr. ROREM. Our recommendations with regard to adequacy of reserves have in every instance gone beyond the requirements of the local State insurance departments.

Senator DONNELL. The thought I had in mind was that, in their busy operation of other duties, members of the hospital staffs, and so forth, might delegate to one or two employees in the Blue Cross office unduly large powers, and wake up some day to find some breach of trust there that would prove very disastrous to the subscribers.

Mr. ROREM. I think the boards are very aware of that danger. If anything, they have erred by watching management more closely than necessary for good administration and protection of the subscriber.

Senator DONNELL. Thank you.

The CHAIRMAN. You may go ahead and finish your statement. We will promise not to interrupt you again.

Mr. ROREM. I do not mind; I enjoy it. But I know your time is limited. I would like to run through topic sentences of this statement, and then only stop to explain them. If they seem to be provable by assertion, we will just go on.

RECENT DEVELOPMENTS IN BLUE CROSS

Most of the American population is now eligible for participation in a nonprofit repayment plan for hospital care. Nonprofit Blue Cross plans now serve 43 States and the District of Columbia, and it is expected that the number will reach 47 by the end of the year (every State except Mississippi). According to present plans, Idaho, South Carolina, and Arkansas will come in; we do not hope to get Mississippi in the movement this year.

Residents of small towns are being protected through community enrollment; farm groups are being served through the activities of the farm bureaus, granges, and unions, and the establishment of specially organized county health improvement associations. Rural producers' and consumers' cooperatives also have served as collection and enrollment agencies. In many urban areas enrollment privileges for self-employed persons are being introduced, and Blue Cross is giving increased attention to these groups.

In Iowa there was a unique program started a year ago, which now cover 50,000 people, called the County Health Improvement Association. It is a separate nonprofit organization that costs \$1 per family per year. It is spearheaded by the farm bureau, which does the work, but the public gets the credit, and is a very generous act on the part of that organization, in my judgment.

Two, over half of the 86 Blue Cross plans offer complete protection for catastrophic illness through coordination with plans for medical and/or surgical care.

Very few of the plans have done very much with home and office calls, for the reasons I have mentioned. It takes just as much time and effort to administer a \$5 benefit as a \$50 benefit, and they come 10 times as often. In terms of amount of money involved, there is about 100 times the expense.

Three, the Blue Cross program has proved adequate for the migrant population of recent years.

The transfer procedures are very simple. When a man moves to a new area and applies for membership, he is accepted first and checked on afterward, not the other way. That saves a lot of time. It results in the admission of imposters occasionally, but we find that it is much cheaper and more in the public interest to give the subscriber the benefit of the doubt.

Four, I think we have discussed that. The substance is that selection of boards of trustees, at the present time, is such as to have in mind continuously the interests of the subscriber.

Five, that is a point that Senator Ellender referred to, the subscription rates are within the ability of most of the population to pay, as evidenced by the participation among enrolled groups.

Some of the people in Louisiana, in New York, and Boston, who would be technically and legally eligible for care at the taxpayers' expense, join the Blue Cross and have free choice of the doctor.

The CHAIRMAN. I think that is the natural disposition of the American people, not to be classified as paupers, but willing to pay. That is the reason that this agitation is developing in the country; a lot of poor people who cannot afford to pay the high prices are anxious to find some kind of a national insurance system which would enable them to come in and pay for their medical care.

Mr. ROREM. That is right.

The CHAIRMAN. And not accepted on the basis of being impoverished.

Mr. ROREM. Employer contribution is becoming the characteristic of Blue Cross participation. That reduces the cost to the worker himself.

Six, the problems of adverse selection are being brought under control. I will not dwell on that, but in the early days, we used to settle for a low percentage of enrollment. The self-respecting policy of demanding high percentage of participation is now the regular thing. It improves the selection among the people, so instead of getting all of the potential hospital cases, we get them as well as the rest of the people. A voluntary plan must make sure that the revenue exceeds the expense.

The CHAIRMAN. What health examination do you give an applicant?

Mr. ROREM. None whatever.

The CHAIRMAN. Any ordinary citizen can walk in and join this organization?

Mr. ROREM. That is exactly what he cannot do; an ordinary citizen cannot walk in off the street. He must join through his place of employment, which is the way to improve the selection of people.

An increasing number of the plans now, however, are supplementing their group enrollment. Group enrollment in Blue Cross does not mean what it does in a commercial sense. It refers to groups of 3 or 5 or 10 people. Those same plans now have periods during which people who are in still smaller groups may enroll. But a man cannot come in when he pleases. He joins when the plan pleases, thus avoiding the adverse selection of getting only people who are incipient hospital cases.

Senator DONNELL. Do you not accept members under these plans in some instances from a bar association? If a man belongs to the bar association, he may obtain membership by reason of his membership in the association?

Mr. ROREM. An association is treated as a group. But even their enrollment is scheduled. It is not casual. There are certain dates on which members must make up their minds, if they cannot decide, they wait until a period later to be determined.

Senator DONNELL. I was contrasting that type with the enrollment originating at the place of employment.

Mr. ROREM. For economic purposes they are the same thing. The same holds true of a farmers' producer cooperative, such as a milk cooperative, or a fruit cooperative, payments are frequently withheld from the monthly checks.

The CHAIRMAN. Could any group in the community, organized group, like for instance the bar association, or the different organizations, like the Women's Professional Clubs, could they make application and every member of their organization be entitled to be accepted?

Mr. ROREM. Yes.

The CHAIRMAN. They could?

Mr. ROREM. Yes.

The CHAIRMAN. That would be true of unions, too; for instance, the bartenders union?

Mr. ROREM. Typically the unions wish to handle their dues through their place of employment, through a check-off directly from the employer. But the craft unions, such as you mentioned, would be an illustration of different handling.

The CHAIRMAN. I do not mean that particular one; just any one.

Mr. ROREM. The hotel employees in New York, for example, are all members. The dues are paid by the hotels, but nevertheless the unionized employees are all members.

The CHAIRMAN. As a general rule, a group employed in a New York hotel would be considered a pretty fair risk.

Mr. ROREM. I do not know anything about their income. I do not know what goes on in the kitchen. They do all right on the lobby floor.

Number 7 is the point Senator Donnell mentioned, there is co-ordination in service to the enrollment areas of the Blue Cross in various ways. I will come back to that later.

PROPOSAL FOR GRANTS-IN-AID TO THE BLUE CROSS

Eight. I would like to read. It is, in a sense, a response to comments that have been made in earlier testimony. You see, we are here for the first time to speak for ourselves. We have been flattered that a good deal has been said about Blue Cross in the past, and we are here now to speak for ourselves.

The scope and content of a voluntary plan are necessarily affected by the economic level and available facilities of the community in which the subscribers are enrolled. More comprehensive benefits are available in communities with high income levels, especially industrial centers where there are sufficient hospital beds and diagnostic equipment. These variations permit the establishment of higher standards, which may serve as examples, in areas where the social consciousness of the population has been most fully developed. This variation suggests the ultimate possibility of equalization in service through the use of local, State, or National Government funds. But the difference of income levels and living standards have many causes and will not be offset by merely introducing a prepayment health program.

The CHAIRMAN. Let me ask you there, any community where the facilities are not up to a high standard, and a member in Blue Cross Plan wished to be sent to another community for a particular operation, would that be covered in your plan?

Mr. ROREM. Yes.

The CHAIRMAN. Very frequently it happens in some communities in the thinly populated sections of the country. They have not the men there qualified to operate on certain kinds of cases.

Mr. ROREM. That is right.

The CHAIRMAN. So they have to ship them to Rochester, Minn., or to Johns Hopkins back here in the East.

Mr. ROREM. There the Blue Cross pays the hospital; it does not pay the train fare, of course.

The CHAIRMAN. It pays the hospital bills where they are required to be sent.

Mr. ROREM. That is correct.

The CHAIRMAN. Because of the inability of the local facilities to take care of that.

Mr. ROREM. That is right. They handle that. You see, the general principle is to provide care wherever necessary when the emergency demands. It is just as much an "emergency" to lack the right kind of medical protection in the community as to be caught while traveling.

The CHAIRMAN. Of course if they were to be taken care of by some specialist in the place where they are sent, there might be some extra fees.

Mr. ROREM. Oh, yes; definitely.

Senator DONNELL. One sentence I am not clear on, as to what you mean by that. You say, after referring to the variation discussed under No. 8, this variation suggests the ultimate possibility of equalization in service through the use of local, State, or National governmental funds.

Am I to understand by that that you look with favor along the line of the use of governmental funds for the purpose of financing the treatment of people?

Mr. ROREM. One of our recommendations with which this testimony closes is the approval of the principle of Federal grants in aid to State-approved voluntary programs, to enable the establishment of low subscription rates to people in the low-income groups.

Senator DONNELL. Do you advocate a plan of compulsory health insurance as distinguished from the grants-in-aid plan?

Mr. ROREM. No; this would be a grant-in-aid plan, a federally approved program for voluntary organizations.

Senator DONNELL. What you are referring to here, with an inference of approval, is a plan of grants-in-aid to local subdivisions, perhaps State or even a lower level of governmental subdivision, and you are not advocating, as I understand it, by this sentence the creation of a compulsory health insurance plan. Am I correct in my understanding?

Mr. ROREM. You are entirely correct. In fact, I would go further, and say not only are we not advocating it, but we would regard that as a last step to take—from our point of view, at the present stage of the organization of health service, a premature step.

Senator DONNELL. That is, you are not favoring it at this time at any rate.

Mr. ROREM. Definitely not.

Senator DONNELL. What do you mean by the last step?

Mr. ROREM. In the light of alternatives. Are we cutting in on anyone else's time?

The CHAIRMAN. Go ahead.

Mr. ROREM. I think we will come right back to that, because that is a point in which we have very great interest. We want help. We need plenty of help, if we are going to make the voluntary system work. We need it right from the top on down to the individual worker. We are suggesting ways in which we believe the Federal Government itself might help. New subscribers are responding in higher percentages, and there are progressively fewer cancellations among beneficiaries. I will not dwell on that, but it is true and significant.

Blue Cross protection and other kinds of voluntary programs are being included in wage agreements as a part of the terms of employment. That is a very important factor at the present time.

Organized labor, which frankly sponsors and supports Senate bill 1606, takes the position that they are also worried about whether they are going to be sick tomorrow or the next day or the next. Here is a chance to get something good immediately on a basis that is sound.

VOLUNTARY PAY-ROLL DEDUCTIONS

Paragraph 10. The largest employer in the United States, the Federal Government, does not yet permit the privilege of voluntary pay-roll deduction. The Blue Cross commission office receives letters daily from units of the United States Government asking for the privilege of protection. Yet there are only 300,000 Federal employees and their dependents participating in voluntary plans because of the difficulties involved in handling organization and payment details through voluntary group leaders who are employees of the Federal Government. Mutually satisfactory arrangements are not possible without the privilege of pay-roll deduction.

Our enrollment of Federal employees is up to now approximately 300,000. It is something like the dog walking on his front legs. You are not surprised that he does not do it better. You are amazed he can do it at all.

I am really surprised that we have as many as 300,000 Federal employees now through group leaders, voluntary collectors, sending the money in, and with somebody walking around and asking for \$2 a month. Yet there are about that number.

Pay-roll deduction on a voluntary basis, if authorized in writing by the individual, on groups composed of divisions or departments or bureaus, would make it easier for those who want such protection to get it.

We are not speaking exclusively for Blue Cross at all. I am not, at any rate.

The CHAIRMAN. You find in many of the big industries of the country they are coming to agreement on this problem of pay-roll deductions?

Mr. ROEM. Yes; if they do not come to such an agreement they do not join the Blue Cross in some areas. Blue Cross is now adopting the policy which was established years ago by commercial insurance companies of demanding pay-roll deductions, a procedure which, of course, is recommended in any program, including the one in Senate bill 1606. Pay-roll deduction is absolutely necessary to economy and to maintenance of membership and general efficiency.

No. 11 refers to overhead costs. We have ben over that pretty well, I think. Overhead costs in my opinion have been remarkably low considering the rapid rate of growth.

Twelve. This is incidental, but worth mentioning, because it comes back to the point we mentioned.

Active sponsorship and encouragement of Blue Cross by Federal, State, and local governments can reduce costs to subscribers and in-

crease the membership throughout the country. Certain Department of Agriculture experiments were mentioned in these hearings, and were described as disappointing. It was stated that, among a group of low-income farmers, only 40 to 50 percent of the eligible families too advantage of the privilege of voluntary prepayment for medical and hospital benefits, even though the Federal Government participated in the cost of the program. Initial participation in a voluntary plan by 50 percent of low-income farmers is encouraging. Farmers are the most individualistic and independent-minded part of our entire population. Many have solved their problem of health service by going without the necessary care. If such an experiment were conducted in an urban community, among a group of low-income workers in an industrial plant, probably 85 to 95 percent of the employees would have enrolled. We are making strides in reaching the rural population, and we hope that we will make greater ones.

Thirteen. I will not elaborate on that unless you ask for it.

Many of the Blue Cross plans have increased their benefits during their period of operation without corresponding increase in subscription rates to the beneficiary. The increased benefits have been made possible through better selection among subscribers and decision to apply reserves to provision of immediate benefits. Blue Cross plans are, of course, concerned with providing protection for all costs of hospitalized illness.

Fourteen. Voluntary plans have been accepted by many veterans as a genuine opportunity for family protection.

Blue Cross has thrown down the bars of group enrollment as a patriotic gesture for the enrollment of the veteran and beginning next month, in about 10 days, there will be a 1-month campaign by which veterans will be completely exempted from the group requirements for Blue Cross enrollment.

Some of the plans are already doing so. I have been surprised at the acceptance in Philadelphia, for example, and in Cleveland; literally thousands of veterans who are entitled to G. I. benefits are enrolling, and for two reasons. First, it gives them free choice of doctor and hospital, and second, they recognize that care of the veteran himself is only one-fourth of the total cost, in hospitalization. The wife and children represent three-fourths of the total cost.

Fifteen. Blue Cross plans have been recognized by Government agencies as administrative units for the provision of benefits. The Veterans' Administration has asked Blue Cross to serve as clearing house for them in providing service-connected benefits, but not non-service benefits. That plan is just starting. We do not know how well it is going to work. The Veterans' Administration likes the idea, and we hope that it will be a genuine service to the public.

Of course that is not what the Blue Cross plans were created for, but they can do it.

VOLUNTARY PLANS IN EUROPE

I hope you will bear with me if I say a word about Europe. Much has been said about Europe, both as a matter of history, and otherwise. I have been there, and I have talked to the people who have administered the health insurance plans.

It seems to me that there is very little affirmative suggestion and recommendation that can come from the experience there. The vol-

untary subscribers in America at the present time equal the total population of Holland, Belgium, Norway, Sweden, Denmark, and Finland. Blue Cross plans alone have more members than the entire population of all the Scandinavian countries, which are very civilized countries. I am a Scandinavian myself. But I do not think that experience in a small compact implies that it would be repeated in the United States. It might be.

But the real point I want to mention comes up in connection with voluntary health insurance generally. In England in 1911 there were, I think it is fair to say, literally thousands of small mutual benefit societies. They were scooped into the national health insurance act, and I understand that British officials are still living with the administrative complexities of those plans. Some were, for all practical purposes, private ventures.

In the United States the picture is different. The largest movement in the country is one with a small number of organizations, each operating unit with an average of more than 200,000 participants. There are only 86 in the entire country, and there ought to be less. I think 75 would be plenty. They are all coordinated, and are a network or foundation for a real public service.

Another angle about the European situation in health insurance is this. At the time when health insurance really began to expand, hospitalization was already tax-supported except in England. In European countries—to mention Germany, Norway, and Denmark—the amounts which the health-insurance funds paid to the hospitals, for acute illnesses, were not intended to cover the cost of the operation of those hospitals. They were local government institutions with salaried doctors. We are considering a national program here at a time when the ordinary American thinks of health as a personal problem, to be handled in some sort of joint action. This is one of the few countries where a man still feels his health service is somewhat his own responsibility.

In England there is a voluntary program consisting of "contributory schemes." That was not set up to relieve the patient, but to relieve the taxpayer. The whole motive behind prepayment in the European countries was to give the taxpayer a break. That is an honorable motive also. But it is quite different here, where the first concern is to relieve the individual patient who might need care. In England, the only difference from the continental pattern was that most of the charity work was done in "voluntary" hospitals, supported by well-to-do people who are not allowed to use these hospitals.

Senator DONNELL. You mentioned something about the number of plans, 86; you thought we might well get along with 75. I would like to know just as a matter of interest in my own State. By your table I see that there are two such plans in Missouri. Would you be kind enough, if you happen to recall, to tell us for the record and for our information, what parts of the State, or what proportion of the State of Missouri is covered by those two plans?

Mr. ROREM. St. Louis handles all localities except about 14 counties in northwest Missouri, which are handled out of Kansas City.

Senator DONNELL. Is the entire State of Missouri covered by those two plans?

Mr. ROREM. Yes. That is in different degrees of intensity, of course.

Senator DONNELL. Take a man in Hannibal, Mo.; take St. Louis; you are familiar with that. Suppose a man wants to join Blue Cross. He belongs to the bar association. Is that the same Blue Cross that the man who works for the Rice-Stix Dry Goods Co. joins in St. Louis?

Mr. ROREM. The same one; the same organization.

Senator DONNELL. I see.

The CHAIRMAN. And the State of Missouri, I notice, has a population of 3,524,790, and your membership enrollment in your plan there is 795,819.

Mr. ROREM. Yes.

The CHAIRMAN. That is what percentage?

Mr. ROREM. 22.6 percent.

Senator DONNELL. Actually over this particular State, Mr. ROREM, what proportion would you say, roughly, of the 795,819 are outside of the two larger cities, St. Louis and Kansas City?

Mr. ROREM. Not a very large proportion.

Senator DONNELL. Are you able to tell us how many hundred thousand in round figures belong in St. Louis and Kansas City?

Mr. ROREM. I would be surprised, if you find that more than one-fourth of the Blue Cross people were outside of those two areas. Maybe as much as one-third.

Senator DONNELL. I do not understand that.

Mr. ROREM. Those 2 towns represent a million and a half out of the State population, that is, out of the 3,600,000. Those two towns would represent a third of the population. They probably have from one-half to two-thirds of the total enrollment. There is greater concentration in the urban areas as a rule, because of administrative difficulties in reaching people outside those areas.

Senator DONNELL. How about the farmers in my State? Are they joining the Blue Cross in any considerable numbers?

Mr. ROREM. Not doing as well as they are in Iowa or in Kansas or in Minnesota, but in considerable numbers.

Senator DONNELL. How about the miners—the lead miners—for instance?

Mr. ROREM. That I cannot answer. The miners are joining in western Pennsylvania and elsewhere. We hope they will be joining in Montana before long.

Incidentally, Senator, you will be interested, if you will look at any figures for Montana lately to know that of the 31,000 more than half have been taken in within the last year through the revitalized management of the organization there.

The CHAIRMAN. It is only in recent years that the question has taken hold.

Mr. ROREM. That is right. It is accelerating now. There used to be a statement—and I remember very well when it was made by a person who was not really administering Blue Cross “the first 10,000,000 are the easiest.” From now on it will be difficult. It has proved to be the other way around.

The CHAIRMAN. These bills that have been filed in the Congress for the purpose of bringing about a system of national-health insurance, stimulated interest in the country, a great deal of it, and have brought about this effort to find some way to cure the condition without having to resort to national legislation. But the fear in my mind is that while the Blue Cross plan is a laudable plan, and a plan that everyone should

belong to at the present time, it does not go far enough to cure the problem which confronts the country. I do not think it ever will go far enough to cure the situation.

Mr. ROREM. That is, of course, the thing that we would like to test by experience. Our general plea, if we make one to the Congress, is essentially that we would like its sympathy, encouragement, and practical support.

One of the questions sometimes asked in a discussion like this—usually in good humor, but sometimes not—is, “Now, Mr. So and So, how long will it take for a voluntary plan to achieve this result.” My answer is very simple and elementary. I do not know. But I am convinced it will not take so long if the Government helps us, instead of discouraging or disparaging our efforts.

The CHAIRMAN. The Government has never interfered with the development of these plans, and has sought to protect plans that were developing in the country with a view of serving the people. They brought an indictment against the American Medical Association because of its efforts to prevent just such voluntary groups as this to develop in this country, so that it cannot be said that the United States Government has ever interfered in any way.

Mr. ROREM. We would like to make a specific type of suggestion, because I think it is illustrative of the type of help we deserve. I refer to the matter of pay-roll deduction for Federal employees. It sounds small only at first, only 3,000,000 people. But the example would be tremendous.

The CHAIRMAN. I would be in favor of it if it could be established that through that system we would develop a program which would really bring medical care to every home in the country. I would be in favor of that. I am sure you do not criticize me or others in the Congress who have advocated some system of national health insurance, because every opportunity was available to the American medical profession to start a study of this situation, and to propose plans for overcoming it, but they failed to do it and somebody had to do it. Those of us who did come to the front and undertake it should not be condemned as Socialists or Communists.

Mr. ROREM. I think you rendered a genuine public service in this way. We are trying to do the same thing, perhaps not as well as possible. But we always are up against the problem of administration, as I mentioned earlier, and there is something about experience that makes a person cautious. We might be more lighthearted in our pronouncements and in our claims if we had not been in the field so long. We know what is involved in arousing the public, as opposed to driving the public. It is hard to drive the public. We try to pull them, try to shepherd them—using that in the best and not patronizing sense—of trying to arouse an interest in their self-respect and to make it easy to implement that.

The CHAIRMAN. I am sure that you are helping us.

Senator DONNELL. I rather get the inference from this table, exhibit No. 1, that the Blue Cross has thus far had its maximum growth in the urban areas. That is true, is it not?

Mr. ROREM. That is true. I was going to say in Michigan and in Kansas, as illustrations, the percentage of enrollment is uniform throughout the State. But in Missouri that is not so.

Senator DONNELL. I notice in Missouri it ranks pretty well up here, 22.58. We drop down here to Kansas and only about half of that percentage, 11.32, and then go right across the State line into Oklahoma, and find only 6.74.

Mr. ROREM. That is true.

Senator DONNELL. Is it a fact that the city of St. Louis and Kansas City are largely responsible for the larger percentage?

Mr. ROREM. The explanation is that Missouri has been going twice as long. Kansas doubled its membership last year.

Senator DONNELL. And do you regard it as practicable to extend the Blue Cross operations in rural areas?

Mr. ROREM. Definitely.

Senator DONNELL. As in urban areas?

Mr. ROREM. Definitely. I once asked a man if he believed in total immersion. He replied: "Believe in it? I have seen it done." We do not only believe in it, but are doing it amazingly well. Groups of farmers will come to a meeting at 8:30 in the evening and take cars with them and go out and do the work themselves.

Senator DONNELL. So you do not regard it as an insuperable difficulty to overcome, the fact that a given community is rural. You think that can be overcome by work.

Mr. ROREM. That is right. We need the economic equivalent of a place of employment or a group, and this is very difficult to find where we have one-family farms. But these units—the Farm Bureau, the special associations, cooperatives, the Grange in the East, particularly—have been very helpful.

The CHAIRMAN. You have been working in the rural areas in recent times, have you not?

Mr. ROREM. Yes; and particularly the last 12 months.

The CHAIRMAN. And you are finding it very promising?

Mr. ROREM. Surprisingly so.

The CHAIRMAN. You expect, then, within the next year or two, you would be able to make much better showing?

Mr. ROREM. In the rural areas, yes; and there has never been a time when the prospects for immediate enrollment were as bright as now.

These four points, can I mention them? This is what we would like to see: (1) complete medical care and hospitalization supported by taxation for all public assistance beneficiaries or indigent members of the population. That is in the bill now.

Senator DONNELL. That is grants-in-aid, as I see it.

Mr. ROREM. Blue Cross would not go into that.

Senator DONNELL. That which is set forth in title I, part C, you are in favor of that?

Mr. ROREM. Yes. Here is some discussion of that.

(2) Government aid in the construction of hospitals and clinic facilities in the areas which require such assistance because of generally low income, sparse population, or sudden shift in size of or the composition of the public. This is in Senate bill 191.

The last two are new. Both would require legislation.

(3) Grants-in-aid to State approved voluntary health programs which are also supported by regular contributions from the bene-

ficiaries. Payments might be made to practitioners or institutions, or to prepayment plans under nonprofit auspices.

Such Government assistance would encourage enrollment and have much the same result as legislative compulsion, but with freedom for localities to determine the timing and character of their health programs.

(4) Permissive pay-roll deduction for Federal employees for participation in voluntary prepaid health service program.

I think the prestige value and the administrative features to which we have referred are very important.

The last few paragraphs admit frankly that we know we are not doing everything perfectly. We are trying to perform this task more effectively than we have, and hope that we will get such support as seems appropriate from interested representatives of the public.

We are very much pleased, really, that Blue Cross has come in for mention so frequently and that we are not ignored in the discussion; we are glad to be here in person and to offer you our thought of cooperation and administrative judgment.

Mr. Mannix, I think, who has been giving me moral support, might have a comment to make. Mr. Mannix is the nonpaid chairman of our commission. He is the executive director of the Chicago plan, which is approaching a million members now, and formerly was the executive director of the Michigan plan, which is well over a million.

The CHAIRMAN. Before turning to Mr. Mannix I should like to ask, do you favor the contribution by the Government of funds to make this system spread all over the country, that is to say, to take care of the cases where they are unable to meet the requirements? You would be in favor of Government subsidy to help that out?

Mr. ROREM. As an aid, as opposed to a substitute.

The CHAIRMAN. But you would only confine it to the plan covered by the Blue Cross system?

Mr. ROREM. Oh, no.

The CHAIRMAN. Would you be in favor of that for full coverage of medical care?

Mr. ROREM. That is the Blue Cross objective.

The CHAIRMAN. That is the Blue Cross objective?

Mr. ROREM. Yes.

The CHAIRMAN. You would be in favor of Government aid that would make that apply to the whole country, and cover every citizen in the country, and cover every type and kind of medical care and treatment, and hospitalization?

Mr. ROREM. The main difference there is that we start with the idea of coaxing or assisting or helping or making it easy—offering a bounty, if you wish—as opposed to compulsion.

The CHAIRMAN. Like subsidies, like we give to the farmers or to the mine owners, to develop scarce metals and minerals, pay them a subsidy for a while, until they get the thing going, and then they can go on their own without the subsidy. Thank you very much.

Senator DONNELL. I assume that the complete statement of Mr. Rorem will go in the record with the tables.

The CHAIRMAN. Yes.

(The statement referred to is as follows:)

STATEMENT OF THE BLUE CROSS COMMISSION OF THE AMERICAN HOSPITAL ASSOCIATION, CHICAGO 10, ILL., ON SENATE BILL 1606

(By C. Rufus Rorem, Ph. D., C. P. A., Director, Blue Cross Commission of the American Hospital Association, Chicago 10, Ill.)

Your chairman stated at the opening of these hearings that they were "a challenge to all who participate, a challenge that can be successfully met only by a sincere determination 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."

We are here to present the facts about Blue Cross plans for hospital care, a program which has enrolled more participants in less time than any voluntary movement in the history of the world. We are directly concerned with the administration of voluntary health service, and its management and achievements. We are anxious to expand its virtues and remove its defects, and thus increase its service to our Nation. We believe it should not disappear from the American scene as a noble experiment.

This witness participated 17 years ago in establishing many of the estimates which have been submitted as evidence that no one can tell when he will be sick or what his sickness will cost him. It is now generally recognized that the costs of severe illness weigh heavily upon a small number of people, whereas the larger proportion are faced with only small annual expenditures for necessary health services. The burden of sickness costs can be most effectively carried by application of the law of averages to the payment of hospital bills. The basic question before your committee is the method and degree of such application at the present time.

This testimony will include three subjects:

First, a description of the character and operation of Blue Cross plans with specific data as to enrollment throughout the United States and in various parts of the country.

Second, recent developments in Blue Cross, which indicate that voluntary effort is capable of increasing service to the people.

Third, suggestions of the Blue Cross Commission for immediate action in bringing the benefits of health facilities and services to the American people.

WHAT IS A BLUE CROSS PLAN?

A Blue Cross plan for hospital service is a nonprofit community organization, which accepts regular and equal payments from groups of members, the combined funds being used to pay hospital bills for those members requiring care. The hospital protection may be supplemented by a medically sponsored plan for medical and surgical care. The cost for hospital plan membership is approximately 75 cents a month per person or \$2 per family. Subscription rates for doctors services in hospitalized cases are about the same.

The governing body of a Blue Cross plan includes civic leaders (from industry, medicine, labor, welfare, hospital, agriculture, government) who serve without pay, just as the trustees of a church, social agency, or educational institution. These persons have no financial interest in the success of the Blue Cross plans, yet they devote many hours to professional and administrative policies. Their only reward is participation in a program of community service.

Benefits are available as hospital services rather than cash allowances. The services to subscribers are guaranteed by contracts with groups of community hospitals numbering more than 3,500 throughout the country. Benefits are usually provided in semiprivate accommodations, and they include the special services necessary to diagnosis and treatment. Benefits are available for each family member, usually for 3 or 4 weeks of "full coverage," with extended periods at discounts from regular hospital charges.

Blue Cross plans are supervised through an approval program conducted by the trustees of the American Hospital Association, and in the various States are regulated and supervised by the insurance department or other appropriate body. Usually the plans have been established through special enabling acts. The American Hospital Association's requirements for approval include nonprofit organization, free choice of hospital and physician, hospital guarantee of service benefits, representation of subscriber interests in control. The standards also

provide for the establishment and maintenance of contingency financial reserves to protect the interests of subscribers and member hospitals.

It is not accidental that protection for hospital bills has expanded so rapidly throughout the Nation. The hospitals of America belong to the people, and hospital service is generally recognized as a community responsibility. The \$4,000,000,000 of capital investment in American hospitals has been obtained primarily through funds donated by the general public, either as philanthropy or taxation. The hospitals have assumed a moral, and sometimes legal, obligation to accept emergency cases regardless of their ability to pay. Instances where a patient is refused emergency care are so unusual as to make headlines, or be the subject of editorial comment.

A hospital bill is a special hazard for the individual. It is unpredictable as to time and amount, frequently requires absence from gainful employment and involves additional expenditures for professional care. It involves a severe physical shock, a high emotional crisis, and a large economic expenditure. No wonder we find people "speaking of their operations."

BLUE CROSS ENROLLMENT

Enrollment in Blue Cross has accelerated during the past few years, and particularly the last few months. Growth during the war years was not entirely due to the increased employment and high wages. The three-month period, ending March 31, 1946, witnessed the largest total net increase in the history of the movement; nearly 1,400,000 persons joined during that period. This growth occurred in spite of conversion from war to peacetime industry, and in spite of many strikes in certain industries where Blue Cross protection had been especially well accepted.

The percentage of population enrolled under Blue Cross has been highest in the eastern and northern States where large portions of the population are engaged in industry. Yet, of the 12 States which show a total of more than 20 percent of their population now protected under Blue Cross, 4 of them may definitely be said to be rural in character (see table). In States with the highest percentage of enrollment, our statistics indicate that the proportion of enrollment in the smaller towns equals that of the industrial centers of the various commonwealths.

The complete costs of medical care for hospitalized illness (including physicians' services) represents approximately 50 percent of the average family budget for health services. Only one-tenth of the people are hospitalized in the course of a year. Yet, 10 percent of the individuals bear 50 percent of the load for the costs of medical care to the employed population and their dependents.

Which is the more important—to cover the 50 percent of the sickness costs which represent the small bills paid by 90 percent of the population, or to cover the 50 percent of the costs loaded upon the 10 percent who suffer serious illness requiring hospitalization? There is no clear-cut answer in principles, but administrative considerations are important.

Access to the facilities and personnel of a good hospital is itself a form of prevention. It removes the economic barrier, and encourages the subscriber to seek early treatment and attention.

It is desirable that patients have early and easy contact with general practitioners and specialists. Yet it has proved very difficult to initiate and administer such benefits unless both subscribers and practitioners are thoroughly familiar with their rights and responsibilities. The problems of administering the benefits for a minor illness are more complex than for a catastrophic illness. Legislation alone will not remove the practical administrative difficulties nor will it provide the facilities essential to a comprehensive prepayment program of health service.

RECENT DEVELOPMENTS IN BLUE CROSS

We now turn to a set of affirmative statements which are presented to explain the progress and prospects of voluntary health programs. Frankly, we are doing much better than many of us had ever expected. Eight years ago, we were congratulated for having reached 1,000,000 subscribers. Now we are criticized for merely exceeding 21,000,000 participants. Friends and critics alike are emphasizing the unfinished task rather than the work already done.

(1) *Most of the American population is now eligible for participation in a nonprofit prepayment plan for hospital care.*—Nonprofit Blue Cross plans now serve 43 States and the District of Columbia, and it is expected that the number

will reach 47 by the end of the year and expect to have every State except Mississippi. Residents of small towns are being protected through community enrollment; farm groups are being served through the activities of the farm bureaus, granges, and unions, and the establishment of specially organized county health improvement associations. Rural producers' and consumers' cooperatives also have served as collection and enrollment agencies. In many urban areas enrollment privileges for self-employed persons are being introduced, and Blue Cross is giving increased attention to these groups.

(2) *Over half of the 86 Blue Cross plans offer complete protection for catastrophic illness through coordination with plans for medical or surgical protection.*—This coverage does not meet the full need of the American people, but it removes the most economically burdensome sickness from the shoulders of the individual. Home and office calls also are being offered in some plans, but the administrative complexities of these services have delayed their general inclusion in prepayment programs.

(3) *The Blue Cross program has proved adequate for the migrant population of recent years.*—Blue Cross plans permit convenient transfers of memberships from one Blue Cross plan to another, and they allow continuance of membership when a subscriber leaves his place of original enrollment. Liberal out-of-town benefits are provided. These privileges have been achieved through formal agreements among the various Blue Cross plans.

(4) *Blue Cross plans are representative of the entire community: namely, employers, employees, agriculture, hospitals, the medical profession, welfare groups, and others.*—The social significance of this voluntary sponsorship and guidance cannot be overemphasized. It is consistent with human values derived from permitting individuals to act voluntarily in removing the uncertainty of their sickness costs.

The economic and social foundation of a community hospital is as broad as the population itself. And the combined resources and support of a group of hospitals in a community or a State may be said to represent the combined resources and support of the entire public.

Hospital administrators and trustees regard themselves as administrators and trustees of public funds. The primary purpose of both Blue Cross plans and hospitals is to maximize service for the people who have built the hospitals, who use them, and who support them.

Critics of Blue Cross plans have sometimes described them as "producer cooperatives," implying that their trustees were concerned only with maintaining the status quo of hospital operation and finance. The analogy is something less than complete. For, although the hospitals sponsor and guarantee the Blue Cross plans which enroll potential patients, the net savings are distributable only to the subscribers as increased benefits or reduced subscription rates.

The proof of the pudding is not in the recipe. Blue Cross trustees have typically been able to strike a balance between the interests of subscribers who provide the money and the hospitals which provide the service. They have used the subscribers' funds economically, having regarded for the necessity of maintaining professional standards through adequate payments.

(5) *Subscription rates are within the ability of most of the employed population to pay, as evidenced by the high participation among enrolled groups.*—In the metropolitan areas of the Atlantic seaboard, large numbers of the population have joined Blue Cross including many of those legally eligible for free medical and hospital care at the expense of the taxpayers.

A voluntary (or compulsory) program will be least popular with a group of workers and their dependents who have been accustomed to receiving the same benefits at some other group's expense. Conversely, there is social justification for asking all regularly employed persons to make some contribution toward the costs of their own care. Employers' contributions have made possible very low costs for voluntary plans, and have brought them within the ability to pay of low-income persons.

(6) *Problems of adverse selection are being brought under control.*—In the early days of Blue Cross, groups were allowed to participate even though low percentages were enrolled. The values of protection are now so definitely established that higher percentages are readily obtained, as well as arrangements for pay-roll deduction which are so necessary for maintenance of membership. For individual enrollment of self-employed persons, other methods have been used to achieve proper enrollment and collection as well as the control of adverse selection.

A voluntary health plan must, of course, make sure that its revenue equals its expenses. This has been a factor in developing administrative economy and restricting benefits to those which can be provided without net losses.

(7) *There is coordination in service to the enrollment areas of Blue Cross.*—As a general principle, only one Blue Cross plan is established in each enrollment area. Coordination in the interests of subscribers (in enrollment, payments, and benefits) has been accomplished by the management and trustees of the respective plans.

(8) *The scope and content of a voluntary plan are necessarily affected by the economic level and available facilities of the community in which the subscribers are enrolled.*—More comprehensive benefits are available in communities with high-income levels, especially industrial centers where there are sufficient hospital beds and diagnostic equipment. These variations permit the establishment of higher standards (which may serve as examples) in areas where the social consciousness of the population has been most fully developed. This variation suggests the ultimate possibility of equalization in service through the use of local, State, or National Government funds. But the differences of income levels and living standards have many causes and will not be offset by merely introducing a prepayment health program.

(9) *Subscribers are responding in higher percentages and there are progressively fewer cancellations among beneficiaries.*—This results from the general tendency to grant pay-roll deductions among employed groups, the increasing practice of employer-contributions toward costs, and the ease of transfer and continuance of membership for enrolled subscribers.

Wage agreements between labor unions and management are often written to provide partial or full payment of prepaid health benefits by the employer. Blue Cross has been specially popular in such agreements because of their nonprofit service-benefit features, and the policy of permitting continuance of membership when employment is interrupted by strike, lay-off, or change to another firm.

The advantage of protection has been demonstrated by a number of organizations during recent strikes. Some of the larger corporations in the country have permitted employees to authorize advances during a strike or temporary lay-off. Conversely, Blue Cross plans have often permitted protection to continue, with the idea that payments would be made for a number of months upon return to work.

(10) *The largest employer in the United States (the Federal Government does not yet permit the privilege of voluntary pay-roll deduction.*—The Blue Cross Commission office receives letters daily from units of the United States Government asking for the privilege of protection. Yet there are only 300,000 Federal employees and their dependents participating in voluntary plans because of the difficulties involved in handling organization and payment details through voluntary group leaders who are employees of the Federal Government. Mutually satisfactory arrangements are not possible without the privileges of pay-roll deduction. Undoubtedly the existing makeshift enrollment and collection procedures have in many instances proven to be inefficient for the Government departments involved as well as for the plans.

(11) *Overhead costs have been remarkably low, considering the rapid rate of growth.*—The average "operating expense" for the entire country, for all Blue Cross plans, was approximately 12 percent of the total income during the year 1945. In some of the larger organizations with established memberships, the operating expenses are less than 10 percent of the total subscribers' payments. On the average, about 3 cents of the subscriber's dollar has been used for consumer education and enrollment activities. About 9 cents has been required for accounting and billing procedures and the payment of benefits. The expenses for general administration are being reduced. Plans are now using streamlined methods for maintenance of enrollment records, authorization of hospital admissions, and other administrative economies consistent with good business practice and efficient public service.

(12) *Active sponsorship and encouragement of Blue Cross by Federal, State, and local governments can reduce costs to subscribers and increase the membership throughout the country.*—Certain Department of Agriculture experiments were mentioned in these hearings, and were described as disappointing. It was stated that, among a group of low-income farmers, only 40 to 50 percent of the eligible families took advantage of the privilege of voluntary prepayment for medical and hospital benefits, even though the Federal Government participated

in the cost of the program. Initial participation in a voluntary plan by 50 percent of a group of low-income farmers is encouraging. Farmers are the most individualistic and independent-minded part of our entire population. Many have solved their problems of health service by going without the necessary care. If such an experiment were conducted in an urban community, among a group of low-income workers in an industrial plant, probably 85 to 95 percent of the employees would have enrolled.

The voluntary plans are making great strides in reaching the rural population, and we hope that national agencies will continue to encourage groups in such participation.

(13) *Many of the Blue Cross plans have increased their benefits during their period of operation without corresponding increase in subscription rates to the beneficiary.*—The increased benefits have been made possible through better selection among subscribers and decision to apply reserves to provision of immediate benefits. Blue Cross plans are, of course, concerned with providing protection for all costs of hospitalized illness.

In some cases, increased costs for labor and supplies in hospitals have necessitated increased rates to the subscribers. Usually, however, this has also been accompanied by increased benefits. But the problem of inflation and its effects upon increased cost of hospital care still faces Blue Cross and any program of health service, voluntary or governmental, if the quality and availability of care is to be increased and assured.

(14) *Voluntary plans have been accepted by many veterans as a genuine opportunity for family protection.*—Even though veterans are entitled to care under existing GI legislation, they recognize that at least three-fourths of the care in their families is received by wife and children. Moreover, Blue Cross benefits permits free choice of hospital and doctor, which are not available at the present time for non-service-connected disabilities. Blue Cross plans have exempted returning veterans from the group requirements imposed upon members of the general public, and thousands are being added daily to the Blue Cross rolls.

(15) *Blue Cross plans have been recognized by Government agencies as administrative units for the provision of benefits.*—Many Blue Cross plans have signed formal agreements to serve as clearing houses for medical and hospital care by private physicians and hospitals for service-connected conditions, when such care is authorized by the Veterans' Administration. Suggestions have also been made that Blue Cross represent the State or local Government welfare departments in providing health benefits to public assistance beneficiaries. No definite arrangements for this type of service have yet been completed, but they are under discussion in a number of States. These various procedures are, of course, merely incidental services of an agency established primarily to offer protection to regularly employed persons.

CONTRASTS WITH EUROPEAN EXPERIENCE

It has sometimes been argued that voluntary health insurance is merely the road (or obstacle) to a compulsory plan, as in Europe. It is suggested that Americans should hurdle these obstacles (voluntary plans), and require the entire population to participate immediately in a complete program.

There are a number of differences between the American situation and the European scene. The typical voluntary health-insurance plan in the European countries, before the passage of compulsory laws (notably England), was a small organization with a few thousand beneficiaries. Many were essentially the ventures of private promoters, although legally established as "mutual" friendly societies.

The United States has more participants in voluntary plans that the combined population of Sweden, Norway, Denmark, Belgium, and Holland, all of which have been cited as evidence of need for a Nation-wide plan in this country. Yet the number of American plans is small. And the most successful plans—the Blue Cross—are organized on a nonprofit basis. Each one serves a large community or an entire State. They are coordinated on a national basis.

The provision of service for hospitalized illness in England and continental Europe has long been primarily a public responsibility. The introduction of health insurance in the European countries was essentially a method of relieving the taxpayer, not the worker. The United States is the only country in the world where the average man has ever assumed that a hospital bill was something for which he should be personally responsible.

BLUE CROSS NATIONAL PROGRAM

The matter of when or whether our population is to be included in a national program of financing health service must be decided by our representatives, the Congress. The decision should be influenced by matters of public necessity and convenience. We hope that the Congress will take into account all of the factors in American life, including the results and prospects of existing professionally and community-sponsored programs. We believe, as the chairman has so aptly stated, that all programs should be considered in the light of facts, rather than slogans or prejudices. It has been the purpose of this testimony to bring some of these facts before you.

The Blue Cross Commission favors the following approach to a health program for the American people:

(a) Complete medical care and hospitalization supported by taxation for all public assistance beneficiaries or indigent members of the population. (This feature is title 1, part C, of Senate bill No. 1606.)

The provision of health service as a right to those already receiving public assistance would clarify the position of charitable organizations in the health field, particularly community hospitals. Acceptance by Government for care of the officially declared indigent would permit voluntary plans to remove this burden from member hospitals, and hence from subscribers.

(b) Government aid in the construction of hospitals and clinic facilities in the areas which require such an assistance because of generally low income, sparse population, or sudden shift in size or the composition of the public. (This feature has been recommended by the President and is included in Senate bill No. 191.)

Adequate facilities are a requirement of adequate care. Voluntary plans would increase in usefulness with the better distribution of hospitals and other health facilities.

(c) Grants-in-aid to State-approved voluntary health programs which are also supported by regular contributions from the beneficiaries. Payments might be made to practitioners or institutions, or to prepayment plans under nonprofit auspices.

Such Government assistance would encourage enrollment and have much the same result as legislative compulsion, but with freedom for localities to determine the timing and character of their health program.

(d) Permissive pay-roll deduction for Federal employees for participation in voluntary prepaid health-service program.

It might appear that this is a small portion of our population, and not a significant factor in developing a program for the country. Yet, this large group of people should be entitled to the same conveniences in obtaining prepaid health-service benefits as the rest of the workers in the Nation. Moreover, the prestige of the National Government, in recognizing the individual's right to participate on the voluntary basis, would be a strong and encouraging example to those private employers, as well as to the States and local governments, which have not yet seen fit to provide permissive pay-roll deductions for their own employees.

In conclusion: The purpose of this testimony has been to tell you enough about the character of the Blue Cross movement and to explain its reputation with the American people at the present time. The Blue Cross plans were started and have been maintained to serve a positive need. We wish their contribution to be considered on its merits. No plan is perfect in every respect, and none is achieving every ideal of public service which its leaders recognize as desirable. We know that there is much to be done. And we also know that administration is difficult; agitation is easy.

It is high tribute to voluntary plans that Blue Cross and other ventures have been mentioned so frequently in this testimony. The Senate committee and the United States Congress are to be highly commended for their sustained interest in developing a national health program for the entire population. We offer you our resources and experience and trust that your committee will take all significant facts into consideration in making final recommendations to the United States Congress.

EXHIBIT 1.—Blue Cross enrollment on Apr. 1, 1946, estimated civilian population as of November 1943, and percent of population enrolled on Apr. 1, 1946

State	No. of plans	Enrollment Apr. 1, 1946	Estimated civilian population Nov. 1943	Percent of population enrolled on Apr. 1, 1946
Rhode Island	1	369,603	694,616	53.21
Delaware	1	115,663	273,614	42.27
Massachusetts	1	1,636,527	4,093,072	39.98
Ohio	9	2,229,731	6,828,352	32.65
Connecticut	1	1,570,000	1,748,402	32.60
Colorado	1	332,556	1,067,095	31.16
District of Columbia	1	1,240,000	816,982	29.38
New York	8	1,350,394	12,442,784	28.16
Minnesota	1	649,207	2,525,558	25.71
Pennsylvania	5	2,204,958	9,273,242	23.78
Michigan	1	1,242,258	5,377,329	23.10
Missouri	2	795,819	3,524,790	22.58
New Jersey	1	1,789,361	4,080,485	19.34
Maine	1	150,000	782,312	19.17
Illinois	6	1,381,629	7,563,770	18.27
New Hampshire and Vermont	1	139,365	769,407	18.11
Maryland	1	348,525	1,982,947	17.58
Wisconsin	1	449,650	2,945,355	15.27
North Carolina	2	389,656	3,346,987	11.64
Kansas	1	190,000	1,678,722	11.32
Iowa and South Dakota	2	311,701	2,821,742	11.05
North Dakota	1	145,000	536,510	8.39
Virginia	5	230,533	2,769,828	8.32
Utah	1	41,898	583,572	7.18
Oklahoma	1	134,078	1,987,941	6.74
Montana	1	30,746	470,033	6.54
Kentucky	2	158,766	2,549,108	6.23
Louisiana	3	141,380	2,316,681	6.10
Alabama	1	149,699	2,718,273	5.51
Nebraska	1	64,199	1,176,023	5.46
Washington	1	102,795	1,905,239	5.40
West Virginia	2	83,299	1,732,355	4.81
Indiana	1	159,885	3,383,312	4.73
Oregon	1	53,000	1,172,674	4.52
California and Nevada	3	354,023	8,012,331	4.42
Arizona	1	21,646	569,357	3.80
Texas	1	144,108	6,259,584	2.30
Tennessee	2	62,896	2,818,226	2.23
Georgia	2	60,076	2,976,645	2.02
Florida	1	39,000	2,012,046	1.94
New Mexico	1	3,037	490,119	.62
Total United States served by Blue Cross	80	20,120,213	121,077,420	16.62
States not served by Blue Cross: Arkansas, Idaho, Mississippi, South Carolina and Wyoming			6,230,464	
Total United States	80	20,120,213	127,307,884	15.80
Puerto Rico	1	20,009	1,869,255	1.07
Total Canada ³	5	1,219,036	11,506,655	10.59
Grand total	86	21,339,258	140,683,794	15.18

¹ Estimated.

² Mar. 31.

³ 1941 population—World Almanac.

EXHIBIT 2.—Total Blue Cross Enrollment—Apr. 1, 1937, to Apr. 1, 1946

Year:	Total participants
Apr. 1, 1937	750,745
Apr. 1, 1938	1,611,371
Apr. 1, 1939	3,463,230
Apr. 1, 1940	4,803,099
Apr. 1, 1941	6,499,078
Apr. 1, 1942	9,048,638
Apr. 1, 1943	11,012,602
Apr. 1, 1944	13,798,996
Apr. 1, 1945	17,652,957
Apr. 1, 1946	21,359,258

STATEMENT OF JOHN R. MANNIX

Mr. MANNIX. I will not say very much in conclusion, Dr. Rorem has covered the subject so thoroughly.

I was very interested in your statement to begin with, Senator Murray, that everybody would agree that Blue Cross would be an ideal way of solving this problem. But concern has been expressed that Blue Cross, first, is not comprehensive enough, does not offer sufficient benefits, and second that it does not reach sufficient portions of the American people.

Well, as regards its being more comprehensive, I would like to point out that until 1937, Blue Cross only offered limited hospital care, and only to employed people, not to the family members. We did not, for instance, offer any maternity service at that time.

The CHAIRMAN. That is only since 1937.

Mr. MANNIX. It has been extended to offer maternity, and nervous and mental diseases.

Mr. ROREM. It also had very little enrollment.

Mr. MANNIX. Up to that time we only had about half a million people enrolled.

Beginning in 1937, the service was offered to families. Maternity service was offered in the same year. Beginning in 1939 medical plans were added to offer surgical and obstetrical, and now in three areas, California, New Hampshire, and Buffalo, N. Y., the plans are offering home and office calls, and the tendency is to offer a more and more comprehensive service just as fast as the public is interested in producing sufficient sums of money to pay for it, and as soon as actuarial service justifies the offering of more comprehensive programs.

The CHAIRMAN. When the Blue Cross system first began, were they met with skepticism by the medical profession? Did they oppose them at first?

Mr. MANNIX. I would say that that varied in different parts of the country. I happen to have been in Cleveland at the time, and a great deal of the support that we got was from the Cleveland Academy of Medicine, and from a Dr. Follansbee, who is one of the officials of the AMA at the time. It is true that the members of the American medical profession in certain areas did oppose it. It is true that hospitals did oppose it. It is true that many employers opposed it. It is also true that the public did not support them very much, and we had a problem of education with all four groups. Now we are enrolling about every 5 days as many people as we enrolled in the first 5 years.

The CHAIRMAN. Do you think that if the Blue Cross undertook to give the same coverage as the bill here pending, that is to say, complete medical and home care and office care, and everything pertaining to medical care, do you think that the medical profession would approve Blue Cross system, if it went that far?

Mr. MANNIX. I definitely feel they would.

The CHAIRMAN. You think so. You think that if the Blue Cross plan is successful in its present drives and undertakes to launch out and give the entire medical care to the American people, that they would approve it?

Mr. MANNIX. I believe that is true.

Mr. ROREM. I would like to say one thing here, because it is worth mentioning. We have spoken of Blue Cross as if it was a corporate

entity that provided the medical care. That is not the typical arrangement. The medical care is provided through a parallel organization administered by the same employees as Blue Cross. However, in few instances, like Delaware, North Carolina, Louisiana, one corporation offers complete health service, which is—and I speak now as an administrator as opposed to a social philosopher—preferable.

The CHAIRMAN. Where is that organization?

Mr. ROREM. It is just that the Blue Cross plan has authority to offer complete medical care, in New York, Delaware, West Virginia, Louisiana, and I think in New Hampshire and Vermont.

Mr. MANNIX. It is about to start there.

Mr. ROREM. And in Rhode Island it will start on that basis.

The CHAIRMAN. They are offering complete coverage there?

Mr. ROREM. Offering such medical care as the medical profession at that particular time will participate in. It is not easy; the question that you asked Mr. Mannix, which he answered in the affirmative, and with which I agree, was answered, I am sure, with the full recognition that individuals in the medical profession still offers a field for considerable effort.

The CHAIRMAN. In these places where you say they are making this wider coverage, the cost there, of course, is greater.

Mr. ROREM. Oh, yes.

The CHAIRMAN. And is that limited to certain classes of people or groups, or is it open to the public generally?

Mr. ROREM. Except in one or two instances where it has proved to be a failure, I mean administratively a failure, where income levels are placed upon permission to participate. That is entirely impractical, and has not proved to be acceptable to the American people at all.

The CHAIRMAN. Of course, it would be impossible for the very low income groups in the United States to avail themselves of that system, I mean to say people that are earning less than \$1,200 a year.

Mr. ROREM. It depends on whether the employer participates. We assume that with the expansion of this larger plan, there will be employer contribution. That is taken for granted.

The CHAIRMAN. The employer would contribute, and the employee also?

Mr. ROREM. Yes.

The CHAIRMAN. At the present time on the voluntary basis it would be impossible to expect that a third of the population of the United States would be able to avail itself of that system.

Mr. ROREM. You mean if they paid it entirely themselves? Comprehensive care requires employer contribution, in my opinion, and in some of the instances the employer has been paying more than half, considerably more. Comprehensive care requires employer contribution.

Mr. MANNIX. The entire American public cannot pay for the care now through a Government program.

The CHAIRMAN. Could you furnish us with a list of the States and the membership in those particular Blue Cross plans that give this extensive coverage?

Mr. ROREM. We have all of that, yes.

The CHAIRMAN. And the costs, all of the items that go with that?

Mr. ROREM. Yes.

Senator DONNELL. As we understood here from the context to which question Mr. ROREM was referring, when he said he concurs in Mr. Mannix's response to the question, I do not know that the record makes that quite clear. Would you please tell us what that question was?

Mr. ROREM. The chairman asked if he thought the medical profession would support a comprehensive medical program as it developed, and his reply was yes.

Senator DONNELL. You concur in that?

Mr. ROREM. With the understanding that we are practical people and know there are variations of opinion within the medical profession.

Senator DONNELL. May I ask one other question? This, I take it, applies to both of you two gentlemen; through your business you naturally come in contact with a great many physicians all over the United States through correspondence or in personal contact. Is that right?

Mr. ROREM. That is right.

Senator DONNELL. It is true of both you and Mr. Mannix.

Mr. ROREM. Yes.

The CHAIRMAN. Thank you very much for your statement.

Dr. Alice Hamilton. Doctor, will you give us a little of the background history of your life, when you entered the medical profession, and what different positions you have held?

STATEMENT OF DR. ALICE HAMILTON

Dr. HAMILTON. I never was a practicing physician. I practiced bacteriology during the first years of my medical life, but very soon became interested in industrial medicine, and the greater part of my professional life was spent in a study of the dangerous trades. I was in charge of an industrial survey in Illinois in 1910, and then from 1911 to 1921 I went to the Bureau of Labor Statistics, investigating the dangerous trades, especially the poisonous trades.

The CHAIRMAN. These industrial diseases have been a great menace to the country?

Dr. HAMILTON. Yes.

The CHAIRMAN. They have destroyed the lives of many hundreds of thousands of people in the country; is that not true?

Dr. HAMILTON. Yes; especially as in the early days very little attention had been called to them, and there were no compensation laws; the situation was very different from what it is now.

The CHAIRMAN. Even after they developed compensation laws, they did not recognize these industrial diseases as a basis for compensation?

Dr. HAMILTON. Very often the diagnosis was not made because there was no instruction in the medical schools at that time concerning the industrial poisons, and many ordinary physicians knew nothing about them. So a great many cases went unrecognized.

The CHAIRMAN. For many years no effort was made to prevent those industrial diseases and to protect the workers from them; it was not until the thing had been agitated for a long period of time that they began to apply methods of prevention in the country.

Dr. HAMILTON. That is true. It was taken as an inherent risk in the trade, and it was some time before remedial measures were taken.

The CHAIRMAN. You are entitled to a great deal of credit, I am sure, for taking an interest in a problem of that kind which means so much to the health and welfare of the country. Have you taught medicine? Have you been a professor in any of the colleges, Doctor?

Dr. HAMILTON. Yes; in 1919, between 1919 and 1935 I taught industrial medicine at Harvard. Now I am professor emeritus.

The CHAIRMAN. You are one of the two United States members of the League of Nations Health Committee.

Dr. HAMILTON. Yes; for 6 years.

The CHAIRMAN. And you are familiar and acquainted with organizations connected with health activities in various parts of the world?

Dr. HAMILTON. Well, I made a good many industrial studies in foreign countries.

The CHAIRMAN. Do you have a prepared statement for us here, Doctor?

Dr. HAMILTON. Yes.

The CHAIRMAN. You may follow your statement.

Dr. HAMILTON. I am representing the Consumers League, Mr. Chairman, and I might explain that that is a league founded by Florence Kelly in the early years of the century, of consumers, in order that they might investigate and do what they could to remedy the conditions of the workers whose goods they consumed. That means that we have had a great interest in all of the laws governing labor, especially child labor and the minimum wage, and inasmuch as one cannot study any group of working people without realizing how large a part sickness plays in their difficulties, we became interested early in compulsory health insurance, and passed three resolutions, which I will not read, but which I might just leave for the record.

The CHAIRMAN. They may be submitted for the record.

(The resolutions referred to are as follows:)

RESOLUTIONS ADOPTED AT ANNUAL MEETINGS OF THE NATIONAL CONSUMERS LEAGUE

December 8-9, 1938—Health insurance

Whereas the National Consumers' League in its many years of effort to help improve labor standards has come to recognize that the problems of ill health and low income are inseparable: Therefore be it

Resolved, That the National Consumers League offers its hearty endorsement of the recommendations of the interdepartmental committee as submitted to the National Health Conference and urges that the State and Federal legislatures consider these recommendations for legislative action, with the least possible delay.

December 7-8, 1939—National health program

The National Consumers' League believes that the interests of social welfare of the Nation make mandatory the enactment of the national health program into law with the least possible delay, and pledges its full support in the effort to secure its passage. It goes on record in support of the principle of a health-insurance program on a Federal basis available to all income groups.

January 10-11, 1941—National health program

Believing that the health of the Nation is basic to national defense, the National Consumers' League urges the reintroduction and speedy enactment of the national health program, and pledges its full support to the effort to secure the passage of this measure, and its full cooperation in securing its effective administration. The National Consumers' League reaffirms its stand in favor of the principle of compulsory health insurance on a Federal basis available to all income groups.

Dr. HAMILTON. I am grateful for this opportunity today to discuss the point of view of the National Consumers League with regard to S. 1606, the national health bill. The Consumers League has, for over 50 years, been concerned with the improvement of the living standards of our people. This half century has seen tremendous progress made, progress of which we can rightfully be proud. But as we review the accomplishment of higher income levels, the establishment of minimum-wage laws, unemployment compensation, old-age security, and survey the current picture, the greatest gap on our present social horizon is our unmet health needs.

UNMET HEALTH NEEDS

We must not boast too much of our national health. You have heard witnesses who have appeared before you say that our health is better than in most other countries, that our death rates have shown tremendous declines. But not only have other countries surpassed us, public responsibility demands that we ask ourselves, "How much better could our health record be if we applied our knowledge to the full, made wider use of known techniques, improved our community organization?" Each year we lose hundreds of thousands of lives which need not be lost. Half of the mothers who die in childbirth today need not die. A third of the infant deaths each year could be prevented. Tens of thousands of tuberculosis victims, victims of pneumonia, cancer, and other diseases could be saved.

Other witnesses have shown in great detail that much of the illness which today claims a grim toll could be prevented; that the length of the average illness could be cut down. They have shown how spotty and uneven is our national record, magnificent achievements in some areas, and a backwardness that is heartrending in others. They have shown that even in many of the more advanced areas the lower-income groups experience sickness and mortality rates as high as they were for the Nation as a whole half a century ago. I need not dwell on the fact that we lag far behind what should be our goal. You have heard much on that subject. Preventable losses of life and health are staggering in their proportions; they spell not only unnecessary human suffering, but impose an almost incalculable economic burden on the community.

The National Consumers League has devoted its attention to this problem for many years. In 1938, 1939, and again in 1941, the delegates to the annual meetings voiced their strong approval of the principles of the national health program and urged immediate legislative action especially with regard to compulsory health insurance on a Federal basis, available to all income groups.

I may say we have had as our presidents Newton Baker, John G. Sinant, Josephine Roach, and we have in our group of vice presidents a number of eminent men and women. We feel that the league, with its distinguished membership of leaders in the universities, the church, law, medicine, social work, and other walks of public life, is typical of informed, social-minded opinion throughout the country. There have been very few public issues in our experience which have met with such enthusiastic and widespread support as the national health program in all its aspects.

Why does the League take its stand in strong support of S. 1606?

TITLE I OF S. 1606

Let me speak first and briefly to title I of the bill which provides grants to the States for public-health services, for maternal and child-health services and for the medical care of needy persons.

It is heartening to see how unanimous has been the support of this title. As a physician I was especially gratified to see my colleagues, representing the American Medical Association, indicate their approval of those parts of the national health program incorporated in this title.

The extension of public-health service is vital to any frontal attack on our health problem. This is the core of preventive medicine. Only as we move ahead in this field can we get at many causes of sickness and death the control of which is now within our power. The expenditure of funds to implement this program will be returned many times over in the savings we can effect.

The human and economic waste due to industrial accidents and disease are greater than are generally realized. Industrial accidents alone produce a loss of time on the job equivalent to the maintenance of an army of nearly a million unemployed, year in and year out. The direct and indirect cost to the public of these losses alone have conservatively been estimated at over \$8,000,000,000 a year. The adoption of programs which will strengthen industrial health education, strengthen control and preventive measures for reducing occupational diseases and increase laboratory and field research will bring rewards which will be felt in every industrial center.

Others will speak in detail about part B of title I for the expansion of maternal and child-health services. I wish only to record the strongest support of the National Consumers League of these important provisions. Particularly do we endorse the amendments introduced on the first day of these hearings by Senator Pepper, and which we believe greatly strengthen the original measure. Grants-in-aid to provide adequate maternal and child-health services in the community and to provide personal health services needed by mothers and children not covered by the insurance provisions, would move us rapidly toward what must be our national maternal and child health goal.

I must express the hope that these services be put under the Children's Bureau. The Consumers League has been a strong advocate of the Bureau from its inception. Indeed our founder, Florence Kelly, was one of those most responsible for the founding of the Bureau, and we have followed its course ever since. It has done an excellent job, and we hope it will be given increased means to carry on for all mothers and children not only for the poor and the semipoor.

That health insurance is necessary if adequate medical care is to be provided for all our people is no longer controversial. Even the American Medical Association represented before you last week has accepted the insurance principle. The argument has now narrowed to the question of whether voluntary health insurance or a Nationwide system of Federal health insurance for all will meet our needs.

SHORTCOMINGS OF VOLUNTARY PLANS

Let us look at the voluntary health insurance picture today. Efforts to establish voluntary health insurance in this country date back to the middle of the last century. After nearly 100 years, only about

2.5 percent of the population have comprehensive medical care and hospital service under these plans. Another 10 percent have part of their doctor's fees covered; 12 to 14 percent have only their hospital bill covered. In general, experience shows that costs are high, prohibitive to the majority of our families. Virtually all medical care plans restrict their membership to very limited groups. The services they provide are, with few exceptions, very limited. Turn-over of membership has been found to be excessive. Participants have little or no representation in management.

For instance, in my home in Connecticut, a country district, with dairy and chicken farming, the Blue Cross is beyond our reach, even if we could afford it. It applies only to groups of 10 under the same employer. My neighbors are self-employed.

Remember that 60 percent of our people had incomes less than \$3,000 in the unusually prosperous year of 1944, according to a study of the Bureau of Labor Statistics. In 1941, a year which, over the long run may prove to be more typical, 80 percent had incomes less than \$3,000; 50 percent less than \$1,900. Providing for a family at this level leaves little leeway, especially with prices what they are. It is no wonder that the great majority of our families feel they cannot afford to participate in these voluntary plans and prefer to gamble on the hope that severe illness will not strike them. Nowhere do voluntary plans show their capacity to reach the great masses of our people who are under the \$3,000 income level. Yet to families in this income group, severe illness with its loss of income and attendant medical costs is a catastrophic blow.

ADVANTAGE OF UNIVERSAL COVERAGE

The advantage of universal coverage is that if each contributes a small percentage of income, far smaller than under voluntary plans, a pool of funds is available sufficient to meet all contingencies and to provide a far greater range of services than voluntary insurance can possibly afford.

The representatives of the American Medical Association last week advanced the view that voluntary health insurance would meet our needs. They held that compulsory health insurance is unacceptable because:

First. It limits freedom of choice of the doctor by the patient.

Second. It destroys the relation between doctor and patient.

Third. It provides inferior service and prolongs illness.

Fourth. It imposes an unfair burden on the high-income families, who now enjoy better health, by making them share in the higher costs of those who suffer greater illness.

Fifth. The overwhelming majority of our people need no assistance; in fact they really do not need voluntary insurance, since, according to Dr. Sensenich, their incomes are now sufficient to pay even for major operations.

Sixth. The lower-income groups for whom medical services are a "hardship," cannot be included in any insurance plan. These families are termed the "indigent" and are a public responsibility. All others can take care of themselves.

Seventh. Willful neglect of illness by the individual is a far greater cause of failure to get medical care than lack of income.

Eighth. We need to go slow, and accumulate further experience before venturing on the road to national health insurance.

I would like to outline our position with regard to these objections.

FREEDOM OF CHOICE OF DOCTORS

Far from limiting the freedom of choice of the doctor by the patient, the bill would greatly increase the freedom of choice of an overwhelming majority. There is far less freedom of choice today than many people seem to realize. Our rural and small town people have little choice. I was a member of a committee appointed in Illinois back in 1915 to look into the question of compulsory health insurance, and I was living at that time in Jane Addams Hull House, and was in very close contact with poor people. I knew what our committee investigation later proved, that the close relation and the power between physician and patient, the family physician relation, was not general among the poor. It varied in the cities. It was very seldom found, and the choice was certainly very limited for those people. Those privileges belong to the well-to-do. They do not belong to the poor. You are not taking away from the poor any beautiful relation between patient and physician by a health insurance system, I can assure you.

As for the country, the rural and small town people have little choice. In my home, the choice is determined largely by distance. You employ the physician who can reach you. We have not many doctors in rural Connecticut, and we take the physician nearest. One of our neighboring towns has had for years a very incompetent doctor who fortunately has gone to his rest now. He had a very large practice because he was there. Our choice is very limited.

They must take the local doctor or go without care. The bill would probably increase their freedom of choice by bringing more doctors to smaller communities, since they would be sure of the adequate income these areas now cannot provide. One quarter of our mothers today are unattended in childbirth by a physician. This is not by choice. The bill would give them a choice. Take the studies which indicate that of the more than 8,000,000 cases of illness, disabling for a week or more, over one-fourth of the patients receive no medical care whatever. The bill would make it possible for them to have it.

I hope this bill will supersede a bill for compulsory insurance. I saw it in a number of industries when I first went into industry because in the dangerous trades, the mining and smelting and the heavier trades, the medical care and surgical care was provided, but what happened was that a certain sum was deducted from the man's wages every week, and that supported the medical and surgical system.

Now, that was absolutely undemocratic. There was no choice there. The doctor was chosen, appointed, paid by the employer, and he was the employer's doctor, and the men all looked upon it as such.

THE CHAIRMAN. Those systems have been in vogue in this country for many, many years.

DR. HAMILTON. They are very much modified now. Most of the larger companies bear the expense themselves, but the doctor is still the company doctor. However, the old system is still to be found. I know that it is in the coal-mining industry, for instance, with all

of its old objectionable features. I should hope that this bill would supersede that. That system is compulsory and yet has none of the safeguards provided by this bill.

The CHAIRMAN. Yet the medical profession have accepted that system in various parts of the country and gladly took employment under that system, did they not?

Dr. HAMILTON. Yes, I think there has been no dearth of doctors and surgeons in those industries. Organized medicine did look upon it with a good deal of distrust in the early years; industrial medicine had a very bad name, and I think partly for that reason. But of course now industrial medicine is a perfectly respected and accepted branch.

The CHAIRMAN. And in many of the sections of the country where that system was in vogue they did not have adequate hospitals or facilities for the treatment on a modern basis that we have now.

Dr. HAMILTON. Many of the company hospitals were very good.

The CHAIRMAN. They have developed them in recent times.

Dr. HAMILTON. Oh, yes, greatly increased; the whole situation is very much improved, but the old system does still remain and some very bad spots are evident.

The CHAIRMAN. The leading members of the profession are rendering service under those systems in the various parts of the country.

Dr. HAMILTON. Yes; that is true.

It means, of course, a great many instances that the worker pays twice for his medical care, because he mistrusts the company doctor and goes to his own doctor.

Our lower income families, as a group, have little freedom of choice. The bill would give many of them the first doctor-patient relationship they have ever enjoyed. I have already indicated how large a proportion of our people have incomes under \$2,000. The Bureau of Labor Statistics studies indicate that the average break-even point for urban families of two or more persons was about \$1,950 after income taxes in 1944. It took that much income on the average to avoid going into debt. In other words, families at this income level have little or no savings. The report of families with \$1,950 a year said:

Such families, averaging three persons in size, lived very modestly, spending an average of barely 22 cents per meal per person, and \$30 per month for housing, fuel, light, and refrigeration.

Despite the higher-than-average earnings during the war years, the Bureau found after studying bond purchases in 1944 that—

total bond holdings at income levels below \$3,000 do not comprise much of a backlog to be used for purchase of goods coming back on the civilian markets.

If a family with less than \$3,000 does not have sufficient savings to buy a washing machine or a vacuum cleaner, it is obvious that it does not, by and large, have the reserves to meet the major emergency illness.

S. 1606 would not be necessary if we all needed a doctor once or twice a year. Most of our families can meet this cost. The bill is necessary because the majority of our families cannot budget for the sudden major illness. None of us can know which among us will be next. And when illness strikes, the burden falls unevenly. One-tenth of the people have to pay 40 percent of the total cost each year.

Even as you go up the income scale to \$4,000 and \$5,000 a year there can be little budgeting for the major illness. And when sickness strikes, it all too frequently even at this higher income range, it wipes out the family's entire savings and drives it to borrowing. It is estimated that 85 percent of our families have incomes under \$5,000. All of these would find the insurance principle a godsend.

DOCTOR-PATIENT RELATIONSHIP

Those who are fortunate enough to have a personal family physician today would keep that relationship under the bill. The only change would be that the doctor would be assured of payment. Surely this could not destroy the doctor-patient relationship. The removal of the fear of the cost would bring many a person in for earlier diagnosis and quicker cure.

The opposition says, "Is not freedom curtailed if the doctor of your choice does not elect to come into the system?" Yes; it would be. But experience in the many countries which have adopted health insurance indicates conclusively that all but a very small proportion of physicians elect to come under the plan. There is no reason to believe they would do otherwise in this country. I know that in my neighborhood our conscientious doctors sometimes do not pay as many visits to a patient as they would like to, because they know that the family is brooding over that bill, and is thinking he is running up a big bill. And that holds them back, which is perfectly natural. There is every evidence that the doctors of England and Canada would not, for one moment, turn back the wheels and return to pre-insurance status.

Further another objection of the opposition:

Is not freedom curtailed if the surgeon general exercises his permissive power under the bill to limit the number of insured patients a doctor may serve? If the doctor of your choice has already accepted his quota, is not your freedom limited?

Yes, it is, but I would point out that a traffic light limits your freedom to go where you want to when you want to, but it gives you greater freedom to get there faster in the end. It is my view that it is wiser to leave this limitation in the bill. Without it, abuses may arise. Limitations of time today compel many doctors to refer patients to others, as we all well know.

SHOULD LOW INCOME GROUPS BE INSURED?

Let me turn to another point made by the opposition. Dr. Sensenich maintained last week that because lower income families experience more illness it is unfair to the higher income families to cover both groups in a single plan, for, he said, this would impose disproportionate costs on the more advantaged.

But let me point out, the higher incidence of illness of these lower income families results in very large measure from lack of care. Provide the care and incidence of illness in relation to income will even out quickly.

I never went to a public school, and I had no children to send to a public school, but it has never occurred to me to resent the fact that I pay a school tax. And it must also be said that it is the rich who

pay disproportionately for our schools. The largest families are in the poor group. Many of the rich send their children to private schools. Yet we consider it perfectly fair that universal compulsory education should be supported by all.

Surely when the National Physicians' Committee suggested last week that those to whom medical care is a hardship, the "indigent" as they were termed, should be given "free medicine," he recognized that this cost would have to be met by those with higher incomes. Either way the cost must be met. But surely there can be only one choice as between the democratic system proposed by S. 1606, which, like our school system, would be available to all alike, and the class system proposed by the National Physicians' Committee. Think of the implications of what that committee proposed. A voluntary insurance system for the upper middle income families; State medicine for those who find the payment of medical bills a hardship, based on the indignity of a means test.

Well, I know exactly what this means to my own town. What we call in the Middle West township a stretch of country with three tiny villages, farming country, and forest land. A long illness, a long sojourn in the hospital is a body blow to most of my neighbors. It eats up the savings and it drives them into debt.

CHARITY MEDICINE IS NOT THE ANSWER

It has got to be met in two ways, one or two ways, either assuming a burden of debt which will hang on the family for years, or going "on the town", as we call it. And to the New Englander that is the ultimate disgrace. He will not go on the town. Our town provides very well for our sick. We pay the hospital bills, and we pay the medical bills, but everybody knows it. Everybody knows that that case went on the town, and they do not do it. They do not get the medical care they need, and what medical care they get leaves them burdened with heavy debt.

It is obvious to all that voluntary insurance cannot and will not provide the full range of medical and hospital services for those with incomes under \$3,000, the great majority of our people. Under the National Physicians' Committee plan, these people would have to claim indigence to receive care in their major illnesses, which indubitably impose financial hardship.

I have seen what great blessing the old-age pension bill has brought to our neighborhood. Instead of the poorhouse which is the ultimate disgrace, our old people collect their pensions with no sense of charity, no loss of self respect. They feel it is their due. The Government gives it. The Government is not charity. It means the difference between the poorhouse or being a heavy burden on your married daughters and being a self-respecting paying guest or living on in your own home.

I long to see something of the same sort come in the control of the burden of sickness.

QUALITY OF MEDICAL CARE

Said our friend of AMA: "National health insurance means inferior care." Surely they attack the integrity of our practitioners when they suggest that the quality of care would decline merely be-

cause the doctor is assured of payment. My experience leads me to believe that our doctors, more adequately compensated as they would be under this bill, and relieved of the unpleasant task of appraising capacity to pay, would be free to render better service.

COST OF HEALTH INSURANCE

The A M A tells us that national health insurance is too expensive, but I doubt if S. 1606 would increase our national medical bill. We pay between 4 and 5 percent of our national income now for medical care. The bill does not impose additional costs; it is merely a device to permit us as consumers of medicine to pool our small contributions and thus build a reserve large enough to meet, above all else, the crippling blow of major illness. This is primarily a problem of consumer organization.

PUBLIC DEMAND FOR HEALTH INSURANCE

The polls show us the people's view. The National Opinion Research Center, in a recent survey, found that a large majority want an amendment to the social-security law for payment of doctor and hospital care, even if this means an increase of 1½ percent taken out of their pay checks. I do not believe the doctors themselves are far behind. I cannot forget that back in 1938, before the National Physicians' Committee began their scare campaign, the American Institute of Public Opinion found that 7 out of 10 doctors favored the insurance principle. As a doctor myself, I believe that the bill would bring a greater freedom and a greater opportunity to serve.

I found when I talked to the students in Harvard Medical School that a great many of those young men were for such a system. They wanted to feel that at least their living expenses would be guaranteed to them during the first years of practice when under present conditions they did not see how they would even pay their office rent.

IS IT TOO SOON?

Finally it is claimed that we must not rush into national health insurance precipitately. We must study the pros and cons. We must move cautiously. I ask "How do they define caution?" We have studied this matter for over 50 years. During the years 1915-20, 11 State commissions were appointed to study the adequacy of our health provisions. The studies and investigations made since that time are legion. Twenty-five, thirty, forty years of study should be enough. We have available a magnificent body of experience on the part of nearly 50 countries.

Since my work for over 35 years was in industry, and since I traveled abroad a good deal, making industrial studies, I came to feel that the American worker in contrast to the worker in Britain and in many industrial countries on the Continent passed his life under the shadow of three great fears. These were the fears of unemployment, of sickness, and of old age. Now we have dealt with two of those fears. We have removed them from his horizon. I hope fervently that we will now remove the third fear, the fear of sickness.

Senator DONNELL. You appear for the National Consumers League of which you are the president; I believe you said that was founded by Florence Kelly.

Dr. HAMILTON. Yes.

Senator DONNELL. When was that founded?

Dr. HAMILTON. It was in the early years of this century. I cannot remember whether it was 1900 or 1901; about then.

Senator DONNELL. The resolutions of which you filed copies I observe were passed in 1938, 1939, and 1941.

Dr. HAMILTON. Yes.

Senator DONNELL. Has the league passed any further resolutions since the January 10 or 11, 1941, on the subject of compulsory health insurance?

Dr. HAMILTON. No; I do not think we have. We have had our national secretary in Washington in the interests both of the minimum wage law and of this one, but I do not think we have passed a resolution recently.

Senator DONNELL. When was the most recent annual meeting held of the league?

Dr. HAMILTON. Was it February of this year? No; the annual meeting, that comes in May, and I suppose the last was also in May. It is about that time.

Senator DONNELL. It was last year?

Dr. HAMILTON. Yes; last year.

Senator DONNELL. About how large a gathering was that, do you recall?

Dr. HAMILTON. No; I cannot recall how large that was. I did not attend it myself.

Senator DONNELL. Where was it?

Dr. HAMILTON. It was at Cleveland. Our membership has never been large. I suppose it is about 5,000 members, but we have had more of an influence than those numbers would indicate, because we have been able to secure the cooperation of a number of very well known authorities in the field of philanthropy and economics.

Senator DONNELL. The statement which you have given to us this morning was composed, of course, by yourself and reflects in large part the experience and observations which you have personally had; is that not correct?

Dr. HAMILTON. Yes; I think it is pretty personal, but the data were gathered for me by the Consumers League. I did not have access to them in my country home. I feel quite sure that I am expressing the beliefs and sentiments of the membership of the league. Of course, you see, I have been in it a long time.

Senator DONNELL. I am sure of your sincerity in that. Actually the last resolution passed by the league was in January of 1941 on this subject of compulsory health insurance, is that right?

Dr. HAMILTON. I think so.

Senator DONNELL. That is the last one that you filed here.

Dr. HAMILTON. Yes; I think so. That does not mean we have lost our interest in it. We have had our national secretary here partly because of this bill.

The CHAIRMAN. So the subject of national health insurance is still a subject of great interest.

Dr. HAMILTON. Oh, yes. That is on our agenda; that is on the program for which we work.

The CHAIRMAN. I thank you very much. You have been very modest in your statement in the opening of your testimony with reference to your activities. I believe that the American people are very proud of your record. You have an outstanding position in the field in which you have labored. Thank you very much.

We will meet in the same room tomorrow at 10 o'clock.

(At 12:45 p. m., a recess was taken until Tuesday, April 23, 1946, at 10 a. m.)

NATIONAL HEALTH PROGRAM

TUESDAY, APRIL 23, 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, and Donnell.

The CHAIRMAN. The hearing will come to order. The first witness this morning is Dr. John P. Peters.

Dr. Peters, take the stand, please.

Will you give your name, your residence, and anything connected with your background that you wish to have appear in the record?

STATEMENT OF DR. JOHN P. PETERS, SECRETARY, COMMITTEE OF PHYSICIANS FOR IMPROVEMENT OF MEDICAL CARE

Dr. PETERS. My name is John P. Peters, New Haven. I am professor of Medicine at Yale University. I am appearing here as secretary of the Committee of Physicians for the Improvement of Medical Care.

The CHAIRMAN. How long have you been a physician, Doctor?

Dr. PETERS. I have been a physician since 1913.

The CHAIRMAN. You reside in New York City?

Dr. PETERS. My residence is in New Haven.

The CHAIRMAN. You are a member of the American Medical Association?

Dr. PETERS. Yes.

The CHAIRMAN. Well, Doctor, you may proceed with your statement.

Dr. PETERS. Since its origin in 1937, the Committee of Physicians for the Improvement of Medical Care has consistently advocated a national health program. It has recognized the inadequacy of the medical care now received by a large part of our population and the economic factors responsible for this situation. As physicians the members of the committee have concerned themselves particularly with those features of a health program that affect the quality of medical care, since this is the province in which they can profess some expertness. It is from this point of view especially that the legislation now under consideration has been analyzed. In order to save the time of the senatorial committee, I should like to present for incorporation in the record of these hearings the official statement of the committee of physicians dealing with the bill S. 1606, together with their statement about the previous bill, S. 1050. The latter is included because reference is made to it so frequently in the more recent statements. This will enable me to devote the time at my disposal to emphasizing certain points of major importance.

With the general purposes of this bill the committee is in hearty accord. The success of the program as a whole will obviously depend in no small part upon the financial provisions in the contemplated social-security legislation by which S. 1606 must be implemented. But separate presentation of the medical provisions brings them into relief and focuses attention upon them.

THE NEED FOR INTEGRATION

The multiformity of these provisions has made it necessary to divide the bill into several component parts which, combined, are evidently intended to constitute a comprehensive program. If this is to function efficiently and economically these component parts must be properly integrated. Presumably because some of them involve existing governmental machinery, compromises have been made that jeopardize this integration and the success of the program. Authority for the maternal and child health services is left in the Children's Bureau of the Department of Labor, while all other health services are placed under the authority of the Surgeon General of the Public Health Service. Such division of authority will not conduce to the best conduct of the program. It should be possible to incorporate the valuable experience and service of the Children's Bureau into the health program under a unified administration. Provision for advisory committees to the maternal and child health service also depart from the pattern followed in other parts of the program, leaving too much authority to the Administrator. This should be changed to conform to the formula of title II, in which the appointment, prerogatives, and duties of the advisory council are carefully prescribed and protected.

It is hoped that the full national health program may be instituted at an early date. If legislation establishing certain parts of the program should precede the institution of the comprehensive structure, these partial steps should be so devised that the ultimate whole will be congruous. The Senate has already passed a hospital construction bill, S. 191, that, as Senators Murray and Wagner pointed out, contains some features not appropriate for the medical-care program, which alone can make it effective. This error should not be repeated.

Under grants to States for medical care of needy persons the State or local public agency is permitted to arrange with the Surgeon General to secure medical care for the needy through the system established to care for persons eligible under the prepaid health services of title II. Such arrangements should be made a necessary qualification for grants-in-aid. Any other procedure will necessitate a means test for eligibility and two system of Government-supported medical care with separate machinery. This implies two grades of medical care which is not consistent with the best interests of national health. The administration of a means test and two sets of machinery will lead to confusion and multiply costs. If it is feared that this would necessitates such a radical revision of existing services that it would unduly delay institution of the national health program, a definite, but short, term of years might be set at the end of which this revision must be completed and an inclusive, uniform program for the needy and the self-supporting must be achieved.

CASH BENEFITS ARE UNDESIRABLE

With respect to remuneration for services of physicians reasonably satisfactory solutions have been found for extremely controversial problems. A notable exception to this rule is found in the provision that payment for medical care to the needy can be made by State or local agencies through "money payment to individuals claiming such care." Cash benefits for service are notoriously conducive to abuse. It is incomprehensible that, while they are excluded in other parts of the legislation, they should be admitted in provisions for the needy who are peculiarly vulnerable. If the needy were made eligible for care through the machinery of title II cash benefits for service would presumably be automatically eliminated because they are not included among the method of payment permitted under that title.

PAYMENT OF DOCTORS

The Committee of Physicians has consistently opposed the fee-for-service method of payment in public medical care programs because it engenders abuses, is not conducive to economy and does not promote cooperative effort. If this were allowed to become the chief or sole method of payment, existing groups and teaching hospitals would be threatened and the further formation of groups would be halted. The immediate and complete elimination of fee-for-service payment, on the other hand, would involve a revolution of the existing system of practice that might delay the development of the program. The general principles on which this controversial matter is treated in title II have been wisely conceived. Although the majority of physicians in a locality may elect the system of payment which shall prevail in that locality, it is provided that—

the Surgeon General may also make payments by another method (from among the methods listed in this subsection) to those general * * * practitioners who do not elect the method of such majority.

The word "may" in this clause should be changed to "shall" or "must" if, as I assume, the intention is to assure experimentation in methods of payment for and organization of medical services. If the permissive term is not changed to the mandatory the Surgeon General, despite the best will, might be subjected to such pressure that he could not exercise his authority and would thereby deny experimentation. Our highest court was compelled to act because experimentation in group practice was obstructed by the American Medical Association in the District of Columbia. The possibility of any similar obstruction must be positively prohibited in this program.

The same section recognizes the rights of groups and finally states that—

nothing in this section 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.

Under the negative clause, "nothing shall prohibit," it is conceivable, if improbable, that the Surgeon General might decide not to contract with an excellent hospital, perhaps a teaching hospital, with unfortunate consequences for medical education. It should be made mandatory upon the Surgeon General to negotiate agreements and to enter contracts with hospitals for inclusive services, subject only to

the condition that these institutions conform to the regulations prescribed for the qualification of such organizations.

The economy and efficiency which may be expected from group practice and practice organized in and about hospitals are highly desirable features, but not the chief purposes of the program. They must be used to improve, not cheapen, the quality of medical service. The relative virtues of group practice and individualistic competitive practice or of any two methods of payment can only be compared if they are established on an equal footing. There should be a provision in the bill, therefore, to assure or attempt to assure the payment to physicians of equal remuneration for equivalent services rendered under all systems of payment or practice. This is especially important with respect to contracts for inclusive services with hospitals, which might compete for contracts on grounds that would debase the quality of medical care and prejudice the cause of group practice organized in and about hospitals.

With these institutions contracts will be made for services of two kinds: One, those rendered by the institution as such, consisting of bed and board, administration, and the use of the hospital facilities; two, professional services rendered by physicians and surgeons. By the general provisions of the bill payment for these two kinds of service are placed in different categories. It should be stipulated in the bill that this distinction must be retained in all contracts between the Surgeon General and hospitals for inclusive services. Payments for institutional services and for professional services must be separately prescribed and must be reserved for the purpose for which they are intended. Without such a provision superior accommodations or administration might be used to offset inferior professional services or vice versa.

Generous provisions for the support of medical education and research have been wisely included. The preferential diversion of these resources for 5 years to the education of servicemen should be seriously questioned. More appropriate and speedy means should be found to meet this urgent need. To divert to this purpose funds earmarked for general education and research can only delay progress and, by robbing the coming generation of part of its rightful heritage, will tend to prolong the evil it is aimed to correct. Research and education can be advanced most rapidly only by the ruthless allocation of resources to those who can best utilize them for productive purposes.

BILL DOES NOT AFFECT MEDICAL PRACTICE

In spite of the arduous work involved in the drafting of this legislation and the long and earnest inquiry and effort given to perfecting its provisions, its passage cannot be expected to usher in an immediate millennium of health. It prescribes no change in the present order of medical practice. It merely enables physicians to give and patients to receive more medical care by providing or distributing the funds to meet its cost. Its proponents and supporters, however, sincerely hope that it will lead also to improvement in the quality of medical care, which, in turn, must involve changes in the method of practice. What direction these changes should take can be determined only by experiment, which must, therefore, be fostered by the program. Experiments by the inept in futile or exhausted fields or with improper facilities should be discouraged. The standards of qualification and

regulations which may and will be imposed under the terms of the bill should be regarded as measures to prevent such futility, the repetition of past errors. But obstructions to the unexplored and restrictions on the manner of its exploration must be avoided because they can only delay the discovery of solutions for the problems of medical care. It is with this in view that I have chosen to emphasize certain points that may seem trivial. The corrections to the bill which I have suggested and which are embodied with others in the statement of the Committee of Physicians will, I believe, give to the program the balance of control and freedom of experiment that will facilitate the development of better methods of medical practice and accelerate improvement in the quality of medical care. Without these corrections some of the weak features of our present system might become consolidated and the natural evolution of the program through experiment might be retarded.

S. 1606 SHOULD IMPROVE QUALITY OF SERVICE

Emphasis has been placed by most of the witnesses upon the benefits which the consumers of medical care will derive from the passage of this legislation. Objections will undoubtedly be raised by members of the professions that the wider distribution of medical care promised by the national health program will be achieved at the sacrifice of quality. It is claimed that it will restrict the freedom of physicians. These opinions, emanating chiefly from official spokesmen who belong to the class of consultants and specialists, are predicated upon the premises that the present status of American medicine is eminently satisfactory and has been brought to this high estate by the existing system of practice. The first of these premises has been repeatedly challenged and refuted by witnesses who have already appeared. The second is equally vulnerable. What virtues American medicine may have lie in the potential powers which have been given it by scientific discoveries for which we have come to depend almost entirely upon salaried persons in institutions. The present system of practice, by isolating physicians in offices, effectually removes them from the field of scientific endeavor. By reason of this remoteness they are deprived of the contacts needed to give them even an understanding of the scientific tools they may use. Competitive practice on a fee-for-service basis furnishes no medium for the training of experts or specialists. It offers no careers in the advancement of medical methods. Its complete failure in these respects was never more evident than it is at this moment when we are confronted with the problem of reeducation and relocation of returning medical officers.

Our teaching hospitals have long been organized on group-practice principles in which employment of physicians by salary for full time has been steadily increasing. Progress in this direction has, however, been delayed by the necessity of sustaining, in addition to rightful educational expenses, the costs of medical care. If the latter were assumed by the public as these bills contemplate, freedom would be granted to our educational institutions to develop with new acceleration and to multiply opportunities to young physicians to embark on careers with new hopes and without the dispiriting knowledge that after only a brief time they must abandon productive endeavor for the merely derivative pursuit of office practice without the facilities which they have learned are essential to the best practice and the con-

tacts that can keep them from becoming dated. In further exposition of this thesis I should like to place on record statement 15 of the Committee of Physicians dealing with the influence of a national health program on medical education.

If we have the wisdom and the will, I see in this legislation, not limitation of the freedom of physicians, but a greater freedom, release from the economic restrictions which have kept physicians from the full development and exercise of their powers. I see in it the promise of a bridge across that great gap between the potentialities and the accomplishments of medicine. Many older and established physicians may not welcome and will not know how to use this freedom; but this program is, I take it, built not for them, but for the coming generation. And among the latter there is a growing appreciation of the need for change and increasing support for a national health program.

The CHAIRMAN. Have you with you those documents that you wish to have placed in the record?

Dr. PETERS. Here are the first two, and here is the last one that I spoke of, and I have very carefully marked it.

Senator DONNELL. Do you have extra copies of those?

Dr. PETERS. I have them.

Senator DONNELL. So we may look them over while you are present?

Dr. PETERS. Yes.

(The documents referred to are as follows:)

COMMITTEE OF PHYSICIANS
FOR THE IMPROVEMENT OF MEDICAL CARE, INC.,

July 13, 1945.

STATEMENT No. 15

PUBLIC MEDICAL CARE PROGRAMS AND MEDICAL EDUCATION EFFECTS ON THE QUALITY
OF MEDICAL PRACTICE

Before the war there was a growing realization that, although scientific discoveries were increasing the potentialities of medicine with ever-greater acceleration, the accomplishments of medicine were not keeping pace with these advances. The lag between the discoveries and their enjoyment by a large proportion of the public is deplorably long. Inquiries into the causes of this delay revealed certain fundamental defects in the system of medical practice. The one that attracted most attention, because it was comprehensible to the lay as well as the professional mind, was the growing cost of medical care to both patient and physician. This arose from the need for more prolonged educational training and technical specialization and for costly physical facilities and expert assistance. A second factor was the transformation of medicine, for similar reasons, from a personal service that could be conducted by one individual with comparatively little special equipment, either physical or intellectual, to a highly technical pursuit requiring a broad scientific background with additional training in a particular field. For the best exercise of this skill, cooperation with other physicians with complementary expertness in an environment providing appropriate facilities was required.

In spite of this transformation, a considerable portion of the lay public and the medical profession have continued to regard medicine in traditional terms of personal service. The subject of medical care is discussed almost entirely in terms of the practitioner, as if distribution were the only ingredient of medicine. The two other ingredients, research and education, without which it could not have attained and cannot improve its present high estate, have been regarded as entirely separate functions requiring little consideration in a system intended to provide medical care. Individual private practice in offices cannot contribute adequately to scientific advances, because it does not provide the equipment, assistance and continuity of effort that research demands. The burden of individualistic private practice too frequently segregates the practitioner from the associations and the opportunities whereby he may acquire the knowledge and training prerequisite to the most effective utilization of the products of research.

In medical schools and teaching hospitals these changes were recognized in part. Curricula had been made more rigorous; clinical teaching was conducted in hospitals equipped with the best physical facilities, their general and special services conducted by integrated staffs of competent experts. The fact that teaching hospitals were forced to adopt this pattern is an indication of its superiority. This is further attested by the outstanding reputation for service that these hospitals and others that have imitated their organization have achieved. Internships in them are especially prized. Through their systems of residencies, fellowships, assistantships, and minor faculty positions they have become the chief sources of specialists. From them has emanated clinical investigation. Within their walls the developing physicians have been brought into contact with investigate work, taught to evaluate its products and imbued with the scientific spirit. This seldom came to full fruition, however, because the organization of these institutions did not provide for the continuous development of physicians; but discharged all but the merest handful, at various states of their development into competitive practice, where most of them were forced to get along as well as they could with few of the perquisites they had learned were desirable; close contact with a hospital service, diagnostic and therapeutic facilities, close association with specialists, contact with new thoughts and methods and their inventors. As evidence that these deficiencies were not altogether unappreciated, however, physicians congregated more and more in urban and thickly populated communities where they might at least aspire to better opportunities, thus creating a serious problem of maldistribution.

With the war these deficiencies have been greatly exaggerated. Premedical and medical courses have been accelerated; internships have been curtailed; the number of residencies has been sharply reduced and the terms shortened. Opportunities for more advanced studies have been almost abolished. The faculties and staffs of medical schools have been so depleted that the quality of clinical teaching has inevitably deteriorated. Clinical investigation has been contracted and largely diverted to military projects. The majority of the younger physicians after entering military service have little opportunity to supplement their education; many are almost completely divorced from medical activities.

Not only has the supply of physicians with superior training been cut off, but the quality of all physicians who have been developed under this program has been lowered. If the standards of medical practice are not to be degraded these deficiencies must be corrected. For this purpose the provisions of the GI bill of rights are quite inadequate. Because of the protracted educational course, by the end of an internship the physician has reached maturity. After a term of service in the military forces is added he cannot be treated like a schoolboy or college undergraduate. He does not require formalized classroom exercises. Refresher courses are inadequate. What he needs is experience under competent guidance. He can no longer afford, however, to spend a period of years in internships and residencies without remuneration or on mere subsistence wages. If he could, there are not enough positions of this kind which really offer educational opportunities to absorb even the continuing output from the medical schools. Under the existing system of medical care the great majority of medical officers upon discharge will have no alternative but to enter competitive private practice. Under these circumstances their chances for self-improvement are exceedingly small.

From polls that have been taken the great majority of physicians in service hope to settle in urban communities. This will only exaggerate the present maldistribution of physicians.

One of the reasons for this maldistribution is the lack of adequate facilities for the practice of high-quality medicine in rural and thinly populated areas. Another is the inability of such areas to support the physicians they require. The Hill-Burton bill is intended to provide the needed facilities by the construction of hospitals and medical centers planned in accordance with the needs of the Nation. This will make practice in rural communities more attractive, but it will not insure its quality unless provisions are included in the bill for the organization and remuneration of the staffs of these hospitals, along the lines suggested in statement 13 about the Hill-Burton bill. A national system of hospitals organized in this manner would permanently increase the number of internships and residencies with educational value and would provide for the continuous development of physicians beyond the internship and residency. If these hospitals are integrated on a State, regional, or national basis, careers would not be limited by geographical boundaries. Were such a system available the reeducation and relocation of returning medical officers would be a less insoluble problem. (See Statement No. 14.)

These hospitals and medical centers should have out-patient diagnostic and therapeutic clinics as well as in-patient services. If this were the case and these clinics were organized along the same lines suggested for the hospitals above, educational opportunities would be further multiplied. Moreover, this would tend toward the coordination of in-patient and out-patient services, a feature too often lacking in hospitals today. Without such coordination there is often so little continuity and consistency in therapy that sojourn in the hospital is a little benefit to many patients, who return to an out-patient clinic that follows altogether different therapeutic principles.

EFFECTS ON MEDICAL EDUCATIONAL INSTITUTIONS

The lay public, practitioners and educators have not sufficiently appreciated the educational implications of proposals for State or national programs for medical care. The most indispensable feature of clinical teaching is exemplary medical services. Students will not develop meticulous habits of thought and action if they are exposed on the wards to demonstrations of inferior practice. A medical school must, therefore, have available both hospital and dispensary services with all the equipment, facilities and personnel required for diagnosis and therapy. Sufficient material in the form of patients must be available for teaching and study, with enough physicians, not only to direct and administer care, but also to instruct students, interns and residents. These physicians must have the time not only to perform their medical and educational duties, but also to see that these are correlated with clinical and investigative activities of their associates. They must have both the training to comprehend the scientific advances in their fields and the technical skill to utilize them. These clinical teachers should themselves be constant contributors to medical science.

It is becoming more and more evident that this is impossible if, for the majority of these physicians, clinical teaching and the care of ward patients are only avocations. For this reason full-time salaried staffs have been gradually established and enlarged. Support of a complete full-time system, however, desirable as it might be, places an intolerable burden on education. The clinical departments of a medical school must assume, in addition to their teaching functions, responsibility for the support and care of patients. A variable part of the cost of maintaining these patients is met by public or philanthropic funds; but physicians' services are traditionally gratuitous. Nevertheless, both these items contribute to the benefit of the community. Under these circumstances extension of the full-time system has been extremely slow. It is confined almost entirely to a few administrative heads of departments and to the lowest grades in the educational scale. The system would break down entirely were it not still possible to delegate a large part of the teaching and care to interns and residents who receive no remuneration or only token wages. It follows that careers in clinical teaching are quite rare and that the material available for professional positions is small and not selected in the best manner, because a large proportion of the superior men are forced into competitive practice early in their careers.

Since the care of patients in these hospitals is a public service, its cost should be assumed by the public. If this were done, either through insurance or by tax funds or both, it would be possible to establish complete full-time faculties in medical school and teaching hospitals, or to remunerate members of the staff for the time spent in the care of patients in these hospitals. This would allow these members to devote their energies earnestly to these clinical responsibilities. At the same time it would relieve the medical schools of the burden of supporting purely clinical activities. The funds now used to support these purposes would thereby be made available for activities more directly relevant to education.

Compulsory insurance bills have been presented to the Congress of the United States and numerous State legislatures. The popular demand for legislation of this nature is steadily increasing. Whether these measures are favorably or unfavorably regarded by medical schools, their enactment cannot fail to affect the systems of medical practice and medical education. They would provide the costs of maintenance and medical care for a large proportion of the patients that now enter the wards of teaching hospitals and thereby might solve for clinical departments of medical schools the financial problem described above. They might enable these institutions to extend the full-time system of clinical teaching. If provision were also made to include the medically needy by a supplementary tax-supported system, the costs of all ward patients would be met.

In this case, indeed, unless the teaching hospitals participated in these systems they would have no clinical material. If they did participate they would be obliged to accept insurance or tax funds, and to use these funds for the purposes for which they were intended, to pay physicians for the maintenance and care of patients.

If these health programs are to benefit educational institutions, however, they must be directed to this purpose. The great majority have placed more emphasis upon free choice of an individual physician than on specifications of quality. Payment by fee-for-service is also included in most of these plans. A typical clause, found in the Wagner-Murray-Dingell bill (S. 1161) has been adopted in many State legislative proposals: Payments to general medical practitioners may be made "(a) on the basis of fee-for-services rendered to individuals * * * according to a fee schedule approved by the Surgeon general; (b) on a per capita basis * * * according to the number of individuals * * * on the practitioner's list; (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 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." Since the American Medical Association is uncompromising in its insistence upon fee-for-service payment, this system would undoubtedly be elected by "the majority of the general medical practitioners." In this case the very existence of teaching hospitals would be jeopardized. If they did not qualify for participation in the program they would have no clinical material; if they did participate they would be forced to become open hospitals which would destroy the present organization of clinical faculties and the possibility of controlling the quality of medical care. This is one of the most cogent reasons for insisting upon organized salaried staffs in hospitals. Medical schools cannot afford to ignore this possibility. It has been recognized in two health programs thus far proposed; the bill presented to the California Legislature in behalf of the Congress of Industrial Organizations and the preliminary prospectus of Mayor Fiorello H. LaGuardia's plan for New York city. Both of these measures have special provisions for the protection of educational institutions.

Committee of Physicians for the Improvement of Medical Care, Inc.:
 Channing Frothingham (chairman), Milton C. Winternitz (vice chairman), Carl Binger (vice chairman), Russell L. Cecil (honorary chairman), John P. Peters (secretary and treasurer), Alf S. Alving, Bertram Bernheim, Ernst P. Boas, Samuel Bradbury, Allan M. Butler, Alexander M. Burgess, Hugh Cabot, Louis Casamajor, Thomas B. Cooley, Robert L. DeNormandie, Nathaniel Faxon, Charles A. Flood,¹ Maurice Fremont-Smith, Harry Goldblatt, F. T. H'Doubler, William J. Kerr, H. Clifford Loos, F. D. W. Lukens, George M. Mackenzie, Harry S. Mackler, Irvine McQuarrie, J. H. Means, T. Grier Miller, George R. Minot, Fred D. Mott, Robert B. Osgood, Walter L. Palmer, H. B. Richardson, G. Canby Robinson, David Seegal, Clement A. Smith, Richard M. Smith, Joseph Stokes, Jr., Borden S. Veeder, Allen O. Whipple, James L. Wilson, W. Barry Wood, Jr., Edward L. Young, John P. Peters, M. D., Secretary, 789 Howard Avenue, New Haven 11, Conn.

COMMITTEE OF PHYSICIANS,
 FOR THE IMPROVEMENT OF MEDICAL CARE, INC.,
 October 3, 1945.

STATEMENT No. 16

A SUMMARY AND CRITICAL ANALYSIS OF THE MEDICAL FEATURES OF THE WAGNER-MURRAY-DINGELL BILL (S. 1050), INTRODUCED MAY 24, 1945

GRANTS TO STATES FOR PUBLIC HEALTH SERVICES

The programs of the Public Health Service for the prevention and elimination of venereal diseases and tuberculosis have more than justified themselves. There is hope that by their expansion, especially if they are coordinated with a general

¹ U. S. Army.

medical care program, these diseases may be reduced to a minimum, or even eliminated.

In statement 14, commenting on the report of the Pepper subcommittee, the need for Federal aid in improving the Public Health Services of the States was asserted. The present bill could be used to remedy gradually the defects mentioned in that statement and in the Pepper report.

Like the other provisions of the bill the ultimate authority to allot grants resides with the Federal Security Administrator to whom the recommendations of the Surgeon General must be submitted for approval.

GRANTS TO STATES FOR MATERNAL AND CHILD HEALTH AND WELFARE SERVICES

In statement 6 (August 15, 1939) dealing with the first Wagner bill, the committee of physicians made the following statements:

"Divided control in the planning and execution of the program is incompatible with any sound program for national health. There should be a unified Federal health authority."

"Although special measures * * * may be expedient, the objective should be to provide in every community a unified program of health service and health care.

"There must be a unified Federal authority responsible for the institution and execution of all parts of the health program.

"The authority for a general health program is properly the United States Public Health Service. It is impossible to separate for administrative purposes measures for the prevention from measures for the treatment of disease. * * * Fear has been expressed that the able personnel and efficient work of the Children's Bureau of the Department of Labor or of the Public Health Service or both may suffer if the identity of either organization is lost by merger. Some formula must be devised by which the Federal agencies dealing with various aspects of the same problem may be coordinated and consolidated without impairing their efficiency. Reorganization must recognize the varied professions and agencies involved in a comprehensive program and provide that the interests of each are safeguarded in order that full advantage may be taken of the expert services of all who may contribute to the success of the program.

"Under the supervision of the general health council provisions should be made to continue present Federal health activities, to expand specific activities of proved merit, and to coordinate and merge all such activities into a future general program of health service and medical care. Titles V and VI provide for expansion of maternal and child health programs under the Children's Bureau of the Department of Labor and for the development of medical-care programs for these groups. Since machinery exists for the continuation of the activities of the Children's Bureau and the Public Health Service and they have proved their utility, their reasonable expansion is warranted. The personnel and facilities involved should, however, be incorporated in the reconstituted Federal Health Agency and their activities subjected to review by the general health council. Public health and medical care should not be separated and the care of children and expectant mothers should be integrated with that of the rest of the population."

The committee of physicians is fully aware and appreciative of the excellent pioneer work of the Children's Bureau and believes that it should be maintained in its present position and authority so long as there is no unified national health program. If there is established a comprehensive national medical-care program in which a large proportion of the hospitals and physicians participate in caring for the illnesses and disabilities of the majority of the population, presumably children and mothers will have to receive their care through this machinery. Surely it would be unfortunate if entirely separate machinery had to be provided. In addition the principle of coordinated medical services, proclaimed in other sections of the bill, would be violated by segregating obstetrical and pediatric services from the rest of the system. A unified system, however, with dual control would not conduce to efficiency and economy, but to invidious rivalry and discord.

The committee is well disposed to the extension of the programs for maternal and child health and care for crippled children, provided these are integrated with the medical-care program and machinery of the contemplated national social insurance system. The child-welfare services, provided in section 521 of the same title, are no less desirable, but have no direct relation to a health and medical-care program. They may suitably be consigned to some other authority than the Public Health Service. There is no reason other than a historical one why this

should ultimately be the Department of Labor. If the development of Federal welfare services becomes accelerated, as other provisions of this bill indicate, it may be more suitable for the welfare of the children to be merged with that of their elders. Thus far these services have accumulated within the control of the Social Security Board. Up to the present time this has been almost entirely a fiscal and administrative agency. Its character will need some change if it is to assume the functions of a service agency.

COMPREHENSIVE PUBLIC ASSISTANCE PROGRAM

Intention

This is an essential supplement to the national social insurance system. Unless provision is made for noninsurable needy persons the best interests of preventative medicine cannot be effectively served. Rehabilitation depends upon the proper care of such persons. The most comprehensive insurance system cannot prevent victims of serious and prolonged illness from falling into this category. In times or regions of economic depression it may grow to include large proportions of the people. If a compulsory insurance system is elected as a means of providing for the majority of the population, separate provision must be made for tax-supported care for the needy.

As the Committee of Physicians suggested in its statement on the Wagner bill of 1939 (statement 6) and reiterated in its statement on the previous Wagner-Murray-Dingell bill (S. 1161) (statement 12), it is the opinion of the committee that, when the major part of the population is to be covered and dependents become entitled to benefits, a tax-supported system may be both more equitable and more economical. The committee, nevertheless, recognizes that political expediency and the temper of the public may compel acceptance of the insurance system, despite these inequities and disadvantages.

Even if it is necessary to establish two methods of finance, two systems of medical care would be intolerable, especially if this meant care of two grades of quality, which would be likely. Provision that the needy may enjoy the privileges of the medical machinery established for insured persons is sound. The bill should offer every incentive to the States to provide medical care through the machinery of the national social insurance system. It would probably be preferable to prescribe this as the exclusive procedure for securing such medical care.

Financial

Acceptance of the principle that appropriations be flexible and proportioned to need, when this need is as variable as it has proved to be, is intelligent. The high Federal percentage proposed is equally wise because it will furnish a desirable incentive to the States to qualify for grants for the medical care of the needy.

Qualifications

The general formula used is quite satisfactory.

Benefits

The medical benefits which may be made available under contracts between the States and the Federal authority through the national social insurance system will be discussed under the comments on this title. Cash benefits are essential supplements to any provisions for medical services.

Authority

The Social Security Board is the appropriate authority for the program as a whole. Properly, contracts between States and the Federal authority for medical care come under the control of the Surgeon General, subject to the approval of the Federal Security Administrator.

NATIONAL SOCIAL INSURANCE SYSTEM

Intentions

The attention given to the committee's criticisms of the previous bill is a proof of the receptive attitude of the proponents of this bill to constructive suggestions and their solicitude for the quality of medical services, the chief interest of the Committee of Physicians. The following comments and criticisms are advanced with confidence that they will be received in the same sympathetic spirit.

Coverage

That a program for medical care should ultimately comprehend the whole population has been the opinion of the committee since its inception. The diffi-

culties which attend attempts to provide at one step for the coverage of such an enormous number of persons (100,000,000 to 115,000,000) as this measure contemplates, cannot be minimized. A more gradual procedure would be theoretically advantageous. It might offer opportunity for the development of machinery and administrative techniques by the experimental method and thereby avoid gross initial errors and commitments that would compromise the quality of medical care. No realistic nor equitable program for less comprehensive coverage has been found. One of the inherent objections to a less comprehensive program is the necessity for the introduction of a means test. Circumstances have arisen, moreover, that mark this as a most advantageous moment for a radical revision of our system of medical care. As a result of the war the medical services throughout the Nation have been dislocated. Reorganization of these services and relocation of physicians is inevitable. Provision must be made for further education and distribution of physicians. Medical and hospital care must be provided for veterans. It has been pointed out in the last three statements of the committee (Nos. 13, 14, and 15) that only the institution of a comprehensive national program for medical care will offer a satisfactory solution to these problems.

The committee regrets that it has again seemed necessary to exclude from participation Federal employees. Presumably the reasons for this discrimination are the same as before. It is also regrettable that employees of States cannot be automatically included instead of having their participation contingent upon special arrangements between the States and the Federal authority. The committee wishes to reiterate that "effort should be made to extend to these Government employees unconditionally at least the medical benefits to which existing arrangements do not entitle them" (statement 12).

The provision that servicemen be given generous credit for their service in the military forces is no more than a fitting acknowledgment.

Financial

The motives which actuated the changes in the size of contributions and the income ceiling and the estimated relation of income by the new provisions as compared to that expected from the previous rates are unknown to the Committee of Physicians. Presumably the subject has been carefully studied by the Government's actuarial experts. In any case such estimates must be considered as provisional. No one can predict with certainty the extent to which costs of care will be increased by expansion of services nor how far these increases will be offset by reduction of overhead and other economies which may be anticipated from more systematic organization of these services. Much will depend on the wisdom and efficiency with which the system is planned and conducted. Every effort should be made to achieve economy; but the quality of care will suffer if this economy is achieved at the expense of needed facilities and by reducing remuneration for services to such a point that personnel of the desired quality will not be induced to participate in the program or, if they are induced, will not have the time needed for self-improvement. Efforts should be made to improve the unsatisfactory incomes of physicians in rural areas. It is expressly stated under *Methods and Policies of Administration* below that "methods of payment should be aimed * * * to provide professional and financial incentives to professional advancement of practitioners; to encourage high standards of quality of service by adequate payment to practitioners * * *." If this policy prevails it may be expected that errors in present estimates will be rectified.

Administration of contributions

Provisions for a trust fund and its administration need no particular comment.

HEALTH AND MEDICAL PROVISIONS

Administration

Authorities.—As before, administrative authority is vested in the Surgeon General of the Public Health Service. It has always been the opinion of the Committee of Physicians that a single centralized Federal authority is essential and that the Surgeon General of the Public Health Service is the most appropriate authority in our present governmental structure. Since the health measures are linked with social-security measures that are not related to the functions of the Public Health Service parallel administrative authority must be given to the Social Security Board. This necessitates some higher authority to which both the Public Health Service and the Social Security Board are responsible. For this office the Federal Security Administrator has been selected and has

been endowed with almost absolute veto powers, without the provisions for appeal that exist throughout lower levels of the administrative structure. Such an ultimate authority is probably inescapable. Intelligent appointment and informed public opinion will have to be relied on to insure the wise use of these powers.

Advisory council.—The composition, methods of appointment, functions, and responsibilities remain essentially as before. The Committee of Physicians expressed its general approval of these provisions. Provision is made that there be some representation of the beneficiaries in the Medical Policy Council. This would appear to be an equitable provision. It is specified in various sections of the bill that in some instances consultation with the Advisory Council is mandatory upon the Surgeon General, in others it is elective. With respect to a few matters the initiative is given to the Council. On the whole the authors of the bill have shown good judgment in adopting for each provision the most appropriate of these formulas for the allocation of initiative. Since this Council properly has only advisory functions the committee has held that special provisions should be made for publication of its decisions, recommendations, and studies, to lend force to these recommendations and to deter the authorities from disregarding them. In the present measure the Surgeon General is directed to include a record of these consultations, reports, recommendations, etc., in his report to the regular session of each Congress. In a matter of such concern to the people at large and one in which reports are likely to be of such general interest and may often have economic and scientific importance, the public interest would be better served if provision were made for the regular publication of reports by the Council on matters which it feels should be called to the public's attention. The right to issue such reports should reside with the Council, unconditioned by the approval of any authority.

The provisions for the institution of special and regional councils and committees and the provisions for appeal bodies and their procedures seem adequate.

Medical and hospitalization benefits

These again follow the pattern of the previous bill with a few notable exceptions to which attention will be drawn.

The personal health benefits are defined in the same unexceptionable terms.

Limitations on benefits.—Objections must again be raised to the provisions in section 210, page 91, authorizing the Surgeon General to limit practitioner's and laboratory services. As we said concerning similar provisions in the last bill: "The exception of first visits from coverage under the bill violates the principles of preventive medicine. It acts as a deterrent to the early treatment of disease, thereby tending to prolong disability. Limitation of laboratory benefits will be a detriment to the best medical care. These exceptions are intended to prevent abuse of the system. Payment of extra fees to physicians for excepted services will aggravate such abuses, because the physician will profit by increasing the number of such exceptional services, while the beneficiary can reduce them only by foregoing what may be an essential item of medical care. These abuses can be more effectively eliminated by establishing sound principles for the program as a whole and efficient administration.

"The limitation of general and special dental benefits, though undesirable, may be unavoidable at the present time. To undertake in any new program to provide the salvage work necessary for the complete dental rehabilitation of the adult population by existing techniques would be beyond the capacity of the available personnel and facilities and probably prohibitively costly. The minimum services available after January 1, 1947, appear well considered. The proposed preferential treatment of children may make it possible in the future to incorporate complete dental care in the program.

"Provisions of home nursing poses another knotty program. Wisely special provisions have been made for the study of this service and dental services.

"In the last bill drugs were not included among benefits, but it was provided that their inclusion at a later date might be possible. In the present bill they are not even mentioned. The committee repeats that such important therapeutic instruments should not be excluded without consideration, but should be made a subject of special study by the Council with a view to appropriate action.

Methods and policies for administration.—The formula for the designation of specialists and consultants remains essentially unchanged. The committee still feels that on the certification of specialists the exclusive utilization of standards and qualifications developed by competent professional agencies is open to objection. The Government cannot properly delegate selective powers to self-perpetuating non-governmental bodies over which it has no control. The stand-

ards and certifications of these agencies could, like any other relevant data, be employed by the Council, but their use should not be prescribed in the bill."

Besides, as it was pointed out, these agencies prescribe standards and certify physicians only for the exclusive practice of a specialty; whereas it will be necessary in the contemplated program to broaden the definition of specialists to meet local conditions and particular medical problems. Such a broad definition of specialists is necessary to assure the development of the more highly qualified specialists.

The provision for appeal by a beneficiary if his practitioner will not recommend the services of a specialist or consultant is a necessary protection for the patient.

The provision that groups as well as individual practitioners be included in the lists to be published by the Surgeon General corrects a grave error.

Fee-for-service payment is still listed among the permissible methods of remuneration for physicians. The choice of a method of payment for practitioners in a given area is also still to be determined by the majority of general medical practitioners in the area. It is, however, provided that the Surgeon General shall make arrangements by which the minority may be enabled to practice under the system of payment that is most satisfactory to each. It also grants special consideration to groups and particularly to groups organized about hospitals. It was pointed out, in both statement 12 and statement 15, that without such a provision, if the physicians of an area elected fee-for-service payment, teaching hospitals and other institutions with salaried staffs would be unable to participate in the program. Although the Committee of Physicians still feels that inclusion of fee-for-service payment is extremely regrettable, if it can not be excluded because of the pressure of organized medicine and the uninformed state of public opinion, the proposed compromise is satisfactory. It will establish competition between individual practitioners, groups and hospital organizations, on fee-for-service or other bases of payments, permitting each to demonstrate its superiority. The declaration that "The methods of administration, including the methods of making payment to practitioners, shall * * * provide * * * coordination among the services furnished by * * * practitioners, hospitals, public-health centers, educational research, and other institutions, and between preventive and curative services * * *" is a profession of real significance.

Hospitalization.—The period of hospitalization has been extended from 30 to 60 days in a benefit year, with possible prolongation to 120 days (instead of 90) if the funds prove sufficient. With the increasing use of hospitals for therapeutic courses this is a change in the right direction.

The definition of hospital benefits remains vague. There is almost a contradiction between the statement that in order to participate in the system hospitals must "meet general standards prescribed by the Surgeon General" and the statement that "The Surgeon General shall exercise no supervision or control over a participating hospital * * * nor shall any requirement * * * prescribe its administration, personnel or operation." Confusion is not diminished by the definition of a participating hospital in a subsequent section. As in the last bill no separate consideration is given to the payment of practitioners in hospitals. Provision must be made for the care in the hospitals of patients referred by practitioners who have no hospital privileges.

In its discussion of the previous bill and its statements 13 and 15, dealing respectively with the Hill-Burton bill and with education, the Committee of Physicians has advocated that participating hospitals be required to have salaried medical staffs and that payment be made to hospitals for complete care of patients, including remuneration of physicians for their services. The funds allocated for hospital care and associated social services should, however, be distinguished from those allocated for medical services, which should be reserved for payment of members of the medical staff.

The present bill does not permit the Surgeon General to make contracts with participating hospitals for such inclusive services. It does not, however, prescribe that payments for physicians' services in these hospitals should be reserved for this purpose and should be made at prevailing rates. Without such specific provisions institutions might be tempted to compete on a basis that would lead to exploitation and economic debasement of physicians. Care should be taken that the distribution of the funds earmarked for physicians' services is not so specifically prescribed that proper organization and rewards for varying competence and utility would be prohibited.

The general increase of maximal rates for hospital benefits manifests a realistic appreciation of the growing costs of hospitalization with the development of new

techniques and the demand for more expert services. Although the contemplated grade of hospital services is nowhere explicitly defined, it seems to be implicitly described in the clause "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," found in the authorization of the Surgeon General to enter into contracts with hospitals. If the system is to serve the population at large it is evident that many of the economically fortunate will prefer semiprivate or private accommodations. For this reason it is provided that participating hospitals may "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." Without such a provision such patients would be deprived of hospitalization benefits under the special contingencies mentioned. Payments for physicians and other personal services must not be treated in a similar manner. Recognition that the quality of such personal services could vary with remuneration would be intolerable.

Disability benefits

These provisions, similar to those of the last bill, are excellent. The method of certifying disability, always a knotty problem, is entrusted to the Surgeon General in consultation with the Social Security Board and is recommended to the consideration of the Medical Policy Council.

Workmen's compensation

The provision that insurance benefits cannot be used in lieu of payments for injury or disability covered by Workmen's Compensation is eminently sound. These acts have proved invaluable weapons in the reduction of industrial hazards. Nevertheless, if the system of medical care is to be largely conducted under the insurance system, it would be unfortunate to exclude persons who have incurred illness or disability for which compensation is authorized from the privilege of using the machinery of the social-insurance system. In fact it may be anticipated that to deprive them of this privilege, as the system grows, might prevent them from obtaining proper care. It is, therefore, important to make this machinery available to them so long as payment for services is made from the sources and at the rates required by compensation acts.

Grants-in-aid for medical education, research and preventive measures

The committee again endorses the consideration given to education and research, without which the quality of medicine will not improve. The importance of educating medical officers discharged from the military services cannot be questioned, but the wisdom of diverting to this purpose for 5 years grants intended for research may be. Some other expedient should be found to rectify errors of the past, the fundamental efforts of research and education should always be directed to the future.

Dental, nursing and other benefits; care and prevention for chronic sickness and mental diseases

The difficulties of including full dental and nursing care in the program have been mentioned. Chronic sickness and mental diseases present somewhat similar problems. A painstaking study of these problems is a necessary antecedent to their solution, which the Committee of Physicians hopes may be found.

COMMITTEE OF PHYSICIANS FOR THE
IMPROVEMENT OF MEDICAL CARE, INC.,
February 13, 1946.

STATEMENT NO. 18

A SUMMARY AND ANALYSIS OF THE WAGNER-MURRAY-DINGELL BILL (S. 1606)
INTRODUCED NOVEMBER 19, 1945

DISCUSSION AND RECOMMENDATIONS OF THE COMMITTEE OF PHYSICIANS

Separation of the medical provisions of national-health legislation from their social and financial frame has one advantage. It permits attention to be focused upon those aspects of the legislation that are concerned with the quality of medical care. Obviously, the medical provisions cannot be made effective unless supplementary legislation is enacted. Legislation to implement the medical program is not only required: it is evidently anticipated. Some of the necessary supplementary bills have already been introduced.

In the separation of the bill into its component parts sufficient attention has not been given to the ultimate integration of these parts into a single comprehensive program. Authority and administration of various categories of health and medical care have been divided among several Federal and State agencies. Obvious compromises, some even involving contradictions, have been included. These may present almost insurmountable obstacles to the efficient administration of the program.

The first notable deficiency is provision for the construction of hospitals and other medical facilities. This will be met by the Hill-Burton bill (S. 191). This bill, which was the subject of statement 13, after hearings before the Senate Committee on Education and Labor, was reported out favorably in an amended form. Since then it has been passed by the Senate without further amendment. It will be discussed in statement 19.

In addition to part B of the present bill, dealing with grants to States for maternal and child-health services, Senators Pepper, Walsh, Thomas of Utah, Hill, Chavez, Tunnell, Guffey, La Follette, Aiken, and Morse have introduced a similar bill (S. 1318) for the same purpose. This will also be separately discussed. Consideration will be given here only to the relations between this legislation and the other parts of the national health program.

Provision for child welfare, for public assistance to the needy other than medical care, and to broaden retirement, survivors, and disability insurance benefits, which were all included in the previous bill, are highly desirable.

Provisions for cash disability benefits (unemployment benefits on account of illness and disability) and to finance the health-service benefits are essential. If the present legislation is enacted they may be expected.

Since, in the sections which have been retained, the present bill follows so closely S. 1050, the reader is referred to statement 16 for the general recommendations of the committee. Only certain distinctive points will be discussed in this statement.

General correlation of services.—Authority for the maternal and child-health services is again vested in the Children's Bureau of the Department of Labor, while all other health services are placed under the authority of the Surgeon General of the Public Health Service. At the State and local levels programs for medical care of needy persons are consigned to "State public-assistance agencies," whereas with respect to prepaid personal health-service benefits the nature of agencies to act at the State or local level is not specified. The Committee of Physicians reiterates its opinion that some formula should be found by which the various medical services will be brought under a single authority without the loss of existing machinery and personnel which have demonstrated their value.

In every section of the present bill a paragraph has been introduced authorizing and directing correlation of the different services. For example, part B, section 128 (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 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." Such cooperation and correlation would be better assured if it were made implicit in the initial organization of the services.

The same principles should be observed at State and local levels.

1. *Grants to States for public-health services.*—See statement 16.

2. *Grants to States for maternal and child-health services.*—Whereas in other parts of the bill provisions are made for advisory councils with defined authorities, in this part the Chief of the Children's Bureau is merely empowered to establish "advisory committees." There seems no good reason why the administrative authority of this service should be singled out in this manner. It is not obvious why he should need less counsel or restraint in the formulation of his policies than any other administrative authority.

3. *Grants to States for medical care of needy persons.*—Section 132 (a) (8) in effect demands that the State agency establish a means test for eligibility. Under section 136 (b) (3) a State or local public agency is permitted, through arrangement with the Surgeon General to secure medical care for the needy through the system established under title II to provide care for those eligible under the prepaid personal health service benefits. This clause is, however, only permissive. In those States that do not elect to take advantage of this provision there will be two systems of government-supported medical care with different

machinery, one for insured persons, the other for the needy. It has always been the contention of this committee that there should not be two grades of medical care nor two systems to provide medical care. The committee recommends that it be made mandatory upon the States, before they may receive grants under this title, institute programs by which the needy may receive care through the prepaid personal health service benefits program of title II. This would require that a State, in order to qualify for grants for medical care of needy persons, make arrangements with the Surgeon General to insure such persons. This would ultimately enable all persons eligible for medical care under the national health program to secure this care through a single system, a highly desirable goal.

The Committee of Physicians emphatically, disapproves the provision in section 136 (b) (1) (A) that payment for medical care to the needy can be made by State or local agencies through "money payment to individuals claiming such care." Cash benefits for service are peculiarly conducive to abuse. There is no inherent assurance that they will be applied to the purpose for which they were intended.

4. *Prepaid personal health service benefits.*—It is, perhaps, an advantage to have the financial provisions for these services considered separately. They belong properly in the field of social security and in the province of actuaries and statisticians. The committee will look for the supplementary legislation with interest, because it is essential that estimates and appropriations shall be adequate and that control of those functions that require expert medical knowledge shall not be diverted from the hands of those that possess such knowledge. This attitude is dictated by no selfish or jealous spirit, but by a sincere solicitude for the quality of medical care.

Administration.—The formula for State and local-area committees, following closely that established for the Federal Advisory Council, appears to be sound.

Regulations for specialists. In the previous bill it was implied that no physician not qualified by the Surgeon General would be permitted to perform the functions of a specialist. In this bill it is prescribed that no unqualified physician may receive remuneration as a specialist for the performance of specialists' functions. To draw the distinction on the basis of remuneration, not function, is more realistic. Physicians are often required to render services of a specialists' characted although they have not qualified as specialists. Indeed, it would be impossible for anyone to learn a specialty unless this were permitted.

Throughout the bill clauses are found which authorize the administrative authorities to enter into contracts with hospitals and other organizations for the provision of medical care, including in most instances physicians' services. In this connection the Committee of Physicians remarked in statement 16 in relation to hospitalization: "The present bill does permit the Surgeon General to make contracts with participating hospitals for such inclusive services. It does not, however, prescribe that payments for physicians' services in these hospitals should be reserved for this purpose and should be made at prevailing rates. Without such specific provisions institutions might be tempted to compete on a basis that would lead to exploitation and economic debasement of physicians. Care should be taken that the distribution of the funds earmarked for physicians' services is not so specifically prescribed that proper organization and rewards for varying competence and utility would be prohibited." This principle is essential for the preservation of the quality of medical care in the national health program. Only if it is carefully observed will competition be established on the basis of service, rather than costs and profits. Only by the careful observance of this principle will the best methods for the provision of medical care be discovered by valid experimentation. The same principle of standard remuneration must be extended to other services for similar reasons. It would be inequitable indeed to write into legislation for hospital construction fair employment clauses, while omitting them in legislation for operation of the same facilities. This principle should be embodied either in a general clause covering all parts of the bill or made a conditioning clause to every provision that permits agreements or contracts for medical services to be made.

Local autonomy.—The committee believes that subject to the standards established by the Federal authorities the operation of the national health program should reside in the States and localities. Although this bill permits State and local participation, it does not define the limits of their participation.

The committee believes that representatives of the health professions and the public should participate at all levels of administration.

Senator DONNELL. You mentioned that you are a professor at Yale University.

Dr. PETERS. Yes.

Senator DONNELL. Are you an active practitioner as well?

Dr. PETERS. I am.

Senator DONNELL. How long have you been practicing medicine?

Dr. PETERS. I have been practicing medicine ever since I entered the field except for 1 year while I was at Rockefeller Institute.

Senator DONNELL. Do you put in most of your time in your performance of duties at Yale University, or in private practice?

Dr. PETERS. That is hard to say, because they are all mixed up. Of course my rounds in the hospitals can be called my duties with respect to Yale. They are also part of a private practice because I do not differentiate in my rounds.

The CHAIRMAN. The hospital is operated in connection with the Yale Medical School, is it not?

Dr. PETERS. That is union between them; they are both under separate boards.

Senator DONNELL. What I was intending to ask further, doctor, are you practicing as a private practitioner, as well as being on a salary with Yale University?

Dr. PETERS. I see private patients; but I am entirely paid by salary. That is, I have a large private, you would call it, practice; it is almost a group practice, with my assistants, and I see private patients regularly, but the salary reverts entirely to the school and to the support of the work, and not to the individual.

Senator DONNELL. So your personal remuneration comes entirely from Yale University?

Dr. PETERS. Yes.

COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE

Senator DONNELL. You are appearing, I understand, on behalf of the Committee of Physicians for the Improvement of Medical Care.

Dr. PETERS. Yes.

Senator DONNELL. How large a committee is that?

Dr. PETERS. The committee itself is about 50. If you wish, I have a list of them here.

Senator DONNELL. Would you mind letting us have that?

Dr. PETERS. I have just the letterhead which has all of the members of the central committee.

Senator DONNELL. Dr. Channing Frothingham is both the chairman of the Committee of Physicians and also chairman of the Administrative Committee?

Dr. PETERS. Yes.

Senator DONNELL. That is right.

Dr. PETERS. Yes.

Senator DONNELL. And Dr. Butler, Allan M. Butler, of Boston, is one of the vice chairman of the Administrative Committee?

Dr. PETERS. Yes.

Senator DONNELL. That is Dr. Allan Butler who appeared before our committee recently?

Dr. PETERS. Yes.

Senator DONNELL. You say that the committee consists of about 50 physicians, is that right?

Dr. PETERS. The committee itself, yes.

Senator DONNELL. And that is the organization for which you are appearing, is that right?

Dr. PETERS. We have the committee, and then a large group of supporters, about 1,500. This is the active working committee that you have before you.

Senator DONNELL. And these two statements, No. 15 and No. 16, they have been prepared on behalf of the Committee of Physicians, is that right?

Dr. PETERS. Yes.

Senator DONNELL. And you are filing those as a part of your testimony here today?

Dr. PETERS. Yes.

Senator DONNELL. Doctor, you refer in your statement to the possibility of the Surgeon General being subjected to such pressure with respect, as I understand it, to the methods of payment, that he could not exercise his authority.

Do you anticipate that the Surgeon General of the United States would be subjected to a pressure that he would be unable to resist in the performance of his official duties?

Dr. PETERS. I think the pressure might be very heavy, and history has shown that it is heavy, to maintain certain systems of payment, and certain prerogatives and systems of practice.

I could defend, of course, the Surgeon General under the circumstances. I believe such pressure could be brought and I believe such pressure is being brought constantly.

Senator DONNELL. You have confidence, however, in the ability of the Surgeon General to use his own best judgment notwithstanding the pressure that is placed upon him.

Dr. PETERS. I have.

Senator DONNELL. That is right, is it not?

Dr. PETERS. I believe he would do his level best.

Senator DONNELL. There are certain very important functions, vested in the Surgeon General by 1606, are there not?

Dr. PETERS. Yes.

Senator DONNELL. And while he has an advisory council, he does have the ultimate decision on some of the matters entirely independent of any legal authority possessed by the advisory council; that is correct, is it not?

Dr. PETERS. Yes.

Senator DONNELL. In fact, as the name applies, the advisory council is merely a council which gives advice and as to the advice given, the Surgeon General makes reports periodically. That is correct, is it not?

Dr. PETERS. Yes; but he is also compelled to report the advice of the advisory council.

Senator DONNELL. That is what I endeavored to say somewhat faultily in my question before. He does make reports of the advice he receives.

Dr. PETERS. Yes.

BRITISH HEALTH INSURANCE

Senator DONNELL. Have you had occasion to study the question of whether or not the quality of medical care has improved or remained stationary or deteriorated under the operation of the British system of compulsory health insurance?

Dr. PETERS. I have no doubt, and I think the British Medical Association, itself, can be taken as a witness on that, that they voted in favor of it, and have stated that it has improved the quality of medical care, and they want to extend it further.

Senator DONNELL. Have you observed the recent action taken by certain representatives of the British Medical Association, reported in the London newspapers of March 22 of this year, with respect to the proposed extension of the compulsory health insurance?

Dr. PETERS. I cannot say that I saw March 22, and identify the exact ones. I know just exactly where the opposition centers are.

Senator DONNELL. You know there is at least among a portion of the Medical Association widespread and very vocal opposition to the extension of the system. You know that, do you not?

Dr. PETERS. Not to the extension of the system.

Senator DONNELL. To what is the opposition?

Dr. PETERS. To the particular type of extension of the system.

Senator DONNELL. To a particular kind of extension?

Dr. PETERS. Yes.

Senator DONNELL. It is opposed to the particular kind of extension that has been suggested in the British Parliament, is that right?

Dr. PETERS. Yes. But may I add to that?

Senator DONNELL. Certainly.

Dr. PETERS. I think that no one can read this without appreciating that the objections are not so much to the method of extension, the quality of care, as to the method of payment. It has been very significant. The papers in England have emphasized the fact that it is a selling of practice that seems to be the chief issue between them, and I think that should be on record in relation to this controversy.

Senator DONNELL. Doctor, among the members of the administrative committee of the Committee of Physicians for the Improvement of Medical Care is Dr. Ernst P. Boas, is that correct? He is the head of the Physicians Forum.

Dr. PETERS. Yes.

Senator DONNELL. Doctor, do you know of any organizations of physicians except the Physicians Forum, and the committee for which you speak today, who favor officially the enactment of S. 1606 into law?

Dr. PETERS. Yes. There are several small ones. There is a group of physicians organized under the Independent Citizens Committee of the Arts, Sciences and Professions, and there are several other smaller groups. One in Hollywood; that is, by the way, a branch of the Independent Citizens group. There is a small one in St. Louis, the Committee of Physicians for the Study of Medical Care. I cannot identify many of them. I have a great many requests from them in correspondence continually for information from our committee.

The CHAIRMAN. Do you know of many individual physicians and surgeons who do not belong to any particular group who recognize the need of legislation?

Dr. PETERS. There is an enormous number of them, especially among the young men. I would like to call attention to, and put on the record the vote taken by the New York County Medical Society yesterday that shows at least there is a large minority favoring legislation. The vote was 503 against the Wagner-Murray-Dingell bill, for compulsory health insurance, and 152 for it. That at least is not a negligible minority, and when you consider that besides the younger men a great many of the older men are afraid to express themselves, you may enlarge that minority considerably.

Senator DONNELL. As I figured hastily the vote that you refer to, 500 against, and 152 for, it means that approximately 76 percent of those voting yes in New York County Association were against the enactment of S. 1606. Is that right?

Dr. PETERS. I think it is significant when you ask whether there are individual physicians or groups of them that you have at the present time, after all of the propaganda that has been brought about, practically 25 percent in a medical association of that kind who can stand up and vote for the Murray-Wagner-Dingell bill.

Senator DONNELL. There has also been considerable publicity in advocacy of S. 1606 throughout the country, has there not?

Dr. PETERS. There has been some, not very well organized, and not very well financed.

Senator DONNELL. On yesterday's vote which is the most recent vote that you know of, is it not?

Dr. PETERS. Yes.

Senator DONNELL. That was taken by doctors, and it was slightly over, I think it is three out of four voted against S. 1606. That is correct, is it not?

Dr. PETERS. Yes.

Senator DONNELL. Doctor, going back again to my question about England, have you personally studied the question over there as to the effect on the quality of medical care?

Dr. PETERS. I have been in touch with it. I have not been personally studying it, because I have not had the opportunity to go to England since the last but one war.

Senator DONNELL. One or two more questions, Doctor.

Are you able to give us, roughly speaking, and I appreciate you cannot do it accurately, but roughly, what is the total membership, total aggregate membership, of all of the associations which you know, which associations have gone on record favorably for compulsory health insurance in this country?

Dr. PETERS. No, I cannot.

Senator DONNELL. You could not do that?

Dr. PETERS. No.

Senator DONNELL. The Committee on Arts and Sciences to which you referred, that is the committee of which Mr. Harold L. Ickes is the present chairman, is that not correct?

Dr. PETERS. He is executive; I forget just what his title is.

Senator DONNELL. That is the committee that he appeared for?

Dr. PETERS. Jo Davidson is chairman.

Senator DONNELL. The committee for which Mr. Ickes appeared recently before this committee, that is the one to which you referred as being in favor of S. 1606?

Dr. PETERS. Yes.

Senator DONNELL. Is that right?

Dr. PETERS. Yes.

Senator DONNELL. That is all.

The CHAIRMAN. Was your attention called to the problem of adequate medical care for the American people by this legislation which is now before the Senate, or were you interested in it long before that?

Dr. PETERS. I have been interested in it ever since I went into medicine from the standpoint of improving the quality of medical care.

The CHAIRMAN. Was there interest evidenced by other physicians and surgeons in the country for many years prior to this legislation, this proposed legislation?

Dr. PETERS. Why, of course there is, because if there had not been, I doubt if the public alone, would ever have brought it to the attention or crystallized it in any kind of a program.

The CHAIRMAN. The reason I asked that, the American Medical Association, through the National Physicians Committee, have advertised this bill as a political medicine, as though it emanated entirely from politicians in the country.

You recognize that in the medical profession itself there has been much discussion among the members of the profession with regard to the need for some such program as this to serve the American people.

Dr. PETERS. There has always been that discussion, and there have always been experiments carried on towards such an end. The institution of full-time medicine in our medical schools, there was a revolution at the time I was an interne which was a significant move in this direction. It was evidence that at least when we reach the improvement of medical care we appreciate that the system of practice had to be changed, and that it was necessary for it to become institutionalized and ultimately—as I have said here and I have said in that statement, and the committee has said—ultimately it would have to be taken over on a broader basis in order that medical care might not be a burden upon education. That movement has gone on as I say, since I was an intern, and it is because of my great interest in that, that long before American medicine came out, long before the National Health Conference, I have been interested in this, and there were a great many in my generation, and the generation since then that have shared these feelings. Most of them have not been vocal because they have been too interested professionally.

The CHAIRMAN. And this agitation with reference to the need for improving medical care has gone on in other parts of the world?

Dr. PETERS. Well, I should say that it has gone on in other parts of the world, so that it is possible that before long you may have to consider that we are the only ones that have not such legislation.

The CHAIRMAN. Sometimes it has been stated that we have the healthiest nation in the world, that conditions in this country excel any other country in the world. And it is argued that the medical profession has brought about in this country such a high degree of scientific care that no other country can compare with it. Is that true?

Dr. PETERS. In the first place, I think if you are talking of health, you must recognize that it is related to wealth, and for the wealthiest nation to also be in some respects the healthiest is not extraordinary.

If you follow over this country yourself, you will see there is the same relation to health and wealth. Besides we have not been torn to pieces by wars as these other nations have, and therefore we have that to congratulate ourselves on.

As to trying to relate the present high state of medical science to the present state of practice, that is to my mind an utter absurdity, and I brought that out in my statement.

The CHAIRMAN. I noticed that.

Dr. PETERS. It was through our educational institutions, through our large foundations, that these things have come about.

The CHAIRMAN. Most of the great advances in medical science have come from men working in the laboratories.

Dr. PETERS. Yes.

The CHAIRMAN. And on salaries.

Dr. PETERS. And you may say, Senator Murray, or at least it is implicit in that statement, that if we are going to have more of them, we have got to have more of the kind of institutional work which has brought this forth, and less of practical, and I go further and say that science and scientific aspects of medicine are so complex at the present time that unless we have some alterations of this kind and the support, that will have to be brought to it from the public, unless we have that, our physicians will become more and more remote, even in the understanding of science, and the things they have to do.

The CHAIRMAN. You pointed out that while the majority voted against the national health bill in New York—what was the name of that institution that cast the vote?

Dr. PETERS. The New York Medical Society.

The CHAIRMAN. That 25 percent of them at least voted for it, which you think evidences a very strong trend in that direction, because it is only natural that men should hesitate to stand up and oppose the existing system.

Dr. PETERS. I think that 25 percent is a very significant and important minority in that committee, because such a minority required not only conviction, but courage, and the combination of the two is not large in any group of the population.

The CHAIRMAN. It was a small minority that started the proceedings in this country that eventually resulted in our independence, was it not?

Dr. PETERS. I believe so. But in a senatorial chamber I should hate to be absolute about matters of politics and government of American history.

The CHAIRMAN. Well, Doctor, at least you do say that this agitation for an improvement in our national medical care does not emanate from professional politicians, but action really from the ranks of the medical profession itself, and from the American people.

Dr. PETERS. The politicians, if anyone around here likes that particular term applied to them, were not far behind the thing, because the cost of medical care investigations, and before that the trial balloons of the Epstein bill, and so forth, were not political, certainly; they came from the people and from physicians, and they preceded the national health conference, which was a natural sequence to agitation that was not from lay people entirely, but also from the medical profession.

Senator DONNELL. Doctor, this meeting of the New York County Medical Society, that was held where yesterday?

Dr. PETERS. I presume it was held in New York. I saw the news in the Times.

Senator DONNELL. In the New York Times this morning?

Dr. PETERS. I have to accept the Times that it is authentic.

Senator DONNELL. Do you know exactly the proposition that was voted upon by the New York Medical Society?

Dr. PETERS. I can only quote that which was in the Times.

Senator DONNELL. Do you have that with you here?

Dr. PETERS. My Times is gone, and I have not another one. It is on the right-hand side of one of the inside pages. I can say this, that according to the Times, the vote was to whether they believed in compulsory health insurance bill, or felt compulsory health insurance necessary to support medical care, and the Wagner-Murray-Dingell bill; I do not know the wording of it.

Senator DONNELL. Do you know who the president or the secretary of that society is, or where he is located?

Dr. PETERS. No; I could not tell you.

Senator DONNELL. It would be in New York.

Dr. PETERS. The Academy of Medicine would be its address.

Senator DONNELL. The Academy of Medicine?

Dr. PETERS. New York Academy of Medicine.

Senator DONNELL. You spoke in your examination by Senator Murray about these two statements. I thought you said or started to say that you had prepared these two statements yourself. Is that right, the statements Nos. 15 and 16?

Dr. PETERS. Do you want me to tell you how those statements came about?

Senator DONNELL. Yes; I would like for you to do that.

Dr. PETERS. In the first place, as in any statement someone has to take the initiative.

Senator DONNELL. Yes.

Dr. PETERS. I have drafted most of them initially. These statements or my drafts are then circulated to the whole of the administrative committee.

Senator DONNELL. That committee is about how many?

Dr. PETERS. That is the small administrative committee.

Senator DONNELL. That is the committee consisting of how many persons?

Dr. PETERS. Five.

Senator DONNELL. Five persons. May I stop you right there? Who are those five persons? Is Dr. Frothingham one of those?

Dr. PETERS. Frothingham.

Senator DONNELL. Is Dr. Butler?

Dr. PETERS. Yes; Dr. Butler, Dr. Miller, Dr. Floyd, and I am on it.

Senator DONNELL. Dr. Mackenzie?

Dr. PETERS. Yes.

Senator DONNELL. And those are the names that appear on the letterhead that you gave to me as being the component members?

Dr. PETERS. That is the end of this thing.

Senator DONNELL. They are members of the administrative committee?

Dr. PETERS. Yes.

Senator DONNELL. Proceed.

Dr. PETERS. They then make their criticisms, send them back to me, and then I do the best I can to swallow my pride and incorporate their criticisms.

Then the statement with those corrections is sent to the whole of this committee.

Senator DONNELL. That is the committee of about 50.

Dr. PETERS. This whole list of about 50, and they all write comments, and then it comes back to me and I have a further headache in trying to see how I can meet the expressions of opinion there, and if we cannot find a suitable answer to that, a meeting of the committee is held in which the whole thing is discussed, and every statement goes through that whole process. So if I write it, at least I am subjected to a great deal of correction.

Senator DONNELL. I realize that.

Did the committee itself actually come together and pass upon statement No. 15 and statement No. 16, the two that you have presented?

Dr. PETERS. 15 was prepared without a special meeting. The other two were prepared at meetings.

Senator DONNELL. 15 and 16 are all I have here. Is there another one?

Dr. PETERS. Yes.

• Senator DONNELL. There is another one?

Dr. PETERS. I sent you the one on 1050, the previous bill, and the present one.

Senator DONNELL. Nos. 15 and 16 are all that I have here, Doctor.

Dr. PETERS. Those were extra copies. They were distributed. I will see whether I have the other ones here.

Senator DONNELL. At any rate it is on S. 1050.

Dr. PETERS. Yes.

Senator DONNELL. Will you file one of those?

Dr. PETERS. It has been filed.

The CHAIRMAN. That has already been filed.

Dr. PETERS. That has already been filed.

Senator DONNELL. As to 15, the committee did not actually come together?

Dr. PETERS. Yes.

Senator DONNELL. Is that true of No. 16?

Dr. PETERS. They came together on that.

Senator DONNELL. That was in October of last year, is that right? The date is October 3, 1945.

Dr. PETERS. Their meeting was somewhat before that, because this thing has to be prepared as the result of their discussion, and sent out to them for editing again.

Senator DONNELL. And the other document that you filed which I have not seen, did the committee come together on that one also?

Dr. PETERS. They did. In the case of a bill, they almost invariably have a meeting on a major bill of this kind.

Senator DONNELL. When was this Committee of Physicians for the Improvement of Medical Care incorporated in form?

Dr. PETERS. In 1937.

Senator DONNELL. In your statement No. 15, Doctor, that is the one that is filed here, under that number, there appears on page 2 this statement, "Compulsory insurance bills have been presented to the Congress of the United States and numerous State legislatures. The popular demand for legislation of this nature is steadily increasing."

Would you tell us please, is there any State legislature in the United States, to your knowledge, that has thus far enacted any legislation providing for compulsory health insurance?

Dr. PETERS. Not unless they have done it very recently.

Senator DONNELL. You do not know of any legislature which has enacted any such legislation; is that right?

Dr. PETERS. That is for general health care.

Senator DONNELL. That is what I mean.

Dr. PETERS. We had it, of course, in workmen's compensation.

Senator DONNELL. I understand, but the compulsory insurance bills to which you refer here in this statement No. 15, that has been presented to the Congress, and numerous State legislatures, you do not know of any of those bills that have been enacted into law by any State legislature; is that right?

Dr. PETERS. Yes.

Senator DONNELL. I am correct, am I not?

Dr. PETERS. Yes.

Senator DONNELL. The popular demand, though, you said, for legislation of this nature is steadily increasing. On what do you base that view, Doctor?

Dr. PETERS. Well, I base it on a great many things; first of all the public statements of organizations, the action that was taken and the amount of pressure that was brought to bear, and the amount of interest that was evinced in California and has been in other States, and on other things, and the increasing amount of time that I have to spend in speaking around this country myself on demand, and also in finding other people to speak, because more and more organizations are demanding it.

I would like to add here one more thing, and that is that at the present time the educational institutions and the students, the internes, and the younger men, are demanding it, so that part of my talking is done now sometimes under the auspices of educational institutions, whereas it used to be done sometimes at the request of a few students. There is no doubt that the large labor organizations and a great many others, the League of Women Voters, and organizations of that kind, have turned suddenly appreciative of the importance and absolute necessity of this thing.

Senator DONNELL. But to quote your statement which you read earlier this morning, "Many older and established physicians may not welcome and will not know how to use this freedom." That is in the closing paragraph of your statement. I judge from that, if I am wrong, please correct me, that you think the primary opposition to leagues of this kind comes from the older physicians, and the primary advocacy comes from the younger ones. Is that right?

Dr. PETERS. I think that if we could vocalize the younger physicians, we would find that there was a great demand. I call your attention to the fact that the medical officers, the younger group, when

they were asked what kind of practice they wanted, returning from service, they voted that they wanted group practice, which is something that under the present system is not available to them, and I believe cannot be until we have some change in a big way and a change in the whole spirit. It is obvious that men that are already established must fear such a thing, and it is obvious that they must control the situation. That is why it was perhaps advantageous that this bill does not contemplate an immediate revolution in the method of practice but only opens the way to a change in method of practice that the youngsters can make.

Senator DONNELL. Do you favor a revolution in the method of practice personally?

Dr. PETERS. I think it must be changed if we are going to have the quality of care we require. And I think the fact that the medicine is more and more gravitating toward hospitals is one indication that we will have it.

Senator DONNELL. Doctor, the two outstanding organizations in this country which have expressed themselves favorably to compulsory health insurance are your own committee, in behalf of which you are testifying this morning, and the physicians forum; is that correct?

Dr. PETERS. Yes.

Senator DONNELL. Of which Dr. Boas, who is also a member of the committee of your committee, for which you are appearing this morning, is president. He is president of the forum. That is correct, is it not?

Dr. PETERS. Yes.

Senator DONNELL. I asked you a little while ago—and I know you said you could not tell us—the aggregate number of associations which have affirmatively approved compulsory health insurance. Would you say that, in your judgment, it would run as high as 10,000?

Dr. PETERS. Well, what kind of organization?

Senator DONNELL. Well, I should have qualified that. I meant any organization of physicians or surgeons, or both, would there be as many? I will put it this way: Are there associations of physicians and surgeons in this country, including the physicians' forum and your own committee, and any others, are there such organizations, the aggregate of membership of which would, in your opinion, be as great as 10,000, and who have expressed themselves by official action as favoring compulsory health insurance in this country?

Dr. PETERS. By official action? You ask for my opinion?

Senator DONNELL. Yes.

Dr. PETERS. My opinion is that there would be that many.

Senator DONNELL. That there would be that many?

Dr. PETERS. In my opinion—and it is only an opinion, and, therefore, I do not know just how much it is worth. I will say this: That at the end of these hearings I hope we will have a better basis for opinion.

Senator DONNELL. The physicians' as I recall it—and I may be in error in this—has 2,000 or 2,500 members, somewhere in there, possibly even less than that. Is that correct?

Dr. PETERS. I do not know.

Senator DONNELL. Are you a member of that organization?

Dr. PETERS. I am not a member of that organization.

Senator DONNELL. At any rate, the testimony of Dr. Boas tells us the membership, whatever it may be.

Senator ELLENDER. If you will permit me, there were a thousand in that organization.

Senator DONNELL. Senator Ellender calls my attention to the fact that there were only 1,000.

Senator ELLENDER. Six-hundred-and-some-odd came out of New York State and the rest are scattered throughout the country.

Senator DONNELL. I remember that very distinctly, and I thank you for mentioning that.

Do you know of any other organization of physicians and surgeons that you can give us the name of here this morning, other than the physicians' forum or the Committee of Physicians for the Improvement of Medical Care, which have taken any official action favorable to compulsory health insurance in this country?

Dr. PETERS. Yes; but they are very small.

Senator DONNELL. Could you give us their names?

Dr. PETERSON. The committee of house physicians for the study of house care.

Senator DONNELL. That is the one that you are here appearing for?

Dr. PETERS. House physicians.

Senator DONNELL. How large an organization is that?

Dr. PETERS. I do not know at the present time. It is a very small one.

Senator DONNELL. A thousand?

Dr. PETERS. Oh, no.

Senator DONNELL. A hundred?

Dr. PETERS. I do not think so.

Senator DONNELL. Less than a hundred, you think; that is the committee of house physicians. What is the next one?

By the way, where is that committee located?

Dr. PETERS. In St. Louis.

Senator DONNELL. St. Louis, Mo.?

Dr. PETERS. Yes.

Senator DONNELL. Who is the head of that?

Dr. PETERS. Richard M. Peters.

Senator DONNELL. Richard Peters?

Dr. PETERS. That is a group of house physicians.

Senator DONNELL. Who is that, Richard M. Peters?

Dr. PETERS. Yes.

Senator DONNELL. Is he related to you?

Dr. PETERS. Yes.

Senator DONNELL. What relationship?

Dr. PETERS. My son.

Senator DONNELL. That has less than a hundred?

Dr. PETERS. I think so.

Senator DONNELL. And when was it organized?

Dr. PETERS. It is less than a year ago.

Senator DONNELL. Was it organized to advocate the passage of legislation of this kind?

Dr. PETERS. It was organized as a study group first. You asked for all of the organizations I know, and it is a small group of house physicians that is expanding, and I do not think it is of great sig-

nificance except to show the spirit among the younger men. On the other hand, there are not organizations of that age group. They are not possible, any more than there are among the veteran groups and the other younger men.

Senator DONNELL. Going back to the house physicians for a minute, in the first place, what is your son's address in St. Louis?

Dr. PETERS. Barnes Hospital.

Senator DONNELL. His first name is Richard?

Dr. PETERS. Richard.

Senator DONNELL. What are house physicians, in the hospital?

Dr. PETERS. They are internes and residents.

Senator DONNELL. Are they men who have gone out into the active practice as yet, or are they completing their course of study?

Dr. PETERS. Completing the course of study.

Senator DONNELL. And that is that organization.

We have then the physicians forum and this committee for which you appear; the forum is constituted of a thousand members—as Senator Ellender points out—600 of whom are in New York State, and your organization that you appear for here this morning, with about 50 members, or I should say 1,500, who are in a sense associates, but the 50 are the active committee; is that right?

Dr. PETERS. Yes.

Senator DONNELL. So we have those two organizations. We will count that as 1,500 for your committee, so as to be perfectly fair on it. Then the house physicians have a maximum of 100.

What other organizations of physicians or surgeons in this country have passed official action favorable to compulsory health insurance?

Dr. PETERS. It is not really an association of physicians and surgeons; there is a council, medical council, and a large medical group or division in the independent citizens committee which has favored it.

Senator DONNELL. Where.

Dr. PETERS. In the arts and sciences branch of the independent citizens committee of the arts, sciences, and professions.

Senator DONNELL. That is the one of which Mr. Ickes is head?

Dr. PETERS. Yes.

Senator DONNELL. I remember Frank Sinatra is in that. He is not a physician.

Dr. PETERS. No; I say within that there is a division of physicians.

Senator DONNELL. Yes. I did not mean any reflection on Mr. Sinatra in the slightest. Undoubtedly a man of great capacity in his profession, but he is not a physician is what I am getting at.

Dr. PETERS. But there is a large group of physicians in their organized division.

Senator DONNELL. How many are there?

Dr. PETERS. You would have to inquire from the offices there.

Senator DONNELL. My recollection, Doctor, subject of course to correction by either of these other gentlemen, is that the testimony of Dr. Butler or Mr. Ickes, one or the other, is about 200; one of them had seen them coming together in a meeting. Do you know whether there is a larger number of doctors than that?

Dr. PETERS. There are more than that.

Senator DONNELL. Are there 500?

Dr. PETERS. I would have to get the figures from New York.

Senator DONNELL. Do you think there are as many as 500 in that committee of doctors, I should say?

Dr. PETERS. I should suspect that.

Senator DONNELL. You think that is a fair figure, an estimate of 500?

Dr. PETERS. Yes.

Senator DONNELL. That is what we call the organization represented here by Mr. Ickes the other day.

What other organization in this country that you know of, of physicians or surgeons has given official sanction to compulsory health insurance?

Dr. PETERS. I do not know of any.

Senator DONNELL. You do not know of any others?

Dr. PETERS, taking your figure, first, the figure of 1,000 for the Physicians Forum, taking your own organization at 1,500, which I think is perfectly liberal, because the active, as I understand it more or less active membership is much smaller, that is right, is it not?

Dr. PETERS. It has to be in any organization. You cannot make 1,500 write a statement.

Senator DONNELL. The actual operating membership of your organization is only about 50, but I want to ask you what the other 1,450 do, we will come to that as an organization.

But taking your organization as 1,500, the Forum so many, the House Physicians of which your son is the head, and the medical components that enter into this organization of which Mr. Ickes is the head, 500, we get a total of 3,100. That of course counts yours at 1,500. But let me ask you about the 1,450 in your organization who are not included in this committee of 50. What do they do in connection with the affairs of your organization?

Dr. PETERS. They subscribe to our principles. That is not the end of our mailing list. I am talking about the physicians in there. They subscribe to our principles and have asked for and receive the letters.

Senator DONNELL. Are those 1,500 physicians?

Dr. PETERS. I can not say whether somewhere between 1,400 and 1,500 at the present time. We are at a loss in two respects. One, we are getting new members, and the other is that servicemen are turning up that we thought were lost, and we cannot absolutely be sure what our list of servicemen is, but it is between 1,400 and 1,500.

Senator DONNELL. And do those 1,400 to 1,500 men come together in annual convention?

Dr. PETERS. No.

Senator DONNELL. Your convention consists of about 50, is that right, sir?

Dr. PETERS. Yes.

Senator DONNELL. And that is the committee, generally speaking, the names of whom are upon this letterhead.

Dr. PETERS. That is the committee.

Senator DONNELL. Doctor, do these 1,400 or 1,500 people participate in committee memberships of your organization, or do they just subscribe and get the benefit of information?

Dr. PETERS. There is not any subscription.

Senator DONNELL. How do they join?

Dr. PETERS. They ask to join and state that they would support us, and are interested in furthering our work.

Senator DONNELL. Have you taken any poll of those people to see whether or not they approve statements 16, 15 and the other statement which has been filed here?

Dr. PETERS. Except that we send them out and ask for their criticism.

Senator DONNELL. Have you taken a poll of them to see whether they approve it?

Dr. PETERS. No.

Senator DONNELL. You have not?

Dr. PETERS. We have in the past, as far as polls are concerned, the average gentleman, when he gets a poll like that is not going to sit down and write right back, and they are not very useful things. Besides that, we are an educational institution. We ask these people to support this. We claim nothing of them. They do say this, that they are supporting us and we have almost no withdrawals and do have an increasing number of requests.

Senator DONNELL. But generally speaking, Doctor, they are not active in the actual preparation of statements.

Dr. PETERS. They are active only in trying to get these statements spread further, and the news. We have by the way, although perhaps our regular mailing list, we have been called upon to send out 6,000 copies of our last Wagner-Murray-Dingell statement.

I might say that it is utterly impossible, may I—

Senator DONNELL. Could I ask the Doctor one thing? Are these men in your organization, these 1,400 or 1,500, generally speaking, members of the American Medical Association?

Dr. PETERS. Almost all of them. I cannot say, exactly.

Senator DONNELL. The members of the AMA are about 125,000, in number, are they not? Is that right?

Dr. PETERS. Yes.

Senator DONNELL. That organization has come out expressly opposing compulsory health insurance; that is correct, is it not?

Dr. PETERS. Yes. It has come out as an organization, and because it has allied itself with the National Physicians Committee, the possibility of organizing other groups of this kind that you have asked me about is greatly diminished. Men and youngsters especially cannot express themselves and organize such groups as long as the ability to get consultation, to have cases, and to get access to hospitals depends on conformity.

Senator DONNELL. Was this statement 15 and statement 16 and the other statement, each of them, sent out to your entire membership for their criticisms before being put in final form?

Dr. PETERS. You cannot have 1,500 people that will do that, any more than the AMA could send theirs out to 125,000.

Senator DONNELL. In other words, these documents in their original draft form from you went out to about 50 people, is that right?

Dr. PETERS. Yes.

Senator DONNELL. Yes. And you got back their criticisms and tried to accommodate those various criticisms and you found in the case of two out of three documents that it was advisable to call together meetings.

Dr. PETERS. We did not have to call it on that account. We called it because we thought the legislation was so important that we would not confine ourselves to simply handing out these statements for writ-

ten criticism, but we would bring the group together so they could talk it all over.

Senator DONNELL. So your 1,500 members then approximately 50 actually participated in the preparation of these statements, and the other 1,450 have merely subscribed to membership and have evidenced their interest in the general proposition, is that right?

Dr. PETERS. Of course. Any other course would be utterly absurd.

The CHAIRMAN. That is the same system pursued by the AMA.

Dr. PETERS. Yes; or any other association.

Senator DONNELL. The AMA house of Delegates is what expresses its opinion.

Dr. PETERS. That meets unprepared once a year.

Senator DONNELL. And that is the—

The CHAIRMAN. Let him answer the question.

Dr. PETERS. My suggestion is utterly out of keeping with the general program of the AMA, whereupon because these have to come from individual States, the natural result if you look over the history of the AMA, is that they are turned over to a committee, and then the committee bring in a verdict the next day. There is a house of delegates that meets for 2 days once a year from a large number of organizations and states, and they can effect the business of the American Medical Association, which is largely affected by its continuing officers, which have been increased of late, with the board of trustees, having a certain amount of action because they meet more often than the house of delegates.

Senator DONNELL. Pardon me for interrupting. The chairman was quite right in stating that I should not. I did not intend to break into your statement.

The fact is, however, that the house of delegates is the official body which enunciates and gives out the opinions of the American Medical Association, is it not?

Dr. PETERS. Yes.

Senator DONNELL. And you know that the house of delegates has expressly opposed compulsory health insurance in the United States; that is correct, is it not?

Dr. PETERS. Yes; but if any party in the United States or any other democratic organization speaks for the organization, that does not mean that it is speaking for 100 percent of the United States, nor does the majority opinion of the spokesmen of the AMA speak for the whole membership of that association.

The CHAIRMAN. The house of delegates also opposed voluntary systems and opposed group systems, and was finally indicted for its conduct in that regard, that is, the American Medical Association was.

Dr. PETERS. I brought that out, that the American Medical Association has in general opposed any kind of experimentation in medical work.

The CHAIRMAN. Do you think that any group in this country should have the right to determine for the American people whether there should be any change in this country?

Dr. PETERS. I think there are two things that they said about that: In the first place, I think that medicine was not made for doctors; it was made for the people, for the patient, to be given by the doctor. So I do not think that any group, professional group, can vote against it on that score alone.

In the second place, I do not believe that one organization has any right to control or dominate a situation of this kind. It is to my mind a most deplorable thing, and probably unconstitutional, if we were to delegate the offices of government to any self-perpetuating private organization.

The CHAIRMAN. But that is exactly what the American Medical Association is seeking to do in this country, is it not?

Dr. PETERS. That is the way I have interpreted their action.

The CHAIRMAN. Do you not think that the American people should have something to say with reference to the kind of medical care that we should have in the United States?

Dr. PETERS. I not only think that they should but I think that the story throughout this world has shown that, although there may be this kind of obstruction which has always been prevalent, wherever any changes of this kind are made we shall follow history and the American people will make the change.

The CHAIRMAN. Do you not think that the American people have already gone on record to a very large degree with reference to the needs for better systems of medical care in this country?

Dr. PETERS. All polls that have been taken with any attempt to really get an expression of opinion have shown that this leaven has worked in and that the public at large is favoring some change, because they know that the present system is not much longer to be tolerated.

The CHAIRMAN. And some very large organizations in this country, for instance, the American Federation of Labor, who had a representative here the other day, Mr. William Green, the president of that organization, testified that their group was in favor of a change in our present system of medical care, and favored the present bill. Other large organizations of the country are doing likewise. Is that not true?

Dr. PETERS. They are, and there are a great many others that are asking for education and a number that are joining in. This procession demanding a change is increasing steadily, as these other groups of citizens in all walks of life are finding out what it is all about.

The CHAIRMAN. Doctor, many large industrial organizations have ignored the present system of medical care and have introduced systems of their own in large industries, such as the Kaiser system out on the Pacific coast. Are you familiar with that?

Dr. PETERS. I am.

The CHAIRMAN. A book was written about that a short time ago, and I remember one or two very distinguished surgeons in the United States called my attention to it, and approved the plan at that time. I understand that the Kaiser plan was originally intended to care for the workers in the plant, but now it has been extended to the families of the workers, and has worked out very satisfactorily. Is that true?

Dr. PETERS. Yes. In some places in some respects; I do not know just how far that has been completed now.

The CHAIRMAN. Then, Doctor, you think that notwithstanding the fact that the American Medical Association appears to be opposing this legislation, that that does not necessarily indicate that it is not a wise thing to do, for the American people to try to reform the present medical practice?

Dr. PETERS. Of course I do, and I point again to the history in other countries, the British Medical Association now is certainly,

and has voted repeatedly that it would not be without its national health insurance system. That has been true of most countries that have taken it up, although they have gone through the same kind of an opposition that you now are meeting here.

The CHAIRMAN. They had quite a struggle there starting their system of public medical care, and as the result it was defective system to start with.

Dr. PETERS. There were other reasons for that. One of them is that it started with the retention of the practitioner system that existed, with the idea that that must be retained. It also restricted all its benefits to practitioner service. And that is a great weakness. It has no doubt improved that, but there was no attempt to go above that level in the British system, and we must not make that mistake.

The CHAIRMAN. You would not advocate establishing such a system as they have in England?

Dr. PETERS. The medical men there, as far as the extension of services is concerned, want a broader extension of services.

The CHAIRMAN. You are not at all surprised at the criticism aimed at the system in England?

Dr. PETERS. No, because it is extremely limited. That has to be taken into account by the practitioner system, but the practitioner service is better under the system and available to more people under the system than it was before.

The CHAIRMAN. Thank you, Doctor.

Senator DONNELL. Doctor, in answering Chairman Murray a few minutes ago, you made reference to some conduct you thought probably would be unconstitutional. And the chairman said, "Isn't that what the American Medical Association is trying to do?"

Dr. PETERS. I said I thought it would be unconstitutional for our Government to delegate its power in any way to allow control of Government to fall into the hands of a self-perpetuating private institution.

Senator DONNELL. You do not know anybody who is advocating such as that?

Dr. PETERS. I think that when you cited the American Medical Association, when the American Medical Association stands for their system and attempts to be the arbiter of our system of practice of medicine, that you are approaching that attitude.

Senator DONNELL. Doctor, do you seriously contend here that the American Medical Association is asking the United States Government to delegate any of its governmental functions to the American Medical Association?

Dr. PETERS. No. In replying to the question, it was, if this large group of medical men favored this thing, should they not control or dominate the action in this respect? I said, no; that it should never be implied, and it seemed you were implying that.

Senator DONNELL. There was never such an implication in my question. I simply had in mind this: Out of a total of 128,000 people in these various organizations, namely, the ones you have listed here, 3,100 or thereabouts in the aggregate, and 125,000 in the American Medical Association; and of course, there is some duplication; nevertheless, the 125,000 association has opposed compulsory insurance, and I think that should be taken into consideration as an important bit of evidence.

Now, certainly, though, there is no one suggesting, and I have heard no one suggest, that the American Medical Association has advocated that the United States Government shall delegate to the American Medical Association any of its governmental powers; and you do not seriously so contend?

Dr. PETERS. No. I said there should not be anything like that done; I think it was Senator Murray who suggested, or at least there was an implicit understanding, and I said it could not be.

Senator DONNELL. We agree, Doctor, do we not, that as far as you have heard, the American Medical Association has never suggested that the United States Government delegate to it any of the governmental powers of the United States Government.

Dr. PETERS. I did not imply that it had. I answered a general question.

Senator DONNELL. And you do not now mean to imply that the American Medical Association has asked, or is now asking, the United States Government to delegate any of its governmental powers to that organization, do you?

Dr. PETERS. No.

Senator ELLENDER. Doctor Peters, the AMA is not acting differently from what you are, are they, in presenting its views before this committee?

Dr. PETERS. No. As for as that is concerned, I am not questioning them.

Senator ELLENDER. You are familiar with the organization in the various States of medical societies?

Dr. PETERS. Yes.

Senator ELLENDER. Do you know of any State medical society that has come out for this bill, that is, for the compulsory-insurance feature?

Dr. PETERS. I believe that California once did.

Senator ELLENDER. Once did, you say?

Dr. PETERS. I do not know whether they have again or not.

I think there has been a recent vote in California, but I would have to look that up. One of the counties.

Senator ELLENDER. I am speaking of the State society.

Dr. PETERS. I said California once did.

Senator ELLENDER. I thought you said a county.

Dr. PETERS. I said recently.

Senator ELLENDER. Recent action was taken by a county.

Dr. PETERS. But I believe the State once did.

Senator ELLENDER. Do you know if the California Medical Society did?

Dr. PETERS. No.

Senator ELLENDER. Do you know of any State medical society that has?

Dr. PETERS. No; I do not see why they should.

The CHAIRMAN. Thank you, Doctor.

The next witness this morning will be Dr. Carl O. Flagstad.

Senator DONNELL. Mr. Chairman, may we have filed with the records of this committee the letterhead which Dr. Peters just presented a little while ago?

The CHAIRMAN. Yes.

(The letterhead referred to is as follows:)

COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC.

Dr. Channing Frothingham, Chairman, the Faulkner Hospital,
Jamaica Plain, Mass.

Dr. John P. Peters, Secretary and Treasurer, 789 Howard Avenue,
New Haven 11, Conn.

ADMINISTRATIVE COMMITTEE

- | | |
|---|---|
| <p>Chairman: Dr. Channing Frothingham,
Jamaica Plain, Mass.</p> <p>Vice Chairmen:
Dr. Allan M. Butler, Boston, Mass.
Dr. T. Grier Miller, Philadelphia,
Pa.</p> <p>Honorary Chairman: Dr. Russell L.
Cecil, New York, N. Y.</p> <p>Secretary and Treasurer: Dr. John P.
Peters, New Haven, Conn.</p> <p>Dr. Charles A. Flood, New York, N. Y.
Dr. George M. Mackenzie, Cooperstown,
N. Y.</p> <p>Members:</p> <p>Dr. Alf S. Alving, Chicago, Ill.
Dr. Bertram Bernheim, Baltimore,
Md.
Dr. Carl Binger, New York, N. Y.
Dr. Ernst P. Boas, New York, N. Y.
Dr. Byron D. Bower, Buffalo, N. Y.
Dr. S. Bradbury, Philadelphia, Pa.
Dr. Louis Casamajor, New York,
N. Y.
Dr. R. L. DeNormandie, Boston,
Mass.
Dr. Nathaniel W. Faxon, Boston,
Mass.
Dr. Harry Goldblatt, Cleveland,
Ohio.
Dr. T. Duckett Jones, Boston, Mass.
Dr. W. J. Kerr, San Francisco,
Calif.
Dr. John S. Lockwood, New Haven,
Conn.</p> | <p>Members—Continued</p> <p>Dr. H. C. Loos, Los Angeles, Calif.
Dr. F. D. W. Lukens, Philadelphia,
Pa.
Dr. Harry S. Mackler, Elizabeth,
N. J.
Dr. I. McQuarrie, Minneapolis,
Minn.
Dr. J. H. Means, Boston, Mass.
Dr. George R. Minot, Boston, Mass.
Dr. Fred D. Mott, Washington, D. C.
Dr. Robert B. Osgood, Boston,
Mass.
Dr. Walter L. Palmer, Chicago, Ill.
Dr. H. B. Richardson, New York,
N. Y.
Dr. G. C. Robinson, Baltimore, Md.
Dr. David Seegal, New York, N. Y.
Dr. Clement A. Smith, Cambridge,
Mass.
Dr. Richard M. Smith, Boston,
Mass.
Dr. J. Stokes, Jr., Philadelphia, Pa.
Dr. Boroden S. Veeder, St. Louis,
Mo.
Dr. Allen O. Whipple, New York,
N. Y.
Dr. James L. Wilson, Ann Arbor,
Mich.
Dr. M. C. Winternitz, New Haven,
Conn.
Dr. W. Barry Wood, Jr., St. Louis,
Mo.
Dr. Edward L. Young, Boston,
Mass.</p> |
|---|---|

STATEMENT OF DR. CARL O. FLAGSTAD, CHAIRMAN, LEGISLATIVE COMMITTEE, AMERICAN DENTAL ASSOCIATION, ACCOMPANIED BY DR. ALLEN O. GRUEBEL, SECRETARY OF THE COUNCIL ON DENTAL HEALTH, AMERICAN DENTAL ASSOCIATION; DR. HAROLD HILLENBRAND, EDITOR OF THE JOURNAL OF THE AMERICAN DENTAL ASSOCIATION; AND GEORGE H. FOX, GENERAL COUNSEL OF THE AMERICAN DENTAL ASSOCIATION, AND SECRETARY OF THE COMMITTEE ON LEGISLATION OF THE AMERICAN DENTAL ASSOCIATION

The CHAIRMAN. Dr. Flagstad, you may give your full name and the name of the organization that you represent.

Dr. FLAGSTAD. I am Dr. Carl O. Flagstad of Minneapolis, chairman of the Committee on Legislation of the American Dental Asso-

ciation. I have been engaged in private dental practice for 35 years and am a professor and chairman of the Division of Prosthetic Dentistry at the University of Minnesota.

The CHAIRMAN. You may proceed with your statement, Doctor.

Dr. FLAGSTAD. I desire to present a statement on behalf of the members of the American Dental Association in reference to S. 1606. I also wish to express the appreciation of our association for this opportunity to present its views in the interests of improving dental health in this Nation.

In order to conserve time, the viewpoint of the American Dental Association has been summarized into a single statement. We request the privilege of inserting supportive technical data into the records so that the additional information may be available to members of this committee and to other members of the Senate. The American Dental Association has in attendance at this hearing various officers, committee members, and technical consultants, all of whom will be pleased to provide further information, if it is desired, at the finish of this presentation. These men have long studied various plans for improving the dental health of our people and, therefore, are qualified to speak with authority.

The American Dental Association presents its statement under the following headings:

First: The American Dental Association and its objectives.

Second: The American Dental Association's attitude towards health security as shown by its past record.

Third: The American Dental Association's concept of the basis for a dental health program.

Fourth: The American Dental Association's attitude towards S. 1606, especially the dental sections.

Fifth: The American Dental Association's proposed dental health program and the dental provisions of S. 1606.

Sixth: The American Dental Association's recommendations.

THE AMERICAN DENTAL ASSOCIATION AND ITS OBJECTIVES

The American Dental Association, whose headquarters are in Chicago, has a membership of 56,000 dentists. This represents more than two-thirds of the 75,000 dentists registered in the United States. The association has 58 constituent societies comprising all of the 48 States, each territory and possession, the Army, the Navy, the United States Public Health Service, and the Veterans' Administration. Within the constituent societies there are 440 organized district dental societies located in all parts of our country, and each of these constituent societies annually selects delegates to send as voting members to sessions of the house of delegates, the policy-making body of the American Dental Association.

The committee on legislation, of which I am chairman, has its members elected by the house of delegates and we serve without personal remuneration.

This democratic pattern of organization with extensive membership in every State of the Union, unquestionably gives the American Dental Association the right to voice the opinion of the great majority of the dentists in the United States. The objectives of the association are in the interest of the public welfare.

THE AMERICAN DENTAL ASSOCIATION'S ATTITUDE TOWARD HEALTH SECURITY
LEGISLATION

The American Dental Association has always been willing to cooperate in every worthy effort leading to the development of sound legislation for the improvement of the general and dental health of our people. The objectives of our association and its 50 years of actual achievement attest the fact that we have continually endeavored to promote dental health programs. Through the efforts of our association and its constituent societies, dental divisions have been established in 44 out of the 48 State health departments; dental health programs, particularly for children, have been established in hundreds of cities and counties and dental health education and dental research have been extensively stimulated and fostered.

In 1939 when legislation similar to S. 1606 (the first Wagner Health bill, S. 1620) was pending before this committee, the association expressed itself as being in accord with the general objectives of such legislation. The association, at the request of the Senate committee, prepared at that time a series of amendments incorporating its suggestions for the development of a national program for dental health. In the intervening 7 years the American Dental Association has consistently pressed for Federal legislation which would translate this program into reality.

On two occasions prior to 1945, in cooperation with the kind help of the chairman of this very committee, Senator Murray, the American Dental Association sponsored the introduction of bills into Congress to initiate its program on a national scale by intensifying dental research. These bills were reported favorably by the committee, but did not proceed to full legislative enactment.

In 1944 the association again called attention to the need for legislation at the national level, and adopted four principles outlining a practical basis for such a program. The four principles are as follows:

1. *Research.*—Adequate provisions should be made for research which may lead to the prevention or control of dental disease.

2. *Dental health education.*—Dental health education should be included in all basic educational and treatment programs for children and adults.

3. *Dental care.*—Dental care should be made available to all, regardless of income or geographic location. Programs developed for dental care should be based on the prevention and control of dental diseases. All available resources should first be used to provide adequate dental treatment for children and to eliminate pain and infection for adults. Dental health is the responsibility of the individual, the family, and the community, in that order. When this responsibility, however, is not assumed by the community, it should be assumed by the State and then by the Federal Government. The community in all cases shall determine the methods for providing service in its area.

4. In all conferences that may lead to the formation of a plan for dental research, dental health education and dental care, there should be participation by authorized representatives of the American Dental Association.

The American Dental Association again in 1945 in keeping with its record of seeking sound legislation for a national dental health

program, sought the introduction of bills to translate this program into reality. Through the cooperation of Senator Murray, Senator Pepper, and Senator Aiken, all members of this committee, two bills were introduced into the Senate. S. 190 proposes a Federal appropriation for the erection of a National Institute for Dental Research as a part of the National Institute of Health at Bethesda, Md., and for providing grants-in-aid to public and private agencies for the intensification of dental research. S. 1099 proposes a Federal system of grants-in-aid to the States for the development of experimental programs in all phases of dental health education, dental treatment, and dental administration. Both bills provide that administration at the Federal level would be in the hands of the United States Public Health Service, Federal Security Agency. A subcommittee of your group, under the chairmanship of Senator Pepper, held a most favorable hearing on these bills in June 1945.

THE AMERICAN DENTAL ASSOCIATION'S CONCEPT OF THE BASIS FOR A
DENTAL HEALTH PROGRAM

In legislation of the type of S. 1606, there has been a tendency to include dental practice and treatment under the categorical head of "medical service." It is true that close cooperation between dental and medical practitioners exists in routine and special practice, but it does not follow that the needs and program of both professions are identical. There are some specific facts about dental disease and dental practice which must be taken into consideration before an intelligent and long-range program can be planned. It is impossible to present these facts in detail in our allotted time so that I have taken the liberty of presenting a summary of them. Additional evidence will be placed in the record to support the various contentions.

1. Dentistry must include in its program provisions for treating a disease that is almost universal. It is almost axiomatic that 95 percent of our population suffer from dental diseases at some point or other in life and that an extremely high percentage need annual dental care.

2. Because of the extremely high prevalence of untreated dental defects, it is impossible to apply the insurance principle.

3. The real causes of the chief dental diseases, dental caries and periodontoclasia, are not entirely known, so it is impossible to prevent them in the true sense of the word by attacking the cause. The best methods of control that are known to date are early and regular dental treatment.

4. If such early dental treatment is not sought, the ensuing dental neglect becomes much more costly than timely dental treatment.

5. If early and regular dental treatment can be given to children, it will assure a definite lowering of serious dental defects later in life and the production of a generation of adults comparatively free from the accumulated defects caused by early neglect.

6. The cost of providing such essential dental service for children is, according to present estimates, less than one-half the cost of providing essential dental service for adults.

7. Since many people do not seek dental care until great damage has occurred, it is absolutely essential to maintain a continuing program of dental health education to inform all of the importance of dental health and to motivate them to secure dental care.

8. Because of the limited number of dentists, it is impossible to carry out any program that promises complete dental care to both children and adults.

9. In the face of this dental personnel problem, it is obvious that the most efficient use should be made of the present number of dentists. It is the opinion of competent dental authorities that in public dental health programs the most efficient use of available dental services is to devote all needed attention to dental disease in children and provide additionally as much service as possible for adults.

10. One of the reasons for dental neglect besides those already mentioned is that the prevention and control of dental diseases have never been given continuing financial support by either public or private agencies.

All of these factors are brought to your attention to demonstrate that legislation even if it may be well designed to meet medical problems and conditions is not necessarily as well adapted to meet dental problems which are quite different in nature. The attitude of the American Dental Association toward the current bill, S. 1606, is based largely on the fact that it does not take into sufficient account the unique complex problem of providing adequate dental care.

THE AMERICAN DENTAL ASSOCIATION'S ATTITUDE TOWARD S. 1606

The American Dental Association is opposed to the enactment of S. 1606 because:

1. The American Dental Association believes that compulsory health insurance for a majority of the population should not be established in this country without preliminary scientific experimentation involving less extensive groups of the population.

2. The American Dental Association believes that it is unsound administration to disperse responsibility for health among the three agencies mentioned by the bill; the United States Public Health Service, the Children's Bureau of the Department of Labor, and the Social Security Board.

3. The American Dental Association believes that a compulsory health insurance system, basically similar to those in effect in foreign countries, should not be established on a national basis until there is incontrovertible evidence that the American pattern is an improvement and that the errors of the foreign systems will not be perpetuated in the American program.

4. The American Dental Association believes that a program the size of the one proposed should not be established without directly facing the problem of expense. This expense should be clearly enunciated in terms of both cost to the individual and cost to the Nation.

5. The American Dental Association believes that the grants-in-aid system has been effective in meeting certain health needs under the Social Security Act. The American Dental Association believes that this system should be enlarged to meet all health needs and that there is no necessity for enacting a national compulsory prepayment plan.

6. The American Dental Association believes that the right of a State to determine the methods of meeting its health needs should not be taken away.

7. The American Dental Association believes that a program as comprehensive as the one proposed should not be designed without seeking the official cooperation of all agencies and professions involved. These are general statements, but time does not permit the documentation of each one.

The dental provisions of S. 1606 have been examined more minutely and the reaction of the profession is recorded in greater detail because of the American Dental Association's particular interest in the dental problem.

The primary objective of the dental profession is to prevent and control dental diseases through the application of sound dental and public health practices. S. 1606 is in direct conflict with this objective.

In the early development of dentistry patients received little more than emergency types of dental service consisting largely of relief of pain, extraction of teeth, and treatment of acute infection. In the light of modern dental practice these dental services constitute only a small part of the routine dental treatment necessary for the protection of dental health. By no stretch of the imagination can such limited services form the basis for a national dental health program, yet only these primitive services are promised to the American people by S. 1606.

Some may be inclined to argue that in years to come the present restricted content of dental benefits proposed by the bill would be enlarged to include more than examination, diagnosis, prophylaxis, extractions, and special treatments. Even if such a possibility exists, which may be doubted in the face of experiences abroad, there is still the undeniable fact that a large segment of the American people will be compelled to pay a tax for dental services which they cannot receive under a national insurance plan because of the limitations on dental personnel.

S. 1606 proposes to make emergency dental care available to larger groups of the population. This proposal involves a false concept in public dental health practice because if only emergency dental treatment is given the problem of dental disease will be as great 10 or 50 years from now as it is today. In contrast to this uneconomic and unscientific approach, the dental profession of this country supports the view that the problem can be solved through a coordinated program of disease prevention and dental care for children. If we cannot prevent the occurrence of dental disease we must concentrate our efforts on dental research. If we cannot provide services to all persons (which is obviously the case) the benefits of the plan must be limited to the age groups in which dental disease begins.

The American Dental Association and the dental profession at large are of the opinion that no dental-care program can be successful if its content is severely restricted in terms of dental service. To illustrate this point a comparison should be made between S. 1606 and the dental-care plan for low-income groups proposed by the Council on Dental Health of the American Dental Association.

S. 1606 provides that dental benefits 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."

Contrast this limited, emergency type of program in S. 1606 with that proposed by the Council on Dental Health: for the 12-18 year age group.

1. Examination using posterior bitewing radiograms at least once a year and other radiograms as may be needed.

2. Prophylaxis at intervals depending on patient need and susceptibility.

3. Restoration of carious teeth with silver amalgam, silicate cement and gold.

4. Pulp treatments including pulp capping, pulpectomy of vital exposed pulps and treatment of putrescent teeth in young patients.

5. Restoration and appliances including prosthetic restorations to replace missing teeth and appliances to maintain space so as to prevent malocclusion.

6. Treatment of mouth infection.

7. Extraction of infected teeth, supernumerary teeth, impacted teeth using local or general anesthesia.

8. Surgery as may be necessary to maintain health including, if necessary, root resection of infected permanent teeth.

9. Health education of the patient.

Authorities in the field of dentistry have agreed after a careful study that the services listed above would be considered minimum services for the protection and maintenance of dental health. Any amount less than that would be inconsistent with modern dental practice.

The vast difference in dental benefits of the two proposals emphasize again the need for technical advice in planning health legislation. Such advice obviously was not sought or taken into account in drafting the dental provisions of S. 1606.

There are other valid reasons for seriously questioning the dental benefits in the proposed legislation. S. 1606 provides, for example, that every insured person will be entitled to receive "treatment of acute diseases of the teeth * * *." A careful reading of the bill does not disclose what is meant by the term "acute diseases of the teeth." If dental decay is an "acute disease" of the teeth, and many authorities believe that it should be so classified, then the bill promises that all types of dental procedures for treating diseased teeth would be included in the plan, and only prosthetic dentistry would be excluded. Under this provision, the American people would not know the amount of dental-health service to which they would be entitled. Such vague and indefinite wordings constitute a basic objection to the proposal.

The American Dental Association also wishes to raise another objection to the dental provisions of S. 1606. Experience in foreign countries reveals that effective dental-health programs have not been developed under the compulsory-health-insurance system.

The following short quotations are taken from the report of an official committee of Parliament appointed to study the British dental program :

Roughly two-thirds of the insured population ; that is, between 13 and 14 million people are entitled to dental benefit, but only 800,000 (less than 7 percent) of these claim it on an average each year.

It is the contention of the American Dental Association that there is something intrinsically wrong with a program which compels 13 or 14 million people to contribute for a service which only 800,000 receive.

Another quotation from the committee's report :

The state of the dental health of our population is bad and its effect on their general health is bad.

The American Dental Association does not believe that any program which must make such an admission after several decades of existence gives any indication that it will aid in rearing a generation of adults less afflicted with dental disease.

Perhaps it might be impressive to add the general opinion expressed by our veterans of the Dental Corps stationed in England during the war. Their opinion is, "The dental health of the people of England is very poor and so is their dentistry."

PROPOSED DENTAL HEALTH PROGRAM

The American Dental Association would be reluctant to end its testimony with mere opposition to the proposal that is now before this committee. So intense have been the interest and activity of the American Dental Association in this great problem of better dental health for our people that it has sponsored two measures which are also pending before this committee: S. 190 and S. 1099. These bills provide, as has been stated, Federal grants-in-aid for intensified dental research and experimental programs in all phases of dental-health education and care. The advantages of this legislation over that proposed by S. 1606 are summarized in these conclusions:

1. Unlike S. 1606, the two bills make use of a well-tried and successful method of providing Federal aid to the States, a method that has proven to be the successful basis of the Social Security Act—grants-in-aid.

2. Unlike S. 1606, the two bills give the States and communities the right, within broad limits, to determine their needs and programs for themselves. This right is traditional in this country. Since the needs differ in various States, so will the programs differ in various States.

3. Unlike S. 1606, the two bills propose an experimental approach to this great problem on which much evidence is still lacking. This experimental approach can be as broad and as extensive as existing personnel and funds permit.

4. Unlike S. 1606, the two bills will place major emphasis upon prevention and control of dental disease, rather than on treatment. The two bills are designed to prevent disease rather than to repair its ravages.

5. Unlike S. 1606, the two bills do not promise something which cannot be delivered.

6. The two bills will encourage the development of new dental resources to meet the problem instead of restricting those already in existence by a monotonous program of primitive dentistry that has little beginning and no ending.

This series could be continued at great length, but I believe the point has been made; the American Dental Association is opposed to the enactment of S. 1606 because it is not good legislation for improving dental health. In its proposal, American dentistry has offered a carefully planned solution which will make lasting contributions to dental health in this country.

The American Dental Association recommends that S. 1606 should not be enacted.

The American Dental Association recommends the immediate passage of S. 190 and S. 1099.

The American Dental Association again wishes to express its appreciation for the privilege of appearing before this committee, and especially do we wish to thank Senator Murray for his many kindnesses to dentistry in the American Dental Association. He has been extremely kind in assisting the dental profession in its development. We shall be pleased to answer any question or supply further information at this time. Thank you.

The CHAIRMAN. Thank you, Doctor, for your able statement. We will probably wish to ask a few questions.

The American Dental Association has issued a statement of principles of the house of delegates of the American Dental Association.

I ask you if what I read here are not the principles of the association:

One. Research: Adequate provisions should be made for research which may lead to the prevention or control of dental disease.

That is one of the main principles of your association?

Dr. FLAGSTAD. Yes.

The CHAIRMAN. You have been kind enough to invite me on many occasions to sit with the representatives of your association with a view of preparing legislation to carry out that idea.

Dr. FLAGSTAD. That is right, Senator.

The CHAIRMAN. And at your suggestion and the suggestion of your organization, I have filed, some years back, a bill to provide for research in the study of dental diseases.

Dr. FLAGSTAD. That is right, Senator.

The CHAIRMAN. And subsequently other bills which have been mentioned here today, have been filed and are now pending, S. 190, I believe, is one of them, and S. 1099 is another.

Dr. FLAGSTAD. That is right.

The CHAIRMAN. Now, the other principles that I have reference to here are as follows:

Dental Health Education: Dental health education should be included in all basic educational and treatment programs for children and adults.

That is another essential principle of your organization?

Dr. FLAGSTAD. That is right.

The CHAIRMAN. Which I believe we all recognize.

Then you have a third principle, entitled: "Dental Care."

Dental care should be made available to all regardless of income or geographic location. Programs developed for dental care should be based on the prevention and control of dental diseases. All available resources should first be used to provide adequate dental treatment for children and to eliminate pain and infection for adults. Dental health is the responsibility of the individual, the family, and the community, in that order. When this responsibility, however, is not assumed by the community, it should be assumed by the State and then by the Federal Government. The community in all cases shall determine the methods for providing service in its area.

Those are the principles of your organization, Doctor?

Dr. FLAGSTAD. That is right, Senator.

The CHAIRMAN. Now, you recognize that there is a grave shortage of practicing dentists in this country and that with the present force of dental practitioners, it would be impossible to give the American people full and complete dental care?

Dr. FLAGSTAD. Right, sir.

The CHAIRMAN. Of course, the fact is that the dental practitioners have been kept busy with people who are able to pay adequately for the treatment they receive, but if dental care was opened freely to the American people, of course, there would not be sufficient dentists to take care of them at all.

Dr. FLAGSTAD. That is right.

The CHAIRMAN. Most people neglect their teeth and as the result permit the diseases to advance in them to such a degree that finally it becomes an expensive matter to treat them, and that is the situation with the great majority of the American people in this country today, is it not?

Dr. FLAGSTAD. To a certain extent, Senator, what you say is true. People neglect the care of their teeth for a number of reasons. One of them may be financial. It may be that they are not motivated. We hope to have a dental education program that will motivate them to the care, and we hope to begin with the children and have an adequate program, and through education they will take care of their teeth, and so we will prevent some of these ravages that occur in later life.

The CHAIRMAN. I agree with you fully, and that is the reason why I was induced to file the legislation which your association proposed.

Dr. FLAGSTAD. We are very grateful to you, Senator.

The CHAIRMAN. It is very obvious that if we could take care of the children of the country and educate them in the early years with reference to the need for dental care, we would put them in a position where, if they continued that care through their lives, they would be less likely to be required to go into any extensive dental treatment in later years.

Of course, I suppose under our modern system of living it is impossible in this country without continual dental investigation and treatment?

Dr. FLAGSTAD. That is the hope of dental research, Senator. That is why we are intensifying research.

The CHAIRMAN. You think dental research would reveal certain methods and practices that could be followed in this country which would give the American people better teeth?

Dr. FLAGSTAD. I believe there is some hope. Changing the habits of people is difficult, as you know.

The CHAIRMAN. I remember when I filed that legislation, I received letters from all over the country, not from dentists or physicians, but from individuals.

Among others I got a letter from a man who was a noted explorer, and he told me that a large cause or an important cause of dental decay in people of this country was the fact that their diet was not proper, and he told me he was in Iceland where they had made investigations and by digging up the graves of people that had been buried for several hundred years, they found that there were people there apparently 100 years old who still had their teeth because they lived on a meat diet, and that he thought that the good teeth of those people was largely due to the fact that they did not eat the kind of food we eat in this country.

So as the result of that investigation, you think it might be revealed that some of our trouble is due to a defective diet?

Dr. FLAGSTAD. I believe that diet is quite a factor. There are many other factors, however.

The CHAIRMAN. In addition to that, cleanliness of the teeth, careful treatment of the teeth in the early periods of life would be effective in preserving good teeth.

Dr. FLAGSTAD. That is right, Senator.

The CHAIRMAN. Now, you do not think that any effort should be made to bring dental care into this national health program that is envisaged by this bill, this S. 1606?

Dr. FLAGSTAD. Unless it could be brought in as we are providing it in S. 190 and S. 1099.

The CHAIRMAN. Well, yes. I approve of that legislation, of course, and hope that it will be enacted. I do not think anyone could oppose that legislation if they understood it.

Dr. FLAGSTAD. The hearing was very favorable, Senator, as you will recall.

The CHAIRMAN. Yes. The National Health Service is, of course, in favor of it, and are already carrying on a certain amount of dental studies but not sufficient to comply with what you think should be done in that direction. So that that legislation, I agree with you, should be made a part of the national legislation as a means of providing better dental health for the American people.

But in addition to that, do you not think that something should be done to provide for the dental care for the people when they grow older and when the dental diseases do become apparent, and they need care?

GRANTS IN AID PREFERABLE TO COMPULSORY INSURANCE

Dr. FLAGSTAD. There are many programs to take care of the adults. We have many programs now. They should be extended, however. But they could also be taken care of under the grants-in-aid system.

The CHAIRMAN. Under a grants-in-aid system.

Dr. FLAGSTAD. Yes.

The CHAIRMAN. Of course, it is very difficult to provide a system of care for teeth under a health insurance program. That is to say, it is not so susceptible to that method of protection as other diseases?

Dr. FLAGSTAD. That is what we have been trying to point out in our statement, Senator. We pointed that out in the statement.

The CHAIRMAN. That is the position of your organization?

Dr. FLAGSTAD. Yes.

The CHAIRMAN. That it should be done by provisions which would provide methods of avoiding dental diseases rather than curing them?

Dr. FLAGSTAD. Accent should be on that particular prevention, and research.

The CHAIRMAN. Accent should be on prevention instead of the cure. But do you think that there should be no effort whatever to provide dental care for the people of the country who are unable to pay for it? The poorer sections? I mean to say, in the lower-income groups where there is a considerable burden on them. Do you not think there should be some way that the people should be enabled to secure some modern dental care?

Dr. FLAGSTAD. Senator, may I have the privilege of calling on the secretary of the council on dental health, who has made a thorough study of this particular subject, Dr. Allen Gruebbel of Chicago.

The CHAIRMAN. He will be here as a witness?

Dr. FLAGSTAD. He is here now.

The CHAIRMAN. Will he appear separately as a witness?

Dr. FLAGSTAD. No; he will not. He can just answer these questions.

The CHAIRMAN. He may answer that question.

Dr. GRUEBBEL. Senator Murray, Senator Donnell, I believe the basic difference between the proposals in Senate bill 1606 and that proposed by the American Dental Association in S. 1099, is that the first would attempt to improve dental health through a national insurance system while S. 1099 is based on the development or expansion of community health services.

The CHAIRMAN. Will your program propose to prevent dental disease rather than cure?

Dr. GRUEBBEL. In addition to prevention we also propose to provide dental services insofar as we are able to provide them on a community basis.

The CHAIRMAN. Oh, on a community basis.

Dr. GRUEBBEL. That is the purpose contained in Senate bill 1099.

The CHAIRMAN. I beg your pardon?

Dr. GRUEBBEL. It is primarily a grant-in-aid bill to provide dental services on an experimental basis on a community level. We believe that past experience shows that such programs, developed on a community basis and designed to meet the need in the community itself, can be very effective. We do not believe that there is any evidence to show that a compulsory health system will do that, because the conditions in the various communities are so different. You cannot, in our estimation, have one blanket program on a national basis which will fit every community, because the circumstances and needs are so very different in the various communities.

The CHAIRMAN. The bill, 1099, you say provides that method of approach to this problem?

Dr. GRUEBBEL. That is right.

The CHAIRMAN. I will have that bill submitted for the record. We do not have a copy here at the present time. I will see that one is filed for the record.

(Senate bill 1099 referred to is as follows:)

[S. 1099, 79th Cong., 1st sess.]

A BILL To amend the Public Health Service Act so as to provide assistance to States in developing and maintaining dental health programs, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That title III of the Public Health Service Act is amended by adding after section 315 thereof a new section as follows:

"DENTAL HEALTH PROGRAMS

"SEC. 316. (a) There is hereby authorized to be appropriated for each fiscal year a sum sufficient to enable the Surgeon General to carry out the purposes of section 301 with respect to developing and maintaining more effective measures for the prevention, treatment, and control of dental diseases, and (1) to assist, through grants and as otherwise provided in this section, States and political subdivisions thereof, including municipalities, in establishing and maintaining adequate measures for the prevention, treatment, and control of such diseases, including dental-care programs for children, the training of personnel for State and local dental health work, and the development and maintenance of effective means for the education of the public concerning dental diseases; (2) to make available to States and political subdivisions thereof, including municipalities, and to educational institutions and other nonprofit agencies, grants for approved studies, investigations, and demonstrations in dental health care and education projects and projects relating to the diagnosis, treatment, and prevention of dental diseases, administrative practices in dental health, the training of personnel participating in dental health programs, and the development of methods of payment for dental services; and (3) to conduct studies and demonstrations and to collect information, by correspondence or by personal investigation, concerning studies which are being carried on within the United States or elsewhere relating to the prevention, treatment, and control of dental diseases, and through appropriate publications or otherwise to make information concerning any such studies or demonstrations available to public and private health agencies and organizations, the dental profession, other health workers, and the general public; 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.

"ALLOTMENTS TO STATES

"(b) For each fiscal year, the Surgeon General, after consultation with the Dental Health Council and with the approval of the Administrator, shall determine the total sum from the appropriation under subsection (a) which shall be available for allotment among the several States for the purposes specified in subsection (a) (1). He shall, in accordance with regulations, make an initial allotment for such purposes to each of the several States at the beginning of each fiscal year, and from time to time thereafter shall make supplemental allotments to such States. All such allotments shall be made on the basis of (1) the population, (2) the financial need of the respective States, and (3) such other factors as the Surgeon General may deem relevant to the accomplishment of the purposes of this section, except that in making any such supplemental allotment to a State the Surgeon General shall also take into account any unexpended balances remaining from previous allotments to such State. Upon making such allotments the Surgeon General shall notify the Secretary of the Treasury of the amounts thereof.

"PAYMENTS TO STATES

"(c) 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 allotment made to such State under subsection (b), and the amount to be paid to each State or other participant pursuant to grants made for the purposes of subsection (a) (2), and shall certify to the Secretary of the Treasury the amounts so determined, reduced, or increased, as the case may be, by the amount by which he finds that estimates of required expenditures with respect to any prior period

were greater or less in any case than the actual expenditures for such period. Upon receipt of any 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.

"(d) Moneys paid to any State for the purposes specified under subsection (a) (1) shall be expended only for such purposes and in accordance with plans presented by the health authority of such State and approved by the Surgeon General. All regulations and amendments thereto with respect to grants to States for such purposes shall be made after consultation with a conference of the State health authorities or their designated dental representatives, and the National Dental Health Council.

"(e) The proportion of the costs of any program or project for which a grant is made under subsection (a) (1) or (2) to be borne by the State or other participant shall be determined, in accordance with regulations, by the Surgeon General.

"(f) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the recipient of any funds appropriated under this section finds that, with respect to such funds, there is a failure to comply substantially with either—

"(1) the provisions of this section;

"(2) the plan or project approved by the Surgeon General; or

"(3) the regulations;

the Surgeon General shall notify such recipient either that further payments will not be made from such appropriations (or in his discretion that further payments will not be made 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 from appropriations under this section, or shall limit payment to activities in which there is no such failure.

"(g) The Surgeon General may cause audits to be made of the expenditure of funds by any recipient thereof under this Act. If the Surgeon General, after review and reasonable opportunity for hearing, finds that any portion of such funds has been lost or unlawfully used, an amount equal to such portion shall, after reasonable notice, be withheld from the next ensuing payment to such recipient unless such amount is replaced by such recipient and expended for the purposes originally intended.

"NATIONAL DENTAL HEALTH COUNCIL

"(h) The National Dental Health Council is authorized to review projects submitted to it or initiated by it for carrying out the purposes specified in subsection (a) (2) and to certify to the Surgeon General its approval of any such project the prosecution of which will, in its opinion, result in valuable contributions to the prevention, treatment, and control of dental diseases. The Council is also authorized to make recommendations to the Surgeon General regarding regulations and amendments thereto relating to grants for such projects."

SEC. 2. (a) Section 217 of the Public Health Service Act is amended by adding at the end thereof a new subsection as follows:

"(d) The National Dental Health Council shall consist of the Surgeon General ex officio, who shall be Chairman, the Assistant Surgeon General (Dental) of the Public Health Service and of six members to be appointed without regard to the civil-service laws by the Surgeon General with the approval of the Administrator. The six appointed members shall be persons, not otherwise in the employ of the United States, a majority of whom shall be leading dental authorities who are outstanding in the treatment, prevention, and control of dental disease. Each appointed member shall hold office for a term of three years, except that (1) 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 (2) the terms of office of the members first taking office shall expire, as designated by the Surgeon General at the time of appointment, two at the end of the first year, two at the end of the second year, and two at the end of the third year. An appointed member shall not be eligible to serve continuously for more than three years but shall be eligible for reappointment if he has not served immediately preceding his reappointment. The Council is authorized to appoint such technical advisers as it deems necessary to assist it in carrying out its functions under this Act."

(b) Subsection (e) of section 209 of such Act is amended by inserting after the words "National Advisory Health Council" a comma and the words "National Dental Health Council".

The CHAIRMAN. Now, of course, in our bill, this bill S. 1606, there was no effort here to provide any complete system of dental care.

It is provided in subdivision (b) of section 210, on page 58:

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.

In other words, it was recognized that there was a lack of sufficient personnel in the dental profession to provide any real adequate system of dental care, and it was proposed only to have a limited system until such time as adequate dental personnel became available.

You are familiar with those provisions?

Dr. GRUEBBEL. Yes, sir; I am.

The CHAIRMAN. Then you do not approve of that. You do not think any effort whatever should be made to provide for dental care under a bill of this kind, under a system of this kind?

Dr. GRUEBBEL. I do not believe it would be effective.

The CHAIRMAN. You think that the system which you propose and which is proposed in the bill, S. 1099, is the adequate system of dental care?

Dr. GRUEBBEL. We believe 1099 will give us an opportunity to experiment with different types of programs and that it will give the community and the State a voice in selecting a plan to meet local needs.

Dr. FLAGSTAD. May we also point out, Senator, that the restricted content there actually promised is of very little value unless the patient follows it up with care for which they must pay the expenses themselves.

The CHAIRMAN. I am in full sympathy, of course, as I have indicated by my advocacy of the dental-research legislation. I believe that a program of that kind, if carried out, would certainly provide for this country a very fine system, and that it would go a long way toward solving the serious problems we have in this country on dental care and decay.

But I do believe that in addition to that, there should be some way in which people who are unable to pay for the very expensive dental care which becomes necessary, when their teeth become in a very bad state of decay; but you feel that they could be handled in a local way through the community service?

Dr. GRUEBBEL. Yes, sir; through community services aided if necessary by grants-in-aid.

The CHAIRMAN. Under a grants-in-aid system.

Dr. GRUEBBEL. Yes, sir.

The CHAIRMAN. Any questions?

Senator DONNELL. Dr. Gruebbel, you come from Missouri, do you not?

Dr. GRUEBBEL. Yes, sir; I do.

Senator DONNELL. You served in the department of health under two administrations there?

Dr. GRUEBBEL. Yes, sir.

Senator DONNELL. Dr. Flagstad, you are the chairman of the committee on legislation of the American Dental Association?

Dr. FLAGSTAD. That is right.

Senator DONNELL. Senator Murray read from a circular, a copy of which I hold in my hand, a statement of the principles of the House of Delegates of the American Dental Association.

I will ask you to state whether or not the American Dental Association has a bureau of public relations.

Dr. FLAGSTAD. Yes; they do.

Senator DONNELL. And has that bureau of public relations considered it to be advisable to issue and circulate a circular opposed to the enactment of S. 1606?

Dr. FLAGSTAD. The Blueprint for Dental Health has been circulated to the dentists.

Senator DONNELL. By the bureau of public relations of the American Dental Association?

Dr. FLAGSTAD. That is right.

Senator DONNELL. And that is the paper which contains these principles from which Senator Murray read?

Dr. FLAGSTAD. Yes.

Senator DONNELL. There is a very concise statement of nine objections here to S. 1606, and, with the consent of the chairman, I ask that that particular Blueprint for Dental Health be incorporated in the record.

The CHAIRMAN. All right.

(The document referred to is as follows:)

Yes! Dental health of the American people can be improved.

BLUEPRINT FOR DENTAL HEALTH

No! Compulsory health insurance will not improve dental health.

Yes! The American Dental Association's plan will improve dental health.

Will compulsory health insurance improve dental health?

No! says your dentist.

Pending in the United States Congress is the Wagner-Murray-Dingell compulsory health insurance bill (S. 1606; H. R. 4730).

Your dentist is opposed to this bill because it will harm rather than improve the dental health of the American people.

Your dentist objects because:

1. The Wagner bill promises little more than emergency dental service and even this cannot be provided for all people. The public will be forced to pay for dental service it will not receive.

2. It will create another huge governmental agency with costly and complex administration.

3. It will require you to pay a tax equal to 3 percent on the first \$3,600 of your earnings each year for health care. The dental service promised will be inadequate to meet your dental needs.

4. It will limit your free choice of dentist—if you seek dental benefits—to practitioners who elect to work for the Government.

5. It will destroy the traditional private relationship between you and your practitioner.

6. It will involve your dentist in extensive record-keeping which will reduce his time for health service to the public.

7. It will subject the health services of the Nation to harmful interference by patronage seekers.

8. It will abrogate the traditional rights of States and communities to select health programs best suited to meet their individual needs.

9. Compulsory health insurance has not improved dental health in any country in which it has been tried.

In short—the Wagner-Murray-Dingell compulsory health insurance bill is not good legislation for dental health!

Will the American Dental Association program improve dental health?

Yes! says your dentist.

In opposing compulsory health insurance your dentist is not arguing for the status quo.

For many years, the American Dental Association has advocated an expanded program to improve the dental health of the American people.

In contrast to compulsory health insurance, the American Dental Association has a logical program. It utilizes professional resources and scientific knowledge to strike at the heart of the problem.

The American Dental Association proposes:

1. Expanded research to discover the cause of dental diseases.
2. Expanded dental health education to motivate people to take better care of their teeth and their children's teeth.
3. Expanded dental care, particularly for children.

The American Dental Association has asked Congress to put this dental health program into action by passing Senate bill 190, which provides funds for research, and Senate bill 1099, which allots Federal funds to assist States to increase dental health education and dental care.

DENTAL HEALTH FOR THE AMERICAN PEOPLE

A statement of principles of the house of delegates of the American Dental Association.

1. *Research*

Adequate provisions should be made for research which may lead to the prevention or control of dental diseases.

2. *Dental health education*

Dental health education should be included in all basic educational and treatment programs for children and adults.

3. *Dental care*

(a) Dental care should be available to all regardless of income or geographic location.

(b) Programs developed for dental care should be based on the prevention and control of dental diseases. All available resources should first be used to provide adequate dental treatment for children and to eliminate pain and infection for adults.

(c) Dental health is the responsibility of the individual, the family, and the community in that order. When this responsibility, however, is not assumed by the community, it should be assumed by the State and then by the Federal Government. The community in all cases shall determine the methods for providing service in its area.

BLUE PRINT FOR DENTAL HEALTH—RESEARCH—EDUCATION—DENTAL CARE

This blue print should be used to build a sound dental health program. United States Senate bills 190 and 1099, sponsored by the American Dental Association, should be enacted.

You can help! Write your Congressman and Senator today!

Tell them that you favor bills S. 190 and S. 1099 in the interest of better dental health for all and that you are opposed to compulsory health insurance and the Wagner-Murray-Dingell bill, S. 1606; H. R. 4730.

BUREAU OF PUBLIC RELATIONS

AMERICAN DENTAL ASSOCIATION

222 East Superior Street, Chicago 11, Ill.

Senator DONNELL. I ask you also, Dr. Flagstad, whether or not there was prepared a statement on a national program for dental health by a joint committee of the council on dental health, committee on legislation, and committee on economics of the American Dental Association?

Dr. FLAGSTAD. There was, Senator.

Senator DONNELL. Has that document been distributed by the bureau of public relations?

Dr. FLAGSTAD. It has—to the dental profession.

Senator DONNELL. Referring particularly to the testimony of Dr. Gruebbel, I call your attention to one paragraph, which I would like to have in the record, from pages 6 and 7 of that document:

In keeping with the traditions that have made this country great, the program is based on the assumption of responsibility by all concerned, and the greatest responsibility is laid upon the American community. In this way local funds and facilities, under local control, can be made to serve the interest of dental health. For this reason, among others, the American Dental Association has not recognized a national compulsory health insurance system as effective or desirable in providing dental care, i. e., because such a system nullifies local responsibility and local control.

Addressing myself to Dr. Gruebbel, I take it that states very distinctly the thought which you set forth a few moments ago in your testimony?

Dr. GRUEBBEL. That is right, Senator.

Senator DONNELL. I believe your testimony, Dr. Flagstad, indicates that the members of the American Dental Association—they are more than two-thirds of the 75,000 dentists in the United States?

Dr. FLATSTAD. That is right, Senator.

Senator DONNELL. The membership of that association being approximately 56,000, and that you have constituent societies comprising all of the 48 States; is that right?

Dr. FLAGSTAD. That is right.

Senator DONNELL. This house of delegates plan has been in effect some years in your organization—that is, the plan of organization whereby a house of delegates is set forth?

Dr. FLAGSTAD. As long as I have been familiar with the association.

Senator DONNELL. And that house of delegates is chosen from the country somewhat similarly to the method by which the house of delegates of the American Medical Association is chosen, is it not?

Dr. FLAGSTAD. I presume it is along the same line. The house of delegates of the American Dental Association is composed of representatives from each State. Each State has a representation in proportion to its dental population, and they are elected by the State association.

Senator DONNELL. And you know, generally speaking, that the American Bar Association likewise has a house of delegates plan of organization, does it not?

Dr. FLAGSTAD. I am not familiar. I will ask our committee.

Senator DONNELL. That is correct, Mr. Fox, is it not?

Mr. FOX. Yes.

Senator DONNELL. What is your full name?

Mr. FOX. George H. Fox.

Senator DONNELL. You are located in Chicago?

Mr. FOX. Yes, sir.

Senator DONNELL. You are a lawyer?

Mr. FOX. Yes.

Senator DONNELL. How many years have you practiced?

Mr. FOX. 18 years.

Senator DONNELL. That is all.

The CHAIRMAN. Doctor, you have, of course, examined this bill?

Dr. FLAGSTAD. Yes; we have examined it quite thoroughly.

The CHAIRMAN. And it undertakes to provide for many of the things that your association is in favor of. Do you not think it would be possible to have in this bill everything that you advocate as proper for the dental care of the people?

Dr. FLAGSTAD. I rather imagine, Senator, that it is possible, yes, but it does not contain it now.

The CHAIRMAN. And it does not contain it now, but it would be possible for you to suggest to us amendments that would make this bill provide the care which would be essential, in your judgment, and which would be the better method of handling the problem?

Dr. FLAGSTAD. I think it would be rather difficult, and I should like to call upon the editor of the American Dental Association Journal, Dr. Harold Hillenbrand, to answer that question.

Dr. Hillenbrand is here.

Dr. HILLENBRAND. I would like to give the informal opinion, that so long as the bill contains a compulsory health insurance program with dental provisions, it would be extremely difficult to amend the bill in that regard.

There is some possibility that S. 190 and S. 1099 might be placed in title I, but that would involve technical considerations which I am not prepared to discuss fully here.

The CHAIRMAN. The bill provides in various sections scattered throughout the bill for local community participation, and it provides for study and recommendations on the full dental program by the Surgeon General. Of course, at the present time you recognize that we would not have the personnel available in this country to give complete dental care for the American people.

Dr. HILLENBRAND. That is right.

The CHAIRMAN. But could not a study be made, and could not provision be made that would be a great step forward in bringing better dental health to the Nation?

Dr. HILLENBRAND. Yes. The American Dental Association has urged that a start be made almost at once. A start, however, which would conserve rather than disperse dental personnel.

A dental program such as mentioned in title II, would cause dispersion of dental personnel rather than conservation of dental personnel. This is not true of a children's program.

The CHAIRMAN. You think, with the present state of the personnel in the profession, that it would be better to concentrate on the provisions with reference to the care of children?

Dr. HILLENBRAND. Yes.

The CHAIRMAN. And that if you attempted to put on a full program, it would be a dispersion that would not be very effective?

Dr. HILLENBRAND. Yes.

The CHAIRMAN. And that is because of the insufficient personnel in the country?

Dr. HILLENBRAND. Yes. Cruel as it may sound, it is not possible for all adults to get all the dental care they need at the present time. We feel that to face this situation, in the best interests of the country, dental personnel should be devoted mainly to children and to the prevention and control of dental disease.

The CHAIRMAN. In other words, there is a great segment of the American population whose mouths have gotten in such shape that it would not be practical to attempt to cure them because of the tremendous task that would be implied in such an undertaking?

Dr. HILLENBRAND. Yes. And that involves two factors.

One is the factor of personnel, and the other is the factor of cost, which would be extensive for many millions of people.

The CHAIRMAN. It would be better to let that go and start now and build up from the children that are with us at the present time to a better dental care system in the United States?

Dr. HILLENBRAND. Yes. Many people have been neglecting their teeth for generations. We feel that rather than undertake an impossible task for such adults, we would rather undertake the more possible program of preventing and controlling dental diseases in children.

The CHAIRMAN. I have had many consultations with you, Doctor, and with the other members of your profession, and I want to say they have always been very satisfactory and very helpful, and I have gained a lot of advice and benefit from my associations with you; and I am sure that you will continue to assist us in working out this problem of national health.

Dr. FLAGSTAD. We will be glad to do so. Thank you.

Senator DONNELL. Dr. Hillenbrand, do you favor the following of a plan of national compulsory health insurance in the administration of dentistry throughout the country?

Dr. HILLENBRAND. No; I do not.

Senator DONNELL. Thank you.

The CHAIRMAN. Thank you, Doctor.

Dr. FLAGSTAD. Thank you. We are very grateful, Senator Murray, the dental profession.

STATEMENT OF DR. MAURICE KAUFMAN, ACCOMPANIED BY DR. SEYMOUR J. SCHOENFELD, SECRETARY, DENTISTS COMMITTEE FOR THE PASSAGE OF THE WAGNER-MURRAY-DINGELL BILL

The CHAIRMAN. Doctor, will you state your full name, and the organization which you represent.

Dr. KAUFMAN. I am Dr. Maurice Kaufman. I represent the Dentists Committee for the Passage of the Wagner-Murray Bill.

The CHAIRMAN. You are a practicing dentist?

Dr. KAUFMAN. I am, sir.

The CHAIRMAN. Where do you reside?

Dr. KAUFMAN. New York City.

The CHAIRMAN. How long have you been a dentist?

Dr. KAUFMAN. 24 years.

The CHAIRMAN. You may proceed with your statement, Doctor.

It is 25 minutes after 12. I am very sorry that I have a meeting up in the Military Affairs Committee, and I will have to leave here now, and I will read your statement carefully after it is put in the record. If I can get back in a few minutes before you conclude, I will be glad to return.

Dr. KAUFMAN. Thank you, Senator. I am sure you will be interested in it.

(Whereupon, Senator Donnell assumed the chair.)

Dr. KAUFMAN. I am Dr. Maurice Kaufman. I represent the Dentists Committee for the Passage of the Wagner-Murray Bill. Since I am appearing here in favor of S. 1606 and against the expressed stand of the American Dental Association, I want to give you some of my qualifications, which I think entitles me to speak as an active and loyal member of the American Dental Association.

I have been engaged in the practice of general dentistry since 1922. I am a member of the American Dental Association, the Dental Society of the State of New York, and the First District Dental Society. I have been a member of the board of directors of the First District Dental Society for many years. Until last year, I represented my society, the largest single component society of the American Dental Association, as chairman of the legislative committee. In that capacity, I have represented the 4,000 dentists in the first judicial district of New York State on many occasions. I hold a special appointment from the president of the New York State Dental Society to represent that body at all State hearings on the subject of rent controls.

The Dentists Committee for the Passage of the Wagner-Murray Bill is a very new organization. It was formed out of necessity. Due to the stifling of democratic procedure within the American Dental Association, there was no other way to give public notice to proponents of the bill.

This new committee is composed exclusively of members of the American Dental Association and is supported entirely by contributions of dentists. The chairman of the committee is Dr. John Oppie McCall, who is also director of the Murray and Leonie Guggenheim Dental Clinic of New York City. Among our sponsors are men who have held the most honored and trusted positions in the American Dental Association and its components.

ENDORSEMENT OF S. 1606

Dr. KAUFMAN. We favor the Wagner-Murray bill, S. 1606, because it provides a much needed and wide coverage of essential health care to the American people. It links dental care with health care, which in our opinion is its proper orientation. The bill is not socialized medicine, retains free choice, and protects the dentist with assurance of adequate compensation. It provides incentive for dentists and protects the public against threat of deterioration of service. The Dentist Committee for Passage of the Wagner-Murray Bill fully supports this proposed legislation.

SUPPRESSION OF FREE DISCUSSION BY AMERICAN DENTAL ASSOCIATION

The American Dental Association, speaking for organized dentistry, has gone on record as opposed to the Wagner-Murray bill. On February 20, 1946, it sent the attached letter to all of its component societies, indicating that it had no wish or desire to foster discussion or understanding of the bill.

With your permission, I will read the letter.

Senator DONNELL. Very well; you may read it.

Doctor, do you not have copies of this for the committee?

Dr. KAUFMAN. I had three copies, one which the recorder got, one which Senator Murray got, and one which I have.

Senator DONNELL. There does not seem to be a copy available for the committee at this time. It is difficult to follow without the benefit of a copy here. However, you may proceed.

Dr. KAUFMAN. Here is a letter, stationery of the American Dental Association, dated February 20, 1946:

COMPONENT DENTAL SOCIETY PRESIDENTS AND SECRETARIES.

DEAR DOCTOR. Information has just reached us that the Senate Committee on Education and Labor will begin public hearings on the Wagner-Murray-Dingell compulsory health insurance bill on March 18, 1946, in Washington, D. C.

The American Dental Association, of course, will present its objections to the bill at the public hearings. It is important, however, that the objections of organized dentistry to this compulsory health insurance measure be intensified all over the country.

On January 18, 1946, you were mailed a packet of material dealing with the Wagner-Murray-Dingell bill and the legislative program of the American Dental Association. This material was sent to you by the committee on legislation of the American Dental Association. Included was a speech to be given at a special or a regular meeting of your society and a preadapted release to be given to the newspapers and radio stations in your community.

We have had reports of many successful meetings and copies of substantial stories in local newspapers. To those who have staged meetings and secured publicity, we send our congratulations and compliments for a job well done.

To those of you who have not yet had a meeting and secured publicity regarding the stand of organized dentistry against the Wagner-Murray-Dingell bill and endorsement of Senate bills 190 and 1099, we urge you to employ immediately this medium for maintaining public opinion in our favor.

It is signed by Lon W. Morrey, director of the bureau of public relations, American Dental Association.

It was seen from this letter that there was to be no period of discussion of the provisions of Senate 1606 and no opportunity for the members of our society to be heard on the proposed legislation. The predetermined stand of the American Dental Association was to be given to this Senate committee and to the public as the majority opinion of organized dentistry.

It is proper that an organization should express the majority opinion of its members. It is proper that these decisions be reached democratically. The representative body of the American Dental Association—that is, the congress of the association—is called the house of delegates. The last meeting of the house of delegates of the American Dental Association was held in October 1944. Herewith is submitted a letter in proof of this statement from a member of our committee who is also a representative to the house of delegates of the American Dental Association. The date on Senate 1606 is November 19, 1945. How can the American Dental Association submit an official opinion when its representative body has not met in the last 18 months?

The Dentists Committee for the Passage of the Wagner-Murray bill sent out letters inviting dentists to join the committee, and many acceptances are coming in. However, two very disturbing letters of a different nature were received from a high official of the American Dental Association.

I have photostatic copies of these two letters which I wish to read into the record. They are from Dr. Carl O. Flagstad, chairman of the legislative committee of the American Dental Association, and they show the lengths to which the American Dental Association has gone to prevent free expression of opinion before your body.

I have a letter here on the stationery of the American Dental Association, dated April 10, 1946, addressed to Dr. Seymour J. Schoenfeld, 140 West Seventy-ninth Street, New York, N. Y.

To save time, I will read those paragraphs particularly pertaining at this moment.

DEAR DOCTOR SCHOENFELD: The enclosed letter bearing your signature, as secretary, has come to our office. I'm amazed that members of the American Dental Association will endeavor to undermine the work of the association by organizing a group to foster opposition to the legislative committee's endeavors in connection with the Wagner bill, S. 1606.

I should like to remind you that on a number of occasions the house of delegates have given specific instructions to the legislative committee on what its attitude and procedure should be in relation to legislation of the type presented by the Wagner-Murray-Dingell bill. Since our association is operated on a representative plan of government, the house of delegates is our official authority. Therefore, through your representatives you had a voice in the decision of the American Dental Association.

I have no quarrel with you over your social philosophy but I'm thoroughly disgusted with a group of members of the American Dental Association who will deliberately organize to oppose the association in a congressional hearing. In accepting membership in the American Dental Association you bound yourself to the discipline of the Association and to the wishes of the majority. In my opinion your present action is a serious breach of loyalty.

I'm in hopes sane judgment will prevail in your group and you will decide to cancel your testimony at the hearing.

Sincerely yours,

CARL O. FLAGSTAD,
Chairman, Legislative Committee.

In reply to this letter, the secretary of our association, Dr. Seymour Schoenfeld, stated the views of our association which were arrived at at an executive meeting of our group, April 21, 1946.

DEAR DR. FLAGSTAD: I have submitted your letter of April 10, 1946, to the committee at a special meeting called to consider the matter you raised. Your letter was given very careful consideration, and I wish to present herewith the agreed viewpoint of the committee, as I advised you in my letter of April 14, 1946, in reply to your of the 10th inst.

First permit me to point out that there has been no meeting of the house of delegates since the introduction of S. 1606 to the Senate. Nor has there been any poll taken by mail of the delegates. It is therefore clear that the elected delegates of the American Dental Association have not had an opportunity to express their opinion on this bill.

You are correct in your assumption that we believe in the philosophy of prepaid health care. The committee does not agree with your view that this constitutes socialization of the health services, and considers the expression "socialization" a misuse of terms when applied to this legislation.

Assuming that if the democratic methods had been used to obtain dentists' opinions, and the majority might have expressed an opinion against the bill, we still reserve the right to express a minority opinion, especially on a matter which concerns the health and welfare of the American people.

Regarding the organization of opposition to the American Dental Association in a Senate committee hearing, we feel that you fail to realize that although we are dentists and members of the American Dental Association, we are first of all citizens of our country.

The committee expresses surprise that so high an official of the American Dental Association should attempt to prevent the presentation of our views in a democratic manner before a Senate committee which is trying to ascertain all the facts so that the United States Senate may intelligently vote on a matter so vital to the Nation.

Sincerely yours,

SEYMOUR J. SCHOENFELD,
Secretary.

These two letters show very clearly that a definite attempt was made to convince our committee that we should not testify here today.

What channels of education have been open to those who favor the principles and provisions of this bill? The Journal of the American Dental Association has published only articles opposing the bill, none favoring it. Meetings opposed to it have been held and widely publicized.

There were two recent meetings, held in New York City, permitting speakers favoring the passage of the Wagner-Murray bill. Judged by the attendance and the applause, there are apparently many dentists who approve the bill or are anxious to learn more about its provisions. Both of these meetings were closed to the press, in striking contradistinction to all previous meetings, which were widely publicized.

The opinions expressed in favor of the bill, both from the platform and the audience, should be of interest to this committee. The stenographic minutes of these meetings are on file at the offices of the First District Dental Society in New York City. I hope that this committee will see fit to obtain these records and break the censorship that, up to now, has been imposed on all favorable opinion of the Wagner-Murray bill within the American Dental Association.

Our committee suggests a few alterations in the bill which we believe will make it stronger. We think the title of part C on page 26 should be changed from "Medical Care" to "Health Services." The word "dental" should be inserted after "medical" on line 15, page 15 (title 1, pt. B). Wherever "Medical" is found in title 1, part C: "Dental" should be added.

On page 58, lines 14 and 15, delete "by the dentist and an attending physician".

Provision should be made for added inducement of extra salary or other remuneration to medical and dental personnel in rural areas and small towns.

Our committee asks that there be written into S. 1606 assurances that the administration of this bill shall be free of discrimination because of sex, race, religion, or color.

I have, in addition to the statement which I have read, another statement which outlines our reasons for approving the bill, and I think proves that the American Dental Association stand, as stated here today, is inconsistent with opposition to this bill.

The Dentists Committee for the Passage of the Wagner-Murray Bill has carefully considered the provisions of the bill and gives it its wholehearted support.

QUALITY OF CARE WOULD NOT DETERIORATE UNDER S. 1606

We find that the opposition of the American Dental Association to S. 1606 is inconsistent with its stated principles. Its spokesmen say that the proposed legislation is—

an example of socialized medicine with all the evils of bureaucratic control. Medicine and dentistry would be regimented under the system it proposes. The welfare of the public's health would not be promoted and the quality of medical and dental service would deteriorate.

Page 42 of the bill refutes the charge of bureaucratic control:

The Advisory Council shall be selected from panels of names submitted by the professional organizations concerned with medical, dental, and nursing services.

The American Dental Association would be the professional organization concerned with dentistry and could make the choice of names as democratic as it wished.

The prevention of deterioration of service would be the responsibility of the dentists on the Advisory Council. They are specifically charged with maintaining a professional standard of quality service.

Under the provisions of S. 1606, special dental services may be given by dental specialists. The Dental Advisory Council is charged with setting up standards for specialization to insure competency of specialists, thus assuring protection to the public.

In another section of the bill, emphasis is placed on the close cooperation of the general practitioner with the specialist in dentistry, with the physician and health facilities, including educational and research centers. Such coordination, carefully worked out on all levels with the advisory councils of the other health services, must improve the quality of dental service.

Opposition based on fear of deterioration of service falls down before these safeguards.

Section 213 provides grants-in-aid to States for the expansion of undergraduate and postgraduate dental education. This financial assistance would make it possible for dental colleges to expand their facilities and for new colleges to be established. The bill could be further strengthened by providing an incentive to study dentistry in the form of public health positions or similar posts upon graduation.

THE NEED FOR DENTAL CARE

The need for dental care is arising five to six times faster than it is being served. From 1930 to 1940, the population of the United States increased by 8½ million people, while the dental population increased by 257 dentists. The demand for dental services has been stimulated by dental health education. Eleven million people in the armed forces met dentistry, many of them for the first time.

This imminent need for greater dental manpower will be met by the effective working of section 213.

One of the state principles of the American Dental Association is, "Dental care should be available to all, regardless of income or geographic location." The purpose of the National Health Act of 1945 is to provide this complete care. It especially provides for improving health services in rural communities, in economically depressed areas, and in other communities or areas where such services are below nationally accepted standards of adequate health services.

Additional stated principles of the American Dental Association which find their realization in the provisions of S. 1606 are the following:

Research: Adequate provisions should be made for research which may lead to the prevention and control of dental diseases.

Programs developed for dental care should be based on the prevention and control of dental diseases. All available resources should first be used to provide dental treatment for children and to eliminate pain and infection for adults.

If the members of the American Dental Association would have an opportunity to see how closely S. 1606 follows the stated principles of their organization, the American Dental Association could no longer hold an official position of opposition to the National Health Act of 1945.

In addition to that, Senator, the secretary of our committee, Dr. Seymour Schoenfeld, is here, who has a very brief statement of, I believe, 3 minutes, which we would like to have the opportunity of presenting.

May I introduce Dr. Seymour Schoenfeld.

Senator DONNELL. Will you state your name, Doctor, for the record; your address, and your professional background, please.

Dr. SCHOENFELD. My name is Dr. Seymour J. Schoenfeld. I am the secretary of the Dentists Committee for the Passage of the Wagner-Murray Bill, S. 1606; a member of the American Dental Association and its local constituents, the New York State Dental Society, vice president of the Dental Veterans Association, a member of the American Legion, a member of the American Veterans' Committee, and a commander in the Dental Corps of the United States Naval Reserve, with 5 years of active duty which terminated on April 5, 1946. I have been a private practitioner for the past 8 years.

I am speaking only as a veteran and as secretary of the Dentists Committee for the Passage of the Wagner-Murray Bill, a newly formed organization of dentists who are members of the American Dental Association.

SELECTIVE SERVICE REJECTIONS FOR DENTAL DEFECTS

The reason for my decision to become a member of this committee and to support this legislation was the experience we had in military service. Examination of millions of young men, the pick of American manhood, disclosed hundreds of thousands whose mouths were permanently mutilated as a result of years of neglect because of inability to secure dental care.

A cursory examination of the draft records shows that of all diseases, preventable dental disease was responsible for the largest single group of rejections.

This bill, with the suggested improvements enumerated by Dr. Kaufman, which he will turn in to your committee, will create in America among the youngest generation, citizens of sound dental and oral health.

SAFEGUARDS IN THE BILL

As a doctor and a veteran, I note with satisfaction that the provisions of this bill do not attack the principles of private practice and the free choice of doctor and patient. It is also reassuring to note that this bill guarantees the right of the dental profession to set up professional standards for the practice of dentistry, and that it provides for only legally qualified dentists to participate in this program. These provisions will assure the maintenance of a high standard of dental service as well as the rendering of dental service by personnel properly qualified and trained.

Few doctors are adverse to the principle of removing financial barriers which at present interfere with the ideal doctor-patient relationship. The removal of these financial barriers is the purpose of this legislation. S. 1606 will benefit the public by improving quality of service. It will prevent the gross accumulation of dental disease among the young. It will strengthen the practice of dentistry and medicine by increasing the income of the doctors. This in itself will attract more people to enter the health profession.

It is regrettable that these facts and provisions are not being properly presented to the dental and medical professions by the organizations which are opposed to this legislation, especially since these groups purport their findings to be the result of impartial analysis. It is important to point out, gentlemen, that if the average doctor, both dentist and physician, were apprised of the correct interpretation of this bill, opposition on the part of the veteran as well as nonveteran doctor would largely evaporate.

Our committee will continue to clarify these matters within our profession. The committee has authorized me to offer our fullest cooperation in the future so that we may more fully aid in the development of a sound health service for the American people.

I have a statement of about 50 words here on the manpower question, which question took some time during these hearings, and I think you might be interested in it.

Senator DONNELL. Very well, Doctor.

SHORTAGE OF DENTISTS

Dr. SCHOENFELD. The position is that we do not want to throw up our hands in alarm over this manpower question. We wish to point out that the shortage of dental manpower is a recognized fact. The American Dental Association is rightly opposed to solving this problem by the introduction of partially trained technicians to operate on dental patients. The American Dental Association's viewpoint is that this would lower the quality of dental health service.

Our committee is in full agreement with this position. However, we feel that it is imperative to point out that S. 1606 provides the education and incentives for fully trained dentists. Failure to enact this legislation would encourage dental mechanics, technicians, assistants, and hygienists to exert political pressure to increase their scope of activity by presenting to the public an unsound short-cut solution to the dental manpower problem.

It has been a pleasure to have the opportunity of addressing this committee, and we wish to offer our cooperation now and in the future.

Senator DONNELL. Have you gentlemen finished your statement?

Dr. KAUFMAN. Yes, Senator.

Senator DONNELL. May I ask just a few questions, Dr. Kaufman? At whose suggestion was the Dentists' Committee for the Passage of the Wagner-Murray-Dingell Bill formed?

Dr. KAUFMAN. It was in the nature of a spontaneous movement within the first and second district dental societies.

Senator DONNELL. In New York City?

Dr. KAUFMAN. That is right.

Senator DONNELL. Was there any one individual who seemed to have more active part than any one else in causing the formation of this committee to occur?

Dr. KAUFMAN. If I give you the background, I think you may understand the set-up.

Senator DONNELL. Yes.

Dr. KAUFMAN. This letter which I introduced into the record, from Dr. Lon Morrey of the American Dental Association—

Senator DONNELL. May I have that letter while you are testifying, Doctor, please?

Dr. KAUFMAN. Oh, yes; surely.

Senator DONNELL. This is a letter dated February 20, 1946.

Dr. KAUFMAN. Yes. The letter was read at the board of directors of the First District Dental Society. I am a member of that. That is a governing body of the largest group comprising the first judicial district of New York City. The letter asks that the dental society hold meetings in essence opposing the enactment of S. 1606, and suggests to the society what is commonly termed a "canned" speech for some speaker and preadopted press releases.

When this letter was read, on my motion in the board of directors—

Senator DONNELL. Pardon me, Doctor. Approximately when was the date it was read?

Dr. KAUFMAN. The letter, dated February, was read the first week in March. We meet the first Monday in the month.

Senator DONNELL. Go right ahead.

Dr. KAUFMAN. At my suggestion, a meeting was proposed to be held in our society to discuss the Wagner-Murray bill instead of merely accepting this predetermined opposition to it.

Senator DONNELL. Was that to be a meeting of the entire society or just of a group?

Dr. KAUFMAN. To be a meeting of the dental society.

Senator DONNELL. Of the dental society. Yes, sir.

Dr. KAUFMAN. Between the time of that meeting and the time the meeting was actually completed, there was a joint meeting of the first district which was held with the second district society. The meeting was held in the Hotel Pennsylvania.

Senator DONNELL. What was the date of that?

Dr. KAUFMAN. I have not the date. Dr. Hillenbrand was one of the speakers. He might know.

Dr. HILLENBRAND. March 6.

Dr. KAUFMAN. Something like that.

Dr. SCHOENFELD. During March 1946.

Senator DONNELL. All right.

Dr. KAUFMAN. At that meeting, Dr. Hillenbrand spoke, representing the position of the American Dental Association, and there was one speaker who accepted the provisions of the bill with reservations, who also spoke from the platform. I believe there were two other speakers opposed to the bill.

There apparently was considerable sentiment of the 650 dentists to either know more of the bill or to want to hear a clear discussion of the pros and cons of the bill, and as the result of the protest that was read by the dental veterans committee of the first district, a second meeting was held, at which time 4 speakers spoke for the bill. Again, there was an attendance of approximately 500 or 550 dentists present.

Senator DONNELL. Where was that meeting?

Dr. KAUFMAN. At the Hotel Pennsylvania.

Senator DONNELL. Approximately what was the date of that?

Dr. KAUFMAN. I can give you the exact date of it, because I have the complete transcript here. The exact date was March 27, 1946.

Both of these meetings that were held in the Hotel Pennsylvania, were declared from the Chair controlling the meeting to be closed meeting to the press. There was to be no attendant publicity to the opinions expressed. This is in contrast to the policy that the same so-

ciety, the first and second districts, held in previous meetings during the year of 1945 on the previous health bills, and other meetings in 1944. At all of those meetings, there were prepared press releases by the press representative of those societies, and statements against compulsory health insurance were sent to all of the newspapers and the press agencies, and on most occasions there was pretty good receipt in the press; but when these meetings were held, at which there was a forum and at which speakers spoke for the bill as well as against it, the meetings were declared closed, and there was no attendant publicity at all.

As the result of that, I have here a volume of material, a verbatim report by a stenotypist of the meeting of March 27, which I have as one of the speakers that evening, but which is not permitted to be given anywhere, because we are bound by the decision of our group that it is held completely without any press release.

We felt, and when I say "we" I am speaking of the group of men who sat on the board of directors and the group of men who met with the economics committee of the society, we felt that there should be some way in which it could be known to this committee and to the public that there were some dentists who approved the basic plan of S. 1606, and that the American Dental Association had not polled its house of delegates since the writing into these health bills of the dental clause.

The last time the house of delegates met was back in 1944, and the Wagner-Murray bill at that time was without peace. There were no provisions for dentistry in those bills.

We feel that it is an incorrect statement that the American Dental Association made here today that they represent the opinion of the dentists of the United States who are in the American Dental Association.

We make no claim that the majority of the dentists in the United States will favor the bill, but we do feel that within an organization of 50,000 or 55,000 dentists, that with something that can affect not only themselves but the health of the people of the United States is at stake, there should be an opportunity for discussion of both the favorable and unfavorable aspects of the problem.

Those were the reasons for the formation of our committee.

Senator DONNELL. Doctor, had the committee been formed at the time the meeting of March 27 occurred, or was it subsequent to that time?

Dr. KAUFMAN. I think Dr. Schoenfeld can give the exact date. He is the secretary.

Dr. SCHOENFELD. You have a copy of the letter I sent out?

Senator DONNELL. Do you have that, Doctor?

Dr. SCHOENFELD. I will have that in just a moment.

Senator DONNELL. Yes.

Dr. SCHOENFELD. As a result of the first joint meeting in the First and Second Districts Dental Societies—

Senator DONNELL. The one of about March 6?

Dr. SCHOENFELD. Early in March; yes.

When it became apparent that there was to be no free access of the press to dental opinion and the minority dental opinion, we decided—

Senator DONNELL. By "we" whom do you mean?

Dr. SCHOENFELD. This group Dr. Kaufman referred to, the men on the board of directors of the first district or the men in various other places within the society, and the men who had been at that meeting.

Senator DONNELL. How many persons were included in this group you described as "we"?

Dr. KAUFMAN. May I tell you how many were on the board of directors of that society? Among our members at the present time there are five men who sit on the board of directors of the First District Dental Society. There are 17 men on that board.

Senator DONNELL. So the group Dr. Schoeneld described as "we," consisted of five?

Dr. KAUFMAN. Plus others who had appeared interested in S. 1606 from the floor or platform at this meeting.

Senator DONNELL. And I did not get the number there. Approximately how many were there?

Dr. SCHOENFELD. At that time I would say approximately 20 was the nucleus.

Senator DONNELL. That was shortly after the meeting of March 6?

Dr. SCHOENFELD. That is right.

Senator DONNELL. Very well.

Go ahead, if you will. What occurred then with respect to the formation of the committee?

Dr. SCHOENFELD. Well, we communicated with one another over the phone and by letter, and we held a meeting.

Senator DONNELL. That is this group of about 20?

Dr. SCHOENFELD. This group of about 20 held a meeting. We held a meeting in the middle of March of approximately a week and a half after this meeting of March 6 at the Hotel Pennsylvania.

Senator DONNELL. Yes.

Dr. SCHOENFELD. And we discussed the problem as to how to democratically give voice to the opinion of what might be a minority opinion on this bill, S. 1606.

As the result of that meeting, I was selected as chairman.

Senator DONNELL. Pardon me, Doctor. That was the organization, then?

Dr. SCHOENFELD. That was an organizational meeting.

Senator DONNELL. Yes, sir; and that was about the middle of March?

Dr. SCHOENFELD. The middle of March; yes, sir.

Senator DONNELL. You were selected as chairman?

Dr. SCHOENFELD. It was a little past the middle of March; I would say around the 20th.

Senator DONNELL. You were selected as chairman?

Dr. SCHOENFELD. As secretary.

Senator DONNELL. And Dr. McCall as chairman?

Dr. SCHOENFELD. He was later selected.

Senator DONNELL. Was there any chairman selected?

Dr. SCHOENFELD. No. You know how those organizations start. They are a small organization with many of these problems.

On the 29th, I sent out a letter to various members throughout the country.

Senator DONNELL. That was 2 days after the second Pennsylvania Hotel meeting?

Dr. SCHOENFELD. Yes. Approximately then.

Senator DONNELL. All right. Go ahead.

Dr. SCHOENFELD. In which I indicated that there was a need to express minority opinion, or some opinion of the dentists who were for S. 1606.

Senator DONNELL. That went to approximately how many dentists?

Dr. SCHOENFELD. Approximately 35 or 40 dentists.

Senator DONNELL. Approximately 35 or 40 dentists in various parts of the United States?

Dr. SCHOENFELD. In various parts of the United States, mostly in and around New York City, because that is where our contacts were. We are rapidly broadening out our membership, of course. As the result of this letter, we were able to secure a committee which we call a sponsoring committee. In other words, they brought a nucleus of 20 people who are fairly well known in dentistry, both in New York and outside of New York.

Senator DONNELL. Do you mean you formed two committees, or is this the dentists committee for the passage of the Wagner-Murray-Dingell bill?

Dr. SCHOENFELD. That is basically the active portion of the committee.

Senator DONNELL. Yes. That sponsoring committee consists of about 20 dentists?

Dr. SCHOENFELD. Yes; approximately 20 dentists.

Senator DONNELL. And they are located, all of them, in or about New York City?

Dr. SCHOENFELD. The majority of them are located in or about New York City, but there are others in Florida and elsewhere, Pennsylvania, and New Jersey, and some of them are members who have held very high positions in the American Dental Association.

Senator DONNELL. And that group of sponsoring committee is about 20 in number?

Dr. SCHOENFELD. That is right.

Senator DONNELL. Very well.

Dr. SCHOENFELD. This sponsoring committee, many of those members, held a subsequent meeting. This meeting was held about a week and a half to 2 weeks ago.

Senator DONNELL. Which meeting was held?

Dr. SCHOENFELD. The subsequent meeting to this first organizational meeting.

Senator DONNELL. The organizational meeting was around the middle of March.

Dr. SCHOENFELD. That is right.

Senator DONNELL. And the letter was sent out by you to 30 or 40 gentlemen around the 29th of March, and then a further meeting was held on what date?

Dr. SCHOENFELD. Let us see, about 2 weeks ago, 2½ weeks ago.

Senator DONNELL. That would be about the 9th of April, is that right?

Dr. SCHOENFELD. Yes, that is about right.

Senator DONNELL. How many persons were present then?

Dr. SCHOENFELD. At that meeting, 20 persons were present. These men were basically the sponsoring committee.

Senator DONNELL. Were any of those from outside of New York City?

Dr. SCHOENFELD. No; they were not. They told us they would not be able to make it.

Senator DONNELL. What is that?

Dr. SCHOENFELD. They told us they would not be able to make it, could not be called away from Florida, and their practice in Pennsylvania, but they kept in close contact with us.

Senator DONNELL. How many persons on the committee as it is now constituted today are from outside of New York City, approximately?

Dr. SCHOENFELD. Approximately 5, 10, approximately 15, I would say.

Senator DONNELL. Approximately 15 outside of New York City, and how many from inside New York City?

Dr. SCHOENFELD. Let me clarify something, if I may, Senator.

Just about the early part of last week, or the latter part of the week before, or about 10 days ago, we sent out a statement to the profession.

Senator DONNELL. Throughout the United States?

Dr. SCHOENFELD. No; we do not have all the money for that.

Senator DONNELL. Where?

Dr. SCHOENFELD. We sent it out mainly to New York City, plus about 25 to 30 outside outside of the city. We sent about 4,000 out, or thereabouts. We sent out our position on this matter.

Senator DONNELL. Yes, sir.

Dr. SCHOENFELD. We also had our members of the sponsoring committee contacting various dentists throughout the city and elsewhere.

As a result of that, this literature was mailed just recently, last week. And as the result of that, we have not had an opportunity to examine our mail completely for yesterday, but we already have 150 dentists who have stated in writing, with their signature, that they are in favor of S. 1606.

Senator DONNELL. Doctor, those 150, do those come largely from New York City also?

Dr. SCHOENFELD. Yes; they would, because that was where our primary mailing was.

Senator DONNELL. So am I correct in understanding that today your sponsoring committee is about 20, but that you have favorable responses to S. 1606 from about 150 other gentlemen; is that right?

Dr. SCHOENFELD. Yes, and I would like to add that this is only the result of this letter of ours which has only been out just a short time, less than a week, so that their response has actually been favorable.

Senator DONNELL. Of this 150, what proportion have come from dentists in New York City?

Dr. SCHOENFELD. Well, the good portion of them are from dentists in New York City and environs.

Senator DONNELL. About what percentage of the 150 are from New York City or environs?

Dr. SCHOENFELD. I have not been able to analyze all these names and addresses. We have just received this mail.

Senator DONNELL. Could you tell us approximately?

Dr. KAUFMAN. We made an attempt to analyze this. We brought the mail with us from New York, and at 2 o'clock this morning we were typing this list.

Senator DONNELL. Yes.

Dr. KAUFMAN. We have not analyzed it to the point of practicality, but I would say the largest percentage are from New York, because that is the area in which our mailing was chiefly done.

Senator DONNELL. Well, according to your past judgment, without tying you down to an exact number.

Dr. KAUFMAN. Say 80 percent of them.

Senator DONNELL. Eighty percent of the men are from New York City, about 120?

Dr. KAUFMAN. Yes.

Senator DONNELL. And the 20 members of the sponsoring committee?

Dr. KAUFMAN. They are from New York City and elsewhere.

Senator DONNELL. Nearly all of them are from New York City?

Dr. KAUFMAN. That is right.

Senator DONNELL. And then about 30 dentists from other than New York City are included in the 150.

Dr. KAUFMAN. I think that is about correct.

Senator DONNELL. Very well.

Do you know how many States are represented by those 30, or have you had time to do that?

Dr. SCHOENFELD. We have not had sufficient time.

Dr. KAUFMAN. I would venture to say not more than six.

Senator DONNELL. Not more than six States?

Dr. KAUFMAN. No, sir.

Senator DONNELL. All right.

Now, you spoke about the house of delegates of the American Dental Association not having a meeting since May of 1944; is that right?

Dr. KAUFMAN. That is right, sir, October 1944.

Senator DONNELL. October 1944?

Dr. KAUFMAN. Yes, sir.

Senator DONNELL. Did the house of delegates at that time pass any resolutions with respect to the general proposition of compulsory health insurance?

Dr. KAUFMAN. I did not receive a transcript of their proceedings. I am not a member of the house of delegates.

Senator DONNELL. So you do not know whether they passed such a resolution?

Dr. KAUFMAN. I do not.

Senator DONNELL. Gentleman, I will ask Dr. Kaufman, in the first instance, have you had any contacts with other organizations, as, for instance, the Lawyers Guild, in the preparation of your committee?

Dr. KAUFMAN. No, sir. My entire presentation and the preparation of our committee—first, my presentation. That was prepared by myself.

Senator DONNELL. Yes.

Dr. KAUFMAN. With consultation with Dr. Schoenfeld and Dr. McCall, the two officers of the committee.

There was no consultation with an outside agency. Our committee, in the formation, has had no consultation with an outside agency in its formation.

Senator DONNELL. Is there anything further you gentlemen desire to submit?

Dr. SCHOENFELD. I would like to make a statement and present further some additional information to show that the activity in the first and second districts in not permitting the press to have access to the meeting, and also to have these one-sided meetings, was resented very much by the Dental Veterans' Association, an association of dental veterans who passed a resolution to the effect that this was not the correct procedure.

May I read the resolution?

Senator DONNELL. Certainly. When was this passed, doctor?

Dr. SCHOENFELD. This resolution was passed at the meeting of the Dental Veterans' Association shortly after the March 6 meeting.

Senator DONNELL. That is in New York City that this meeting took place?

Dr. SCHOENFELD. Yes. The Dental Veterans' Association:

Whereas it is recognized that dental research and dental health education must continue to expand; and

Whereas a program of dental service for caries control in children is not only desirable, but feasible; and

Whereas the great public dental need and demand is recognized by investigators as well as the profession; and

Whereas public and private prepayment plans of varying degrees of service are now being proposed up and down the land; and

Whereas the interest of the public and the profession impose special responsibilities upon the leaders of dentistry; and

Whereas it is incumbent upon that leadership to keep the general membership of dentistry fairly and fully informed of all matters affecting the practice of dentistry; and

Whereas the joint special meeting (of the First and Second District Dental Societies) on Tuesday, February 26, 1946, at the Hotel Pennsylvania, called for the purpose of discussing the Wagner-Murray bill, S. 1606, presented four out of five speakers who opposed the bill, and none in favor of it: Therefore be it

Resolved by the Dental Veterans' Association, whose members are part of the First and Second District Dental Societies of New York, That in the interest of a fair presentation another joint meeting be called for sometime during March 1946 by the respective boards of trustees, at which meeting experts (dentists and/or others) will present—with equal opportunity—the pros and cons of the National Health Act of 1945, S. 1606, otherwise known as the Wagner-Murray-Dingell bill, and the pros and cons of the New York State Senate bill No. 268, known as the Farbstein-Corcoran medical care bill, introduced on January 14, 1946, by Senator Corcoran, and at present in the committee on finance

When this resolution was passed, I appeared before the board of directors of the First District Dental Society and read this resolution to them, and as a result of this protest by the Dental Veterans' Association, the second joint meeting of the First and Second District Dental Societies was held.

Senator DONNELL. That was the one of March 27?

Dr. SCHOENFELD. That is correct.

Senator DONNELL. Thank you, gentlemen.

Dr. KAUFMAN. Besides thanking this committee, I would suggest, if this committee has the power, that you get the transcript of that March 27 meeting. There you would find the expression of opinion of the dentists voluntarily appearing, themselves, from the floor in favor of and against the bill.

It is one of the most interesting forums held.

Thank you, gentlemen.

Senator DONNELL. May I ask Dr. Flagstad to resume the stand for a moment?

FURTHER STATEMENT OF DR. CARL O. FLAGSTAD, CHAIRMAN OF LEGISLATIVE COMMITTEE, AMERICAN DENTAL ASSOCIATION, ACCOMPANIED BY DR. HAROLD HILLENBRAND, EDITOR OF THE JOURNAL OF THE AMERICAN DENTAL ASSOCIATION

Senator DONNELL. Doctor, will you be kind enough to tell the committee anything you may desire to offer with respect to the statement made by Dr. Kaufman, to the effect that the House of Delegates of the American Dental Association, has not met since October of 1944. Is that a fact?

Dr. FLAGSTAD. The house of delegates has not met since October 1944, in conformity with the request of the Office of Defense Transportation and inability to secure hotel accommodations since the restrictions were removed.

In the meantime, the board of trustees, which is composed of representatives from each American Dental Association district, has transacted necessary business for the association. At their ad interim meeting in February 1946, the present Wagner-Murray-Dingell bill, S. 1606, was thoroughly discussed and the legislative committee was instructed to proceed on the basis as presented here today.

Senator DONNELL. Well, Doctor, by what authority has the bureau of public relations and the joint committee of the council on dental health, the committee on legislation, and the committee on economics of the American Dental Association, issued the literature which has been referred to in your testimony here this morning?

Dr. FLAGSTAD. The house of delegates, ever since this type of legislation was first introduced, has had this problem before it practically every year, and always they have reiterated their stand that they are against compulsory health insurance.

Senator DONNELL. When was the last reiteration of that stand?

Dr. FLAGSTAD. At Chicago in October 1944 by the house of delegates and by the board of trustees in February 1946.

Senator DONNELL. When was the first statement to that effect, if you recall, made by the house of delegates?

Dr. FLAGSTAD. I will ask Dr. Hillenbrand to answer that.

Dr. HILLENBRAND. 1935.

Senator DONNELL. 1935.

Doctor, would you personally, so that we may know to whom to look, see that there is furnished to this committee, within the next 10 days, a copy of each and every resolution adopted by the house of delegates of the American Dental Association, including and since the first resolution relating to its position on compulsory health insurance; will you do that?

Dr. FLAGSTAD. We shall be happy to supply you with the proceedings of the house of delegates.

Senator DONNELL. There is one other matter Dr. Kaufman mentioned that I would like to ask you about.

He stated that there was nothing in the Wagner-Murray-Dingell bill which precedes the present one with respect to dental matters.

Is that in accord with your recollection?

Dr. FLAGSTAD. The bill considered in Cincinnati in 1943 and Chicago in 1944 provided that a study would be made of the dental needs and that within 2 years after that time a decision would be made as to

the inclusion of dentistry. This was discussed by the committee and the house at that time. There was, however, no definite commitment as to the dental benefits in the former Wagner bill.

Senator DONNELL. Is there anything further you desire to add in regard to the attitude of the house of delegates of the American Dental Association in regard to this matter?

Dr. FLAGSTAD. Dr. Hillenbrand, have you anything to add?

Dr. HILLENBRAND. I would like to say in reply to the fact that the Journal of the American Dental Association has not published an article, I now have an article in press, by Dr. John McCall, chairman of the committee which Dr. Kaufman and Dr. Schoenfeld represent.

Further than that, the house of delegates was scheduled to meet since 1944, but owing to difficulties in transportation, and at the request of the Government for cooperation, that meeting was canceled, and no meeting has been held since that time because of the difficulty in wartime transportation.

Senator DONNELL. Have there been any articles that appeared in your journal in advocacy of the passage of S. 1606?

Dr. HILLENBRAND. I would say one or two since the President's message.

Senator DONNELL. Would you be kind enough to furnish those articles for the record?

Dr. HILLENBRAND. I would be glad to.

(Subsequently the following correspondence and articles were submitted for the record by the chairman:)

AMERICAN DENTAL ASSOCIATION.
Chicago, Ill., April 30, 1946.

Senator JAMES E. MURRAY,
Chairman, Committee on Education and Labor,
Washington, D. C.

MY DEAR SENATOR MURRAY: AS requested by Senator Donnell at the hearings before the Committee on Education and Labor, I am sending you material which has been published in the Journal of the American Dental Association on the Wagner-Murray-Dingell bill.

As you will note, most of this material attempts to present the factual content of the bill.

The letter from Dr. John O. McCall, New York City (p. 913, July 1, 1945), will be of interest, since Dr. McCall is chairman of the recently formed Dentists' Committee for the Passage of the Wagner-Murray-Dingell Bill. You will also note that the Journal has devoted space to a book on the Health of the Nation written by Dr. Michael M. Davis, who has been very active in urging adoption of the bill. The article by Dr. Charles Hyser is of interest since his proposals are at variance with official policies of the American Dental Association.

At the hearing the statement was made that the Journal has not been open to the publication of material in favor of the bill. I have examined the Journal's manuscript records since January 1, 1945, and do not find a single instance in which a manuscript favoring the bill was received for publication. The records show that one letter to the editor favoring the bill was rejected on the grounds that the author had just had two previous communications published in the Journal.

I believe that the Journal is receptive to manuscripts giving both sides of any controversial subject provided that they meet acceptable standards of professional and literary presentation.

I hope that you will call on me if there is additional material that you or your committee need.

I enjoyed seeing you again, and I want you to know that I feel that the hearings should be productive in bringing about a clearer understanding of the issues involved in this great problem.

Cordially,

HAROLD HILLENBRAND, D. D. S.

[Journal American Dental Association, vol. 32, November 1-December 1, 1945]

REPORTS OF COUNCILS AND COMMITTEES

COMMITTEE ON LEGISLATION

AN OUTLINE AND ANALYSIS OF THE WAGNER-MURRAY-DINGELL BILL

The Wagner-Murray-Dingell bill of 1945 includes an extensive program for dentistry. The bill was introduced in the Senate (S. 1050) by Robert F. Wagner, New York, and James E. Murray, Montana. In the House of Representatives the bill (H. R. 3293) was introduced by John D. Dingell, Michigan. The bill would enlarge the benefits and extend the coverage of the social-insurance program. Congressional hearings will probably be held in the near future. Dentists will be concerned chiefly with title II of the bill, which provides personal health-service benefits.

The committee on legislation has prepared the following outline and analysis of the bill:

The Wagner-Murray-Dingell bill of 1945 (S. 1050 or H. R. 3293) is composed of several separate and distinct parts. An index to these parts is as follows:

1. Amendments to the present Public Health Service Act to provide grants and loans to the States for hospital and health-center construction (pp. 1-31).

2. Amendments to the present Public Health Service Act to provide grants to the States for venereal disease and tuberculosis prevention, treatment, and control programs (pp. 32-42).

3. Amendments to the Social Security Act to provide grants to the States for maternal and child health and welfare services (pp. 43-55).

4. Amendments to the Social Security Act to provide grants to the States for assistance to needy individuals (pp. 56-64).

5. Establishment on a Federal basis of a national system of public employment offices (the present system technically consists of a coordinated State system) (pp. 65-70).

National social-insurance system

6. Amendments to title II of the present Social Security Act (pp. 71-185). Title II, the portion of the present law that provides for the old-age benefits, is entitled "Federal Old-Age and Survivors Insurance Benefits."

Title II will be renamed "National Social Insurance System" and the new title II will be divided into the following eight parts:

Part A sets up a new "prepaid personal health service insurance" system (pp. 71-105).

Part B revises the present provisions for unemployment compensation and adds temporary disability-insurance benefits (pp. 106-115).

Part C revises the present provisions for retirement and survivors insurance benefits and adds extended disability-insurance benefits (pp. 115-141).

Part D creates the national social-insurance trust fund (pp. 141-147).

Part E gives a special social-insurance credit to men in the armed services for military service (pp. 147-150).

Part F lists the coverage provisions (pp. 150-164).

Part G levies the taxes to be collected, which are called social-insurance contributions (pp. 164-168).

Part H provides for judicial review (pp. 169-185).

The following outline will treat only with the portion of the bill that establishes the prepaid personal health service insurance system, and with such other portions as are related to it.

Persons entitled to benefits

The bill provides that any person who has been paid wages of, or, if self-employed, has rendered personal services (yielding), not less than \$150 during the first four of the last six completed calendar quarters; or any person who is eligible for an old-age pension, or who has fulfilled other requirements, and their dependents are to be entitled to receive personal health service benefits.

The term "dependent" means an unmarried child who is under age 18 or is under a disability and not entitled to disability payments, a wife, a disabled husband who is not entitled to disability benefits or a parent who has attained age 65 if male or 60 if female and is not entitled to retirement benefits. All dependents must be living with or receiving regular support from the individual on whom they are dependent.

Exclusions

¶The following persons are not entitled to receive personal health service benefits:
Assistance cases.—All assistance cases (needy individuals) are not entitled to personal health service benefits. However, any State may enter into a contract with the Surgeon General to insure assistance cases by making payments to the trust fund.

Unemployed individuals and their dependents.—All individuals who have been unemployed for a period of 27 months or more, and in some cases a shorter period, and their dependents, will not be entitled to personal health service benefits for the reason that such individuals cannot qualify as insured individuals.

Excluded dependents.—The following dependents of insured individuals are not entitled to receive personal health service benefits:

1. All dependent unmarried children over age 18.
2. All dependent married children.
3. All dependent grandchildren.
4. All dependent nieces and nephews.
5. All dependent brothers and sisters.
6. All dependent parents under age 65 if male, or 60 if female.
7. All dependents related by marriage.

Employed individuals and self-employed individuals.—Employed individuals and self-employed individuals, who are engaged in any of the following types of employment, are exempted from the provisions of the Social Security Act and, therefore, are excluded, including their dependents, from receiving personal health service benefits.

1. Casual labor not in the course of the employer's trade or business.
2. Service performed by an individual in the employ of his son, daughter, or spouse, and service performed by a child under the age of 21 in the employ of his father or mother.
3. Service on a non-American vessel outside the United States.
4. Service performed in the employ of the United States or of an instrumentality of the United States which is (a) wholly owned by the United States or (b) exempt from any social-insurance contributions by virtue of any other provision of law.
5. 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.
6. Service performed by a minister or a regular member of a religious order.

Definition of benefits

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

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.

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 specialists or consultants.

The terms "general medical benefit" and "special medical benefit" are substantially similar in meaning in relation to physicians, as are the terms "general dental benefit" and "special dental benefit" in relation to dentists.

Limitations on dental benefits

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 January 1, 1947, the restricted content of general dental or special dental benefit shall include at least (1) examination (including an 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. 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 practicable.

Administration

The bill places upon the Surgeon General of the United States Public Health Service the duty of carrying out the provisions of the act. All of his duties are to be performed under the supervision and direction of the Federal Security Administrator. The Surgeon General is also required to consult with the Advisory Council as to questions of general policy and administration.

The Surgeon General is authorized to appoint local area committees to aid him in the administration of health benefits and to make reports and recommendations to local area officers or to the Surgeon General. Such committees are to include representatives of those receiving and of those furnishing personal health service benefits. There is no provision, however, regarding either the size of these committees or the qualifications of the members, or their compensation, or the term of their appointment.

The Surgeon General is authorized to transfer the administration of health service benefits to any State or local department or agency on the basis of a mutual agreement with them and he may delegate to the officers or employees of any State or local department or agency such of his powers and duties as he may consider necessary, except that of prescribing rules and regulations. He is required to give priority to the use of the facilities and services of State and local departments and agencies.

When an agreement has not been made with a State or local department or agency, the Surgeon General may carry out his duties through the United States Public Health Service, or any other Federal department or agency, and he is authorized to delegate to the officers or employees of the United States Public Health Service or of any Federal department or agency such of his powers and duties as he may consider necessary, except that of prescribing rules and regulations.

The Surgeon General is authorized to prescribe and publish such rules and regulations and to require such records and reports as he may consider necessary to efficient administration, except that whenever he has entered into a mutual agreement with a department or agency of the Federal Government or of a State government or of a political subdivision thereof, such rules and regulations shall be made by the Surgeon General after consultation with the other party to the agreement. All rules and regulations must be approved by the Federal Security Administrator.

Advisory Council

The bill creates a national advisory medical policy council called the Advisory Council, to consist of the Surgeon General and 16 appointed members who are to be selected from panels of names submitted by professional and other agencies. The 16 members of the Advisory Council are to be appointed by the Surgeon General, subject to the approval of the Federal Security Administrator.

The duty of the Advisory Council is to advise the Surgeon General with reference to questions of general policy and administration, including professional standards, designation of specialists, methods to stimulate the attainment of high standards through the coordination of professional and other services, standards for hospitals, methods of payment, grants-in-aid for professional education and research projects, and the making of studies and surveys.

The Advisory Council is authorized to establish special advisory, technical, regional or local committees to advise upon professional and technical subjects and questions concerning administration.

Agreements with practitioners, free choice and panel lists

The Surgeon General is authorized to purchase whatever supplies and commodities are necessary and to enter into agreements with dentists, physicians, nurses, and hospitals to furnish their respective services.

All dentists, physicians, or nurses who are legally qualified in a State are also qualified to furnish their respective professional services, except in the case of specialists. Every individual is to be entitled to the free choice of a practitioner, subject to the consent of the practitioner. Every such individual and every group of such individuals are to be permitted to make such selection through a representative of his or their own choosing and to change such selection. However, the Surgeon General may prescribe maximum limits to the number of patients per practitioner and these limits need not be nationally uniform.

The Surgeon General is required to publish in each local area a list of the practitioners who have agreed to furnish health services in that area. These lists shall include both general practitioners and specialists.

Specialists

The Surgeon General is to designate specialists and to prescribe general standards regarding specialists, and in so doing he is required to utilize the standards developed by competent professional agencies. A specialist will ordinarily be available only upon the advice of a general practitioner.

Payments to practitioners

Payments to general practitioners may be made by fee schedule, per capita, or salary, either whole-time or part-time, or any combination of these methods which the Surgeon General may approve; according in each local area as the majority of the general practitioners in each profession shall elect, except that the Surgeon General may make payments by another method to the general practitioners who do not elect the method of the majority. Similar payments may be made to specialists, including payment on a per-session basis, as the Surgeon General and the specialists may agree. Payments for services need not be nationally uniform and may be adapted to regional or local conditions.

In any local area where practitioners are paid only on a per capita basis, the Surgeon General shall make per capita payments on a pro rata basis among such practitioners for all those individuals who have failed to select a practitioner or who have been refused by a practitioner.

In each local area, the practitioners are made collectively responsible for the furnishing of health benefits to the beneficiaries in that area.

Hospitals

The Surgeon General is authorized to prescribe standards concerning hospitals and to publish a list of participating hospitals. There is a further provision that the Surgeon General shall exercise no supervision or control over a participating hospital nor shall he prescribe its administration, personnel or operation as a requirement for participation.

The maximum number of days of hospital benefit in any year shall be sixty days, except that the Surgeon General may increase it to 120 days if sufficient funds are available.

Hospitalization for mental or nervous diseases or for tuberculosis is excluded from the hospital benefit.

Grants-in-aid

The bill provides that a fund equal to 1 percent of all Social Security benefits, or equal to 2 percent of the personal health service benefits, whichever is the lesser, shall be available to the Surgeon General to be used for grants-in-aid to nonprofit institutions and agencies for research or professional education.

Hearings

The Surgeon General is authorized to conduct such investigation as he may deem necessary and to establish hearing bodies to hear complaints. He may administer oaths, examine witnesses and receive evidence, even though such evi-

dence may not be admissible under the rules of evidence applicable to court procedure. He has the power to issue subpoenas requiring the attendance and testimony of witnesses and the production of any evidence that relates to any matter under investigation.

Penalties to prevent abuses

The surgeon General may determine that every individual may be required to pay a fee to his dentist, physician or nurse for the first or for each service in a period of sickness or course of treatment. Such determination shall be made only when it is necessary to prevent or reduce abuses. The Surgeon General may 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. Such fees may be limited to home calls, to office visits, or to both; a maximum may be fixed for each sickness, and the fees may vary between the various states, between communities or between urban and rural areas.

Compulsory social insurance contributions

There is to be a compulsory tax on all employed individuals equal to 4 percent of their wages, up to \$3,600 per year, an additional tax equal thereto on all employers, and also a tax of 5 percent on the market value of the services of the self-employed, up to \$3,600 in any calendar year. These taxes are called social insurance contributions.

The compulsory tax collected is to be allocated to personal health service benefits in an amount equal to 1.5 percent of the employe's wages from the employe and the same amount from the employer, making a total equal to 3 percent of the employe's wages, and 3 percent of the value of the services of the self-employed.

Since the self-employed are not eligible for unemployment compensation benefits or for temporary disability benefits, their contributions are set at 5 percent of the value of their services instead of 8 percent.—*George H. Fox, Secretary.*

COUNCIL ON DENTAL EDUCATION

GRADUATES IN THE DENTAL SCHOOLS OF THE UNITED STATES FOR THE YEAR ENDING JUNE 30, 1945

The council on dental education has completed compilation of the figures showing the total number of graduates in the 39 dental schools of the United States for the year from July 1, 1944, to June 30, 1945. The number is 3,212, the highest since 1924. This unusual number is due to the accumulated effect of the accelerated program in the schools.

Under normal conditions, the number of graduates was 1,784 in 1942. This number increased to 1,926 in 1943 and to 2,470 in 1944. We have now passed the peak of the increased output due to the accelerated plan. It is expected that the great majority of the schools will go back to the conventional procedure as speedily as is practicable. The number of graduates annually will now gradually decrease until the full effect of the present low enrollment of freshmen is felt, three or four years hence.

TABLE 1.—*Graduates of dental schools in the United States for the year ending June 30, 1945*

School	Pre dental college training						Total	Per cent with degree	Number graduating in combined courses
	Less than 2 years	2 years	3 years	4 years without degree	Bachelor's degree	Other degree			
Physicians and surgeons.....	23	13	1	5	1	43	14	12	
California.....	28	3	1	13	4	45	29	45	
Southern California.....	139	11	3	16	4	173	12	48	
Georgetown.....	41	19	7	30	1	97	31	0	
Howard.....	2	5	5	12	1	19	63	0	
Emory.....	106	25	1	37	1	169	22	0	
Loyola-Chicago.....	45	15	5	21	1	87	25	0	
Northwestern.....	46	28	5	25	5	109	28	0	
Illinois.....	26	12	4	10	1	52	19	42	
Indiana.....	14	15	5	5	1	39	13	4	
Iowa.....	22	14	2	4	2	44	14	16	

TABLE 1.—*Graduates of dental schools in the United States for the year ending June 30, 1945—Continued*

School	Pre dental college training						Total	Per cent with degree	Number graduating in combined courses
	Less than 2 years	2 years	3 years	4 years without degree	Bachelor's degree	Other degree			
Louisville.....		34	20	8	25	1	88	30	0
Loyola, New Orleans.....		18	10	4	9		41	22	0
Maryland.....		84	17	1	32		134	24	0
Harvard.....							0		
Tufts.....		69	44	4	36	7	160	27	0
Detroit.....		18	6	1	8		33	24	2
Michigan.....		29	19	3	8	2	61	16	3
Minnesota.....		54	18	3	5		80	6	0
Kansas City.....		52	21	3	20	1	97	22	6
St. Louis.....		53	35	3	31		122	25	0
Washington.....		17	3	4	9		33	27	0
Creighton.....	1	33	13	1	7		55	13	6
Nebraska.....		21	5		1	1	28	7	22
Columbia.....			15	1	75	4	95	83	6
New York.....		19	98	8	117	11	253	51	31
Buffalo.....		13	13	5	12		43	28	0
Ohio.....		56	19	6	28	2	111	27	0
Western Reserve.....		26	32	6	25	1	90	29	30
North Pacific.....		59	35	18	28	6	146	23	0
Temple.....		63	20	6	17		106	16	0
Pennsylvania.....		86	34	1	68	4	193	37	0
Pittsburgh.....		46	15	1	19		81	23	7
Meharry.....		3	1		12		16	75	0
Tennessee.....		18	11	3	7		39	18	1
Baylor.....		33	6	2	4	1	46	11	5
Texas.....		15	4	2	12		33	36	0
Virginia.....		17	19	5	26		67	39	2
Marquette.....		50	13	3	18		84	21	4
Total.....	1	1,478	706	136	837	54	3,212	28	292

[The Journal of the American Dental Association, Mid-Monthly Issued, December 15, 1945, vol. 32, No. 22]

TRUMAN ASKS FOR COMPULSORY HEALTH INSURANCE SYSTEM IN SPECIAL MESSAGE TO CONGRESS

President Truman told Congress in a special message November 19 that the "health of this Nation is a national concern" and asked for immediate action on a five-point legislative program including a compulsory health-insurance system that will undertake to furnish dental benefits. These benefits, the President said, should include dental care "as fully and for as many of the population as the available professional personnel and the financial resources of the system permit."

Immediately after the reading of the message, a bill incorporating the President's major proposals was introduced in the Senate by Robert F. Wagner, New York, and James E. Murray, Montana. A companion bill was introduced in the House by John D. Dingell, Michigan. The Senate referred its bill to the Committee on Education and Labor, of which Senator Murray is chairman. The House referred its measure to the Interstate and Foreign Commerce Committee.

The new bills in their major proposals parallel previous versions of the Wagner-Murray-Dingell bill. Significantly, the latest versions carefully avoid specifying how the program will be financed. This omission was made for strategic purposes by the administration, for, by elimination of the financial provisions, the bills were removed from the consideration of the Senate Finance Committee and the House Ways and Means Committee. These two committees had never brought earlier proposals to hearings. Under the present referrals, it is presumed that hearings will be held in the near future.

The President took pains to anticipate arguments that the bill proposed socialized medicine for this country. "What I am recommending," he said, "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." The President did not point out that his definition is not one which has general acceptance among those who are familiar with the problem. More commonly, the President's definition would apply to so-called state medicine.

Besides the compulsory insurance feature and a new plan for the "payment of benefits to replace at least part of the earnings that are lost during sickness and long-term disability," the President proposed:

1. Broadening the present program of grants-in-aid to States for the construction of hospitals and related facilities.
2. Expanding public health, maternal and child health services.
3. Strengthening professional education and medical research.

Excerpts from the special message follow:

"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 of * * * sickness.'

"Millions of our citizens do not 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.

"Draftees unfit.—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. * * *

"Inequality.—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.

"BASIC PROBLEMS

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

"Distribution of physicians.—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. * * *

"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 or impossible for doctors who practice there to make a living. * * *

"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. * * *

"*Public-health services.*—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. * * *

"*Need for research.*—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.

"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, 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. * * *

"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 any one doubts this, let him think of penicillin, plasma, DDT powder, and new rehabilitation techniques.

"*High cost of care.*—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 * * *.

"Loss of earnings.—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 * * *.

"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 * * *.

"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 prepaid 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 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 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 percent 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.

"*Coverage.*—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 unit 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.

Fees.—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 any 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.

Freedom of choice.—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 to carry on in individual practice or to point 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 non-profit institutions and their families.

Provisions for needy persons.—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 direct 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 * * *.

"Many millions of our veterans, accustomed in the armed forces to the best 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."

[The Journal of the American Dental Association June 15, 1945]

FEDERAL HEALTH LEGISLATION

NEW WAGNER-MURRAY-DINGELL BILL PROPOSES COMPULSORY HEALTH INSURANCE PLAN AS EXPANSION OF SOCIAL SECURITY ACT

A new Wagner-Murray-Dingell bill, which proposes far-reaching amendments to the Social Security Act, was introduced in the Senate May 24 by Robert F. Wagner, New York, and James E. Murray, Montana. A companion bill (H. R. 3293) was introduced in the House by John D. Dingell, Michigan. In the Senate, the bill was referred to the Committee on Finance, Walter F. George, Georgia, chairman; in the House, to the Committee on Ways and Means, Robert L. Doughton, North Carolina, chairman.

The new bill, like its predecessors in 1939 and 1943, proposes a series of amendments to the Social Security Act that would expand benefits and extend coverage to many persons who do not now come under its provisions. A system of compulsory prepaid personal-health-service insurance is proposed for all employees covered and for certain specified dependents. Unlike the previous versions, the 1945 bill specifically includes dental benefits. The contribution rate has been lowered from 12 percent in previous bills to 8 percent, 4 percent of which would be paid by the employee and 4 percent by the employer on the first \$3,600 of annual earnings.

A summary of the general provisions of the bill follows:

Health provisions.—The Surgeon General of the United States Public Health Service would administer the technical and professional aspects of the health program. He is directed by the bill to establish a national advisory policy council, who would be appointed from panels of names submitted by professional and other organizations concerned with the service. The advisory council must also include representatives of the public.

The Surgeon General is directed to decentralize the administration of the program by giving priority and preference to the use of existing State and local agencies. Where no such arrangements have been made, the Surgeon General is directed to establish committees in each locality to aid in the administration of the program and to assure that the program will be adapted to local needs. Such committees shall include representatives of the various groups concerned with the program. The Surgeon General is also directed to make studies, in conjunction with the Social Security Board, and to report to Congress on dental, nursing, or other services not provided under the insurance system. The Surgeon General is directed, with the advice of the National Advisory Medical Policy Council, to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education. Such grants would be made for projects showing promise of making valuable contributions to the education and training of persons in furnishing health insurance benefits, or of making valuable contributions with respect to the cause, prevention or methods of diagnosis or treatment of disease. Provision is made for giving preference to educational projects for returning servicemen seeking postgraduate education or training in medical, dental, or related fields.

The bill does not use the word "compulsory" in any place in relation to the prepaid personal-health-service provisions. In fact, a definite effort has been made to minimize any compulsory features. The fact remains, however, that the 4 percent tax on wages up to \$3,600 annually will be compulsory for the employee, even though he may not wish to avail himself of the service.

Outline of Wagner-Murray-Dingell bill

Section 1: Short title; social security amendments of 1945.

Sections 2 and 3, Grants and loans for construction of health facilities: Provides a 10-year program of Federal grants and loans for construction and expansion of hospitals, health centers, and related facilities to be financed out of general revenues. The Federal Government will pay at least 25 percent of the cost of a project and up to 50 percent in accordance with a State's per capita income. Loans may not exceed an additional 25 percent of the cost of the project.

Section 4, Grants to States for public-health services: Provides Federal grants to States from general revenues for expansion of public-health services. The Federal Government will pay at least 25 percent of the amounts expended by a State and up to 75 percent in accordance with a State's per capita income.

Section 5, Grants to States for maternal and child-health and welfare services: Provides Federal grants to States from general revenues for maternal and child-health and welfare services. The Federal Government will pay at least 25 percent of amounts expended by a State and up to 75 percent in accordance with a State's per capita income.

Section 6, Comprehensive public-assistance program: Provides for Federal grants to the States for public assistance to needy individuals—aged, blind, dependent children, or others. Federal Government will pay at least 50 percent of amounts spent by States and up to 75 percent for States in accordance with a State's per capita income.

Sections 7 and 8, National system of public employment offices: Provides for a continuation of Federal operation of the United States Employment Service.

Section 9, National social-insurance system: Consisting of health insurance, insurance, unemployment insurance, temporary disability insurance, and retirement, survivors' and extended disability insurance.

Part A—Prepaid personal health service insurance: Provides for insurance of medical care costs, including certain dental benefits.

Part B—Unemployment and temporary disability insurance benefits: On a Federal basis. Benefits of \$5 to \$30 per week up to 26 weeks; if funds are adequate, up to 52 weeks for unemployment.

Part C—Retirement, survivors', and total disability insurance benefits: Provides for more liberal benefits than existing law. Minimum, \$20 per month; maximum, \$120.

Part D—National social-security trust fund: All funds invested in United States Government bonds.

Part E—Credit for military service: \$160 wages credited under the insurance system for each month of military service.

Part F—Coverage provisions and definitions: Extends coverage to about 15,000,000 additional persons.

Part G—Social-insurance contributions: Four percent each on employers and employees. Government contribution authorized when necessary.

Part H—General provisions: Judicial review, National Advisory Council, and rehabilitation of disabled persons.

Health service.—The method under which health services will be given is a familiar one. The Surgeon General is directed to make known in each local area the names of medical and dental practitioners who agree to furnish services as benefits. Any physician or dentist licensed by a State will be legally qualified to become a member of such a panel. A beneficiary may select any practitioner appearing on a panel to treat him, but must obtain the consent of the practitioner.

Payments to general medical and dental practitioners may be made (1) on the basis of fees for services rendered, according to a fee schedule, (2) on a per capita basis, the amount being decided by the number of individuals entitled to benefits who appear on a practitioner's list, (3) on a salary basis, full or part time, and (4) on a combination or modification of these methods.

Dental benefits.—Every person who is currently insured is entitled to receive personal-health-service benefits. Every dependent of such persons who is not receiving benefits in his own right is also entitled to personal-health-service benefits, which include general-medical benefit, special-medical benefit, general-dental benefit, special-dental benefit, home-nursing benefit, laboratory benefit, and hospitalization benefit.

The term "general dental benefit," in the words of the bill, 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 a hygienist under his direction, and including preventive, diagnostic, and therapeutic treatment, care and advice, and periodic examination."

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 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 specialists or consultants."

These benefits, until January 1, 1947, are subject to restriction in accordance with the following provision of the bill:

"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 * * * benefits shall have such restricted content as the Surgeon General may determine: *Provided*, That, on and after January 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 disease 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 * * *.

Wagner statement.—Excerpts from the statement issued by Senator Wagner on introduction of the bill in the Senate follow:

"The legislation which I have introduced includes six provisions which will make available basic health services to all of the people wherever located and whatever their income.

"First, there is a program of Federal grants-in-aid and loans to the States for the construction of needed hospitals.

"It should therefore be possible, over a period of years, to assure that essential and modern hospital and related services are available in all parts of the country, especially the rural areas which are so sadly in need of these services. The most urgently needed hospitals should be built first.

"Second, the present Federal grants-in-aid to the States for public health services are broadened and increased, to speed up the progress of preventive and community-wide health services.

"Third, the community-wide maternal and child health and welfare services, aided by Federal grants-in-aid to the States, are similarly broadened and strengthened.

"Fourth, health insurance is made available to 135,000,000 persons.

"All four of the measures which I have just mentioned will greatly help to round out the health services of the Nation. By preventing sickness, disability, and premature death, they will pay vast dividends in human welfare and, at the same time, reduce the costs of other parts of the social security program. However, unless we provide a method for spreading the cost of medical and hospital care through social insurance, people will still not obtain the treatment they need.

"Fifth, funds are set aside from the social insurance contributions to aid in the rehabilitation of persons who are disabled.

"Sixth, grants-in-aid are provided from social insurance funds to nonprofit institutions engaging in research or in professional education.

"The financial barrier to adequate hospital and medical care is the basic reason for the unequal distribution of doctors and hospitals as between urban and rural areas, and as between prosperous and underprivileged communities. It is the basic reason for the failure of low-income families to receive as much medical care as the well-to-do, although they have more sickness. It is an important cause of the shockingly high rate of rejections under selective service.

Health insurance.—A health insurance system will go a long way toward breaking down this financial barrier. Such a system will enable the people to obtain all needed medical care through small, regular prepayments based on their earnings, and will give them security against catastrophic costs for which they cannot budget individually. It will encourage doctors to settle in rural areas and communities to construct needed hospitals, health centers, and diagnostic facilities, by assuring adequate incomes, equipment, and facilities for modern medical practice. It will benefit patients, doctors, and hospitals.

"Propagandists against health insurance shout 'regimentation' of doctors and patients, 'lowered standards,' 'political' and 'socialized' medicine, and so on. But health insurance is not socialized medicine; it is not State medicine. Health insurance is simply a method of paying medical costs in advance and in average amounts. It 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 the doctor or the hospital. Therefore, it should be obvious that health insurance does not involve regimentation of doctors 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. * * *

"The health insurance provisions of the bill provide that each insured person has the right to choose his own doctor from among all doctors in the community who participate; each participating doctor has the right to accept or reject a patient, just as he does now. Every legally qualified physician and every qualified hospital has the right to participate. The same is true for groups of physicians; and the same is true for dentists. Hospitals are guaranteed protection against interference in the management of their own affairs. Physicians, dentists, and hospitals are specifically given the right to select the method by which they are to be remunerated for the services they furnish. Every effort has been made to similarly protect the professional position of nurses and nursing organizations. Throughout the health insurance provisions of the bill, 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 the bill as the method to be used, and that is the democratic way of doing things. * * *

"Every effort has been made to keep a fair balance in the bill between the principles of administrative responsibility and democratic administration. The administrative officers are given duties to perform and the necessary authority so that they can carry out their duties efficiently and promptly. But their authority is carefully limited through checks and balances. Limitations are carefully specified in the bill; for example, the rights of insured persons and of physicians and hospitals are set down. Also, the administrative officers are required to consult with a national advisory council on all important questions of policy and administration, and this council must contain representatives of both the public and those who furnish health services. Provision also is made for advisory bodies at the local level as well. Moreover, the administration is to be decentralized to the maximum extent possible, and administration through the States and localities is given preference and priority wherever the State and local authorities wish to take over the responsibility.

"High standards of medical care are protected and encouraged through incentives for the professional advancement of doctors, postgraduate study, professional education, research and the availability, regardless of the patient's ability

to pay, of consultant and specialist services, hospital and similar facilities, laboratory services, and X-ray services to all. Provision is made for the addition of dental and home-nursing services as rapidly as practical. The bill is clear in requiring that the arrangements to provide the medical and related services shall be worked out so that they are mutually agreeable to the administrative officers and to those who agree to furnish the services. * * *

COMMITTEE ON ECONOMICS

ECONOMICS COMMITTEE URGES STATE LOCATION SURVEYS

A program under which State dental societies will be urged to undertake surveys designed to aid the returning dental officer in finding a location for practice has been undertaken by the committee on economics of the American Dental Association, Leslie M. FitzGerald, chairman. To aid in this project, the committee has compiled a suggested outline, which is available for the guidance of State dental societies. Community or county report forms will be used to secure the essential information needed to answer inquiries concerning opportunities in specific localities. Additional data can be secured from the procurement and assignment service. The committee also advises that the cooperation of local civic groups and other postwar planning agencies may be enlisted to make the survey more comprehensive.

Inquiries regarding these surveys should be addressed to Joseph E. Bagdonas, committee on economics, American Dental Association, 222 East Superior Street, Chicago 11, Ill.

COMMITTEE URGES RETURN OF QUESTIONNAIRES IN INCOME STUDY

Questionnaires to survey various phases of dental practice have now been mailed to 24,000 civilian dentists in 19 States, according to J. E. Bagdonas, secretary of the committee on economics of the American Dental Association. The survey is being conducted by the committee to obtain a current record of the economic status of the dental profession and to ascertain the amount of service being provided. The survey form requires only a brief summary of information concerning organization of practice, income, and weekly patient-load of the dentist.

Leslie M. FitzGerald, chairman of the committee, urged dentists to cooperate by providing the desired information as soon as possible.

ERROR IN STATEMENT ON ARIZONA DENTAL LAW

Attention has been called to an error in the report on State dental legislation in the April 15 issue of the Journal. R. K. Trueblood, secretary, Arizona State Dental Board, has stated that Arizona has reciprocity with no State and that the reference to the basic science law was applicable to medicine, but not to dentistry.

[Journal American Dental Association, vol. 32, July 1, 1945]

A PROPOSAL FOR GROUP PRACTICE IN DENTISTRY

Charles L. Hyser, D. D. S., New York, N. Y.

American dentistry, in its national, State, and local organizations, offers many manifestations of deep concern as to how the profession shall best meet the challenge of the postwar era. It should be said at once, however, that the war has merely brought into sharp focus needs and trends in dental practice already in the making. Many of us believe that whatever postwar plan of dental practice finally evolves will be the result of a long steady process, and that it will represent evolution rather than revolution.

This is not to say that certain fundamental changes in dental practice are not needed. The changes needed, however, are radical only in the way in which they provide for different and more efficient forms of utilizing our present resources. They are developmental rather than fundamental changes. Few will dispute the thesis that some way must be developed for getting better dental service and service to a great many more people than now receive or apply for dental care. This article is concerned with some of the ways in which this objective might be achieved. The heart of the proposal is the group practice of

dentistry, with fractionation of the mechanical part of dental work—both of these to be set forth more fully hereafter.

This is not the first presentation of the proposal that forms the basis of this article. Several years ago, when it was clear that the Selective Service System and the Army were faced with a huge problem of dental rehabilitation, this proposal was offered to these authorities in the belief that it would insure a better solution of the military dental problem than was achieved, for instance, during the last war at Camp Upton, where I served in the dental force. The proposal was given serious consideration by the military authorities and, when it was finally decided that the plan could not be put into military operation at that time, the rejection was accompanied by the opinion that the plan was adapted to dentistry as a public health problem and that it should be tried in civilian life. The plan was brought before the Pepper committee¹ and has been presented to leaders in dentistry, medicine and social economy, who, feeling that experiments in the group practice of dentistry should be tried, have formed a committee of sponsors,² advocating experimentation on the basis of this plan.

It seems to me important that American dentists themselves should work out and present the plan designed to meet the present dental needs of the Nation, whether present or postwar. It seems quite clear that if American dentists do not undertake this task, others will assume it, for there are at work urgent forces which forecast action of some kind. When 95 percent of the people need service as definitely as they now need dental care, something will be done about it. When more than 20,000 dental officers are demobilized, something will be done about it. It behooves the dentists themselves to direct and do what is to be done, providing for definite experimentation in the most hopeful possibilities and ceasing to rely upon the literary expression of progressive attitudes at annual meetings and in our dental journals.

These are the problems: (1) to find a way of getting dental care to the 80 percent of the population that now receives none; (2) to find ways and means of making the benefits and imperative need of dental rehabilitation clear to the millions who now have no conception of this; (3) to meet the further problem caused by the fact that a vast number of people cannot afford high-grade dental care, if they can afford any at all; (4) to establish on a national basis a progressively expanding children's program, aimed at the kind of preventive dental service that would make impossible the situation revealed by the first draft, in which 200,000 of 1,000,000 men were rejected for dental defects alone; (5) to develop the dental personnel and manpower to do the country's dental job on a national basis, since there are not even one-third as many dentists as would be required if the Nation's whole dental need were to be met, and (6) to incorporate, in any new ways that may be explored by providing good dental care, the four principles established by the American Dental Association.

Unless dentists prove themselves capable of devising a comprehensive practical plan, we shall have plans from various sources and with complex motivation presented to us, and very possibly forced upon us. These plans will range from patchwork proposals to have the Government subsidize the training of one-third more dentists than now exist to proposals such as the Wagner-Murray-Dingell bill. This bill did not propose to solve the dental problem of the country. It merely accorded the country's dental needs a certain honorable mention by proposing a 2-year "study" of the problems involved in providing adequate dental care to the population. It is in the legislative tradition to propose a study of these subjects with which the framers are unable to deal. It is my opinion that there are now in American dentistry forces competent to present a statement of needs and to evolve experiments for meeting them without 2 years additional study. Dentists have a responsibility for preparing now a plan for dental practice that will take into account the dental needs revealed by the draft; the need of preventive dentistry for the whole population through an adequate children's program, and the need of using to the utmost the dentists now in practice and those who will be demobilized. The latter represent about one-third of all the dentists in the country.

¹ A subcommittee of the Senate Committee on Wartime Health and Education.

² The committee of sponsors include: J. L. T. Appleton, D. D. S., vice chairman, dean, school of dentistry, University of Pennsylvania; Finn J. Bronner, D. D. S., college of Dentistry, New York University; Charles L. Hyser, D. D. S., Chairman; Esther Everett Lape, American Foundation, Westbrook, Conn.; John Oppie McCall, secretary, Guggenheim Clinic, New York City; J. Raymond Walsh, vice chairman, Economic Advisor CIO, New York City; William C. Webb, Jr., D. D. S., director, Philadelphia Mouth Hygiene Association, Philadelphia, Pa., and Milton C. Winternitz, M. D., Yale Medical School, New Haven, Conn.

All of us salute legislators who reveal a knowledge of social needs. No bill in the pattern of the Wagner bill will solve the dental problem of the country because it is based on social theorizing rather than on a scientific approach to a profound scientific problem. The Wagner bill is in the familiar pattern of proposals by those who feel that every new social problem can be met by extending insurance provision to cover it. The chief concern of the Wagner bill is to work out ways and means by which people can pay for medical care. What is needed first, however, is to achieve, on a Nation-wide basis, medical and dental care that are worth distributing and worth paying for. I propose that instead of working out any more Government-aided insurance schemes, in the German tradition of the last generation, we direct Government initiative toward ways and means of providing adequate and scientific dental and medical care on a basis that will make it possible to reach the millions at present untouched. Whatever aid it is necessary for the Government to give should be made available through direct taxation. Social insurance is a patriarchal rather than a democratic pattern. It is not in the American tradition.

There is another way. We have it in our power to work out a sounder relation between government and medical and dental science, a relation that will provide high-grade care for all, at practicable costs, met by the individual and supplemented by direct health taxation—not by the indirect taxation of insurance, and not by the unsound application of the theory of hazards and percentages to a need that affects the whole population at all times. The development of preventive medicine and preventive dentistry, which, in the long run, is the only rational definition of "adequate" medical and dental care, has nothing to do with the principles upon which social insurance is based. Social insurance is based on the principle that illness is a hazard, a calamity that does not come to all, and that it is possible to work out, on the law of averages, a scheme by which the money saved on those that are not ill can be applied to the care of those that are ill. It is an unsound principle. Preventive medicine and preventive dentistry are needed by all. They are logical objectives of direct taxation and they are not logically subject to intricate schemes based on the law of averages.

The plausible contention is, of course, that voters find indirect taxation more palatable than direct taxation. This seems to be an unwarranted assumption. In the course of history, the voters have learned to pay willingly for what they want.

I want to see any dental bill along the lines of the Wagner-Murray-Dingell bill defeated by a sound and comprehensive proposal emanating from American dentistry. Such a proposal will need to take into account how the 95 percent of the population that needs medical care is to pay for it; but an adequate dental proposal must do much more than envisage the consumer's difficulty in paying for dental care. It must insure the existence of sufficient dental care of the highest order to meet the Nation-wide need. This objective, the Wagner bill pattern, with its preoccupation with the consumer's problem of payment, does not meet.

On what principles, then, will we evolve a plan that will make it possible to stretch our present obviously inadequate resources to cover an expanding national need? I believe that, however we may disagree on administrative details, we must admit that the only principles that will achieve this end are those I have mentioned above, i. e., the group practice of dentistry and the fractionation of much of its mechanical procedure. The mostly highly developed experiments in medical practice, i. e., the teaching hospitals with the associated medical schools, and groups such as the Mayo Clinic, have conclusively proved that group practice results in infinitely better medicine.

In dentistry, there is particular reason for group practice. There is need for a group of experts, in such a dental clinic as I propose, for diagnosis and for charting dental work, in every case on the basis of the whole mouth. The members of this diagnostic and supervising group would have to be more highly trained in dentistry and medicine, expert in the basic sciences. This diagnostic and supervising group would be responsible at all times for the quality of the dental care provided by the clinic. It would be responsible for the basic research that must be associated with such a clinic, and for the type of medical education to which the clinic would contribute.

Division of the operative work of the dental clinic proposed especially lends itself to the application of the group principle. Many of the procedures in dentistry are mechanical procedures. They require expertness, but they are high-grade mechanical practices that lend themselves readily to the principle of fractionation. With the large number of patients contemplated in the clinic

plan, young graduates could be used in the various mechanical procedures. They would become progressively expert in every operation and, by careful rotation, the training of every man could be rounded to include every form of operative work. Nor is it to be for a moment forgotten that these operators would work under the expert direction of the diagnostic and supervising group of highly and broadly trained men. If this is borne in mind, the criticism that the plan proposed would "mechanize" dentistry or lower its standards has no relevance. Clearly, every operator concerned could not fail to achieve a broad gain in competence and in scientific understanding of the way in which his work fits into the whole picture. There would be no substandard dentists anywhere in this plan. I am definitely opposed to the use of any but competent graduate dentists in dental work. I think, however, that we should consider the possibility of using properly trained assistants where they can be effectively used to increase the efficiency of the operating dentist. In the practice of dentistry, there are many minor services which trained assistants could offer and which would save the operating dentist time and energy.

No "mechanizing" of the profession is involved in group practice. The plan contemplates more comprehensive and more intensive dental work for every case. The increase in volume of work involves no sacrificing of quality to quantity. It is obvious that great numbers of patients and efficient fractionation of mechanical procedures will greatly increase the amount of work done, and sharply lower its cost. It is very likely that most of the illustrative figures used in the plan would be revised upward or downward. The important consideration is the soundness of the principle that time and money will certainly be saved by (1) a large volume of patients, (2) reduction of overhead and equipment resulting from group practice and (3) maximum output for each operator achieved by efficient fractionation of work. Too much stress cannot be laid upon the fact that while there are many economic and practical reasons for urging group practice, the outstanding argument for group practice is the fact that it will lead to better dentistry, a better and more biologic type of health service. The advantages arising from the saving of time and the lowering of cost to the patient are "byproducts" rather than the real argument for group practice.

In summary, then, the principles upon which the plan rests are: (1) expert and complete charting of the needs of the mouth as a whole, for every case that the clinic admits; (2) fractionation of the dental work and organization of mechanical procedure, and (3) expert supervision at every stage.

In this conception, the group practice of dentistry insures better dental care for every case, the proper relation of medicine to dentistry and the maximum savings in time and money, with vastly lowered costs to the consumer. By way of concrete illustration: Approximately 100 dentists could care for 30,000 badly broken-down mouths per year, with complete rehabilitation. If we figure, for example, on a 300-day year, that would mean 100 patients a day. Roughly, in prosthetic dentistry (bridgework and platework) a group of eight operators might consist of two taking impressions (with the new colloid impression material, it is easily possible to take five impressions for bridges or partial dentures per hour, if everything is ready and the inlays are fitter and completed), two taking bites and choosing the colors and four fitting the bridges and dentures. This prosthetic group would be capable of finishing 10 partial dentures or bridges per hour, or 80 in an 8-hour day. When costs of material, equipment, and salaries (even good salaries) are divided by the 30,000 patients, it must be clear that savings would be immense. The effectiveness of the clinic proposed is of course dependent on large numbers of patients. It should be added that there are certain problems to which the fractionation system would not be adaptable, for instance in deep and complicated cavities (which would too greatly slow up the line), root canal work, bite restoration and edentulous mouths. These may require individual attention and treatment, which would be provided for and carried out in the proposed line.

Some of the critics of my plan, evading consideration of the principles involved, have devoted all their energies to attacking one or another of the foregoing figures. The proposal, let me hasten to say, is based not upon particular figures, but upon the soundness of the principle that fractionated and coordinated work by men whose expertness increases daily definitely shortens time and lessens cost. This economic principle was advanced by Adam Smith in 1778 and has been demonstrated many times since then. By and large, I consider the illustrative figures that I have used conservative. The important consideration, however, is that they are illustrative and can be made final only through experimentation.

The principle of the plan outlined applies, with certain obvious omissions and differences, to the operation of a children's clinic. In dental work with children, prosthetics is almost nonexistent except for accidents, but the operative work is the same. The crown of a child's permanent tooth is formed, finally and completely, when it erupts and, if it decays, it should be filled with a permanent material. That is far more economical than refilling the tooth every few years because of leaky or changing materials. X-rays show up cavities long before they endanger the pulp, and if the pulp does not become involved, infection of the root cannot develop. A vital tooth never develops an apical abscess, and thus extraction and the resultant bridges are avoided.

To orthodontia in children, the principle of the fractionation of work is easily applicable. The most important factor in orthodontics is diagnosis, and the next factor in importance is the logic of basing the treatment on dental need and not on the financial background of the patient. One man could plan and control the treatment of 15 or 20 subordinates in a children's clinic with little trouble. Apparatus could be made in a laboratory by technicians. By such methods, orthodontia, instead of being the luxury it now is, could be dropped into a class of work available to every child.

How is the patient to pay for the high-grade comprehensive dental care provided by the proposed clinic? Clearly, since preventive dentistry for all is our concern, the popular hospital insurance plan, which rests upon the premise that only a part of the population is going to need hospital care and that most of the others need it only at rare intervals, is not pertinent. It would be possible, however, to build up a membership organization on the basis of average costs. For the sake of discussion, let us assume that the fee for individual membership would be \$10, for which a member would receive full X-ray examination, careful prophylaxis, possibly some minor surgical service, and a thorough examination and complete diagnosis. On the basis of this diagnosis, the patient would have outlined to him the amount of work needed for rehabilitation of his mouth at that period. The amount of dental care needed varies in all patients, and since an average cost would be unfair and impractical, the mouths the condition of which was thus diagnosed would fall into one of possibly three classifications of needed work:

Group A: x —number of fillings.

x —number of extractions.

Group B: x —number of plastic fillings.

x —number of inlays and possibly some restoration.

Group C: All cases which do not fit into the two former groups.

The A, B, and C groups would be charged different fees, the exact amount of which could be established only by experiment, but which might possibly be \$20 to \$30 to \$40, respectively. After rehabilitation, the mouth would be maintained in a healthy condition, on an annual basis, for a yearly membership fee of \$5.

The comprehensive, thoroughly scientific dental care that is needed can never be provided to 100 percent of the population on the basis of the individual practice of dentistry. I propose the cooperative organization of our dental personnel and facilities at this time, on the initiative of American dentistry, as the only healthy and effective means of offsetting schemes for regimenting the practice of dentistry without fundamental benefit to the consumer, to the dentist or to the science of dentistry.

While this article has been chiefly concerned with illustrating the concrete working out of the group practice of dentistry, implicit in every part of the plan is the impact that group practice will have on dental education and dental research. The clinics proposed cannot help becoming the postgraduate centers of the country and as such they will necessarily influence the undergraduate curricula, which will produce the dentists of the future. In the field of research, the clinics offer opportunities for research data and research interest not available in the system of individual practice. For research purposes, the clinics should be operated on the basis of records to be worked out by a group of scientists, involving, for instance, the disciplines of dentistry, medicine, chemistry, physics, anatomy and anthropology. These scientifically devised and uniform records covering thousands of patients would prove or disprove many observations that are now matters only of speculative theory. Through such research, the group practice of dentistry will directly minister to achieving and maintaining the integrity of dental science.

[Journal American Dental Association, vol. 32, July 1, 1945]

CASES AND COMMENTS

A NATIONAL HEALTH PROGRAM

To the Editor: I read with interest a statement in the April 1, 1945, issue of the Journal by a joint committee of three American Dental Association committees, dealing with the national program for dental health (pp. 498-503).

After a review of the situation which the profession faces in regard to dental health and dental diseases in the Nation, the statement outlines the platform of research, health education, and dental care as the basis of its program. These are all needed, and under one or another of these headings can properly be placed any activity directly aimed at improving national dental health. I am struck, however, by the repetition of this theme appearing so often in recent years, but with so little amplification as to methods.

Then I note in the conclusions the following statements, which also have appeared before: "This program is not revolutionary—it is evolutionary. It makes use of existing mechanisms, strengthening and improving them where there is need. * * * It is not prohibitively nor legislatively impracticable."

These statements are put forth as though they were self-evident truths and desiderata. I think that we may well question them. Take the first statement, with its assumption that a revolutionary program would be harmful. That does not necessarily follow. Many revolutions have resulted in highly desirable reforms and improvements in the lot of mankind. The harm associated with some of the highly publicized revolutions has often resulted from unwise resistance to the needed reforms rather than from any socially undesirable features of the changes themselves; and when pent-up pressures burst their bounds, people get hurt, but that need not happen if desirable changes are not opposed.

We then come to the second statement that the program makes use of "existing mechanisms," with the implication that these are the best possible devices or, at least, that they ought not be changed. What, I ask, is sacrosanct about these existing mechanisms? Are they necessarily the best simply because they are in existence? If by "existing mechanisms" is meant dental care in the individual private office on the usual fee-for-service basis, we may, I think, well question the implication that existing mechanisms offer the best means of providing regular dental care for the 75 to 80 percent of people not now receiving it. Is there an effort here to bring more people to the private office and a belief that this offers the best means of meeting the situation? Organized medicine is making the same effort. Yet many leaders of medical thought, those experienced in the actual provision of medical care to the underprivileged, agree that group practice, in one form or another, provides the best medical care. Is it not possible that the same thing applies to dental care?

Let us study existing mechanisms by inquiring as to how they have met some of the recognized problems. First, let us look at dentist distribution. The tendency of dentists to set up practice in cities instead of balancing between cities and smaller communities indicates that there is something wrong with existing mechanisms in that regard. The problem is obviously economic, and we cannot blame dentists for wanting to make a living. But people in the country have toothache the same as in the city. However, even under present conditions, not all people in the city get all the dental care they should have. Economic again, in large part.

One of the results of this lack of dental care has been, first, a high rejection rate in the draft on account of dental defects and, when this was discovered, a complete abolition of dental requirements in physical examination for the armed forces (even the Navy, with its initially higher standards, had to give in). This resulted in drafting of one-third of the dentists of the Nation into the services. And what did these 22,000 dentists do, once they were in the Dental Corps? Protect the troops against new dental disorders? For the most part, no. They had to rehabilitate wrecked mouths so that soldiers and sailors could chew their food and be able to endure the rigors of military campaigns. Can we expect to prevent a repetition of this in a possible World War III by continuing to depend on existing mechanisms?

Our leaders say that this can all be prevented in the future. How? By spending more money to turn out more dentists to practice in private offices. And this brings us to the third statement quoted from the committee statement, that the proposed program is not prohibitively expensive. If practice in the individual office is more expensive than practice in a clinic, with its saving in overhead (to

say nothing of other advantages), to choose the existing mechanism in locations, such as cities, where clinics can well be established, is to choose the more expensive mechanisms, a course which it is difficult to defend if it is claimed that it is not "prohibitively" expensive.

Reverting again to existing mechanisms: These are based on the law of supply and demand, and under this law prosthetic dentistry, the replacement of teeth lost through disease, is more profitable than operative dentistry, the filling of teeth to keep them in the mouth. How can we expect, if we continue existing mechanisms, to induce dentists to devote a large amount of time to children's care, which is largely operative dentistry, and which the Council on Dental Health rightly advocates as the foundation of the national dental-health program? More could be said regarding children's dental care and present-day dental practice, but the point need not be labored.

I end on a note of interrogation. Is it not time to think of planning new ways to meet the national dental problem?

JOHN OPIE McCALL,
422 East Seventy-second Street, New York City.

[Journal American Dental Association, vol. 33, February 1, 1946]

BOOK REVIEWS

Man Against Pain: The Epic of Anesthesia. By Howard Riley Raper, D. D. S. 337 pages. Illustrated. Bibliographical Appendix. Index. Price, \$3.50. New York: Prentice-Hall, Inc., 1945.

The tragic, fascinating, and often sordid story surrounding the discovery of anesthesia has been told so often by advocates, scenario writers, historians, partisans, and fiction writers that one might well question the value of a reconsideration of the subject. Too often in the past writers on this topic have been carried away from an objective exposition by the need to espouse a cause or defend a reputation. *Man Against Pain* has escaped these twin pitfalls because the author rigidly marshals the best available evidence toward sound conclusions. This is a book, therefore, that has the dramatic pace of a detective story and the critical attitude of truly scientific writing. There is some new material, but the real value of the book lies in the author's evaluation of the evidence.

On the celebrated question of priority for Horace Wells or W. T. G. Morton, Raper says:

"One reason why it has been so difficult to name the discoverer of anesthesia is that *there is no discoverer of anesthesia!* No one man earned exclusive right to the title. The *discoverers* are Wells and Morton—Wells, in the sense that he found it and passed it along to Morton; Morton, in the sense that he introduced it into surgical practice. Wells received the ball from center and passed it to Morton who stepped over for a touchdown. It is highly improbable that there would have been much controversy if Morton had acknowledged his indebtedness, for no other candidate could have won any significant recognition against such a combination based securely on truth." [Italics in the original.]

Man Against Pain, which has been a selection of the Scientific Book Club does not limit itself to the controversy but tells the entire story of man's conquest of pain by hypnotism, narcotics, and local and general anesthetics. There is also a section devoted to some of the newer anesthetics whose wider use was given impetus during the war. The short sections on dreams could have been eliminated with no loss either in effectiveness or in completeness. More than 40 pages of critical bibliography, set apart in an appendix so as not to interfere with the progress of the story, comprise a valuable contribution to the involved history of the subject.

The author tells his story dramatically and convincingly. The style is sprightly and fast-paced enough to interest the lay reader as well as the dentist and physician. Occasionally the organization of the material seems sketchy, and the illustrations certainly do not match the high quality of the text. These are minor defects, however, that do not impair the book's very great value as intelligent entertainment and as a solid contribution to the history of anesthesia. Raper, himself a dentist, has finally set Horace Wells and the others involved in the controversy in proper perspective. Because so many other authors have failed in this job, Raper's book can be considered as an achievement of the highest order.

School Health Policies. By the National Conference for Cooperation in Health Education. 46 pages. Second Edition. Price \$0.25. New York 14: Health Education Council, 10 Downing St., 1945.

This excellent booklet should be in the hands of all persons interested in the development of health activities for children and adults. The recommendations for school health policies were formulated by specialists in the health field representing school systems and the dental, medical, nursing, and public health professions.

In far too many instances recommended procedures for the promotion of health and physical education are indefinite and impractical and are not based on a comprehensive knowledge of the problems involved. This booklet, on the other hand, presents clearly stated and practical suggestions for improved school health programs. While the suggested procedures are directed to the school administrator, they are also addressed to all persons concerned with the health of the school child, so that these persons too may cooperate in carrying out programs for the health of students and, indirectly, of all members of the community.—*Allen O. Gruebbel.*

The Health of a Nation. An analysis by Michael M. Davis, Chairman, Committee on Research in Medical Economics, New York City, and Bernhard J. Stern, Department of Sociology, Columbia University. Teaching Aids by Lavone A. Hanna, Acting Assistant Professor of Education, Stanford University. 84 pages. Price \$0.30. Washington 6, D. C.: National Education Association, 1201 Sixteenth St. NW.

The Health of a Nation is number 17 of a series of pamphlets entitled "Problems in American Life," prepared under the joint sponsorship of the National Council for the Social Studies and the National Association of Secondary School Principals, which are departments of the National Education Association.

Although the Health of a Nation is prepared primarily for teachers in secondary schools, dentists and others interested in the social and economic aspects of the Nation's health problem will gain much by reading it. Part 1 consists of an analysis by Michael M. Davis and Bernhard J. Stern. Its seven short chapters present information on the nature of the problem; the individual's health; health and the community; health technology and economics; processes and goals; reading references, and agencies providing information. The authors point out that individuals have the important responsibility of looking after their own health, but that health is also a concern of society. "In what degree, by what methods, through what agencies," they ask, "should control be exercised by group action over the elements that affect health and over the institutions and vocations that deal with it?" Under the general subject of individual health, mental health, foods, food fallacies, physical exercise, rest, cleanliness, ventilation, and avoidance of harmful drugs are discussed. The chapter on community health presents some vital information on communicable disease, changing birth and death rates, life expectancy, health and income, industrial accidents, and occupational diseases. Information on health service personnel and their geographic distribution is presented. The number and distribution of hospitals are discussed. The Nation's health bill, supply of and demand for health services, physicians' and dentists' incomes, private and public health agencies, and health legislative proposals are presented in a clear, understandable manner.

Dentists interested in socio-economics will like part 1 of this booklet, although they will regret that it does not contain more information on the dental aspect of the problem.

The only serious criticism that might be directed at the Health of a Nation is its lack of dental statistics. Two serious typographical errors were noted.—*Lon W. Morrey.*

THE PRESIDENT'S HEALTH PROGRAM AND THE NEW WAGNER-MURRAY-DINGELL BILL

Enough time has elapsed since President Truman sent his message on health to Congress November 19, so that its purpose and impact can be estimated. It is now apparent that the message was drafted for the President by the same advisers who developed the formula for the third Wagner-Murray-Dingell bill, introduced into both Houses on the day that the presidential program was announced. It is also apparent now that the new bill was changed in several respects, only to make possible its referral to more favorably inclined committees in both the House and the Senate. This maneuver was successful, and it is to be expected that hearings will soon be held by the Senate Committee on Education and

Labor, of which Senator James E. Murray, one of the sponsors of the bill, is chairman. These hearings undoubtedly will be used to bring about a renewed public discussion in the hope that public demand will cause legislators to do something about a health measure that has at least twice before won studied indifference from many Members of the Congress.

The American Dental Association will oppose the new Wagner-Murray-Dingell bill, but not because it favors the status quo, not because it believes that legislation is unnecessary and not because purely professional interests are said to be endangered. The American Dental Association will oppose the Wagner-Murray-Dingell bill because, quite simply, it is not good legislation for the establishment of a sound dental program in this country.

The American Dental Association, however, is not content with mere opposition. It has already sponsored two bills which it believes will constitute a more constructive effort toward improved dental health than this, or any other, Wagner-Murray-Dingell bill. In order to make this point very clear, it is necessary to examine some other aspects of this problem.

Previous legislation.—The Social Security Act of 1935 did not contain provisions for a national health program, as it might reasonably have been expected to do. The first effort to amend that act in this regard came in 1939 with the introduction of the first Wagner health bill. At that time, the American Dental Association expressed itself as wholly in sympathy with the objectives of the bill but opposed the mechanism established by it. Recognizing the extent of the dental problem in this country and realizing, also, the need for Federal aid in its solution, the association then proposed amendments to the bill. These amendments proposed grants-in-aid to the States in order to foster (1) dental research, (2) dental health education, and (3) dental care, particularly for children. They were formally presented to Congress, but the bill was allowed to lapse by the administration. In an effort to initiate this constructive plan for improved dental health, the association subsequently introduced two bills to realize the first part of its program—intensified dental research. Despite the firm backing of the association, these bills were not passed by both Houses of Congress, through achieving favorable votes in one.

These points are made at some length merely to indicate that the American Dental Association recognized the dental problem long before the selective service examinations brought tardy official and public attention to its importance, and that the association moved consistently forward with a program of its own even when the threat of adverse Federal legislation did not exist.

Further developments.—Later, in an effort to define its attitude unmistakably, the house of delegates of the American Dental Association unanimously approved the four following principles:

1. Research: Adequate provisions should be made for research which may lead to the prevention or control of dental diseases.

2. Dental health education: Dental health education should be included in all basic educational and treatment programs for children and adults.

3. Dental care: (a) Dental care should be available to all, regardless of income or geographic location.

- (b) Programs developed for dental care should be based on the prevention and control of dental diseases. All available resources should first be used to provide adequate dental treatment for children and to eliminate pain and infection for adults.

- (c) Dental health is the responsibility of the individual, the family, and the community, in that order. When this responsibility, however, is not assumed by the community, it should be assumed by the State and then by the Federal Government. The community in all cases shall determine the methods for providing service in its area.

4. In all conferences that may lead to the formation of a plan for dental research, dental health education and dental care, there should be participation by authorized representatives of the American Dental Association.

This clear enunciation of the association's basic belief was followed by the introduction of two bills into Congress to translate the three-point program into reality.

American Dental Association legislation.—S. 190 and H. R. 3816 were introduced into Congress by Senator James E. Murray, Montana, and Representative J. Percy Priest, Tennessee. These bills were sponsored by the American Dental Association in order to implement the first point of its program: intensified dental research. The bills provide for the appropriation of Federal funds to permit (1) the erection of a national institute for dental research as an integral

part of the National Health Institute near the Nation's Capital and (2) grants-in-aid to public and private agencies for the intensification of dental research.

S. 1099 was introduced by Senators Claude Pepper, Florida, and George D. Aiken, Vermont. Companion bills, H. R. 3412 and H. R. 3414, were introduced by Representatives Walter E. Brehm, Ohio, and Philip A. Traynor, Delaware. These bills are an essential complement of the research bills, since they incorporate provisions for the second and third points of the American Dental program. These bills, when enacted, will make Federal grants-in-aid available to the States and their subdivisions for programs of dental health education and dental care. These grants would be administered and controlled largely by the States and subdivisions themselves under the broad program of the United States Public Health Service. In designing its program, the United States Public Health Service would have the counsel of an advisory board, the majority of which would be dentists according to the terms of the bill.

This legislation has certain other important characteristics. Its provisions are almost identical with the provisions of legislation which have made the national campaigns against cancer, venereal disease, and tuberculosis so effective. It approaches the entire problem of dental health on an experimental basis and does not attempt to impose upon the country an untried, questionably designed program which the States would have very little power to alter or control. Through this bill, experiments can be conducted in the many phases of this problem for which data are now almost entirely absent; these experiments will be set up and carried out by the State and community which have a knowledge of their own needs as well as definite desires as to how these needs should be met.

This legislation must be compared with the Wagner-Murray-Dingell bill, which proposes an untried, compulsory, illusory, administratively costly scheme for the entire country. The house of delegates of the American Dental Association has repeatedly declared itself against a national system of compulsory health insurance in which dentistry is included. This opposition is not based on reaction but solidly on the fact that no country which has tried this scheme has ever materially improved the dental health of its people or the character of the dental service rendered. It is also based on the undeniable fact that a national system of compulsory sickness insurance negates the traditional right of a State to meet its own needs in its own way.

The American Dental Association and its numerous component and constituent societies have labored for many years to focus national attention on the size and the importance of the problems of dental health. It has made its counsel and the results of its studies available to every agency interested in the matter. It has enunciated its own program and pioneered in legislation to establish it. There is no good reason why these carefully constructed gains should be sacrificed now by yielding to the inferior proposals of the Wagner-Murray-Dingell bill. There is still less reason for capitulating to legislation that gives little promise of fostering real improvement in dental health, merely because it has considerable vocal support.

The Wagner-Murray-Dingell bill, in short, is not as good dental legislation as that proposed by the American Dental Association. These two association bills should be vigorously pushed toward enactment by all of the resources of the profession aided by an informed public opinion. Only in this way can the maneuvering of those who toy with the national health by contradictory and purely tactical proposals be ended.

COUNCIL ON DENTAL HEALTH

SUMMARY OF THE NEW WAGNER-MURRAY-DINGELL BILL

President Truman announced his proposals for a national health program in a message to Congress November 19, 1945. A new Wagner-Murray-Dingell bill was introduced immediately in both houses, S. 1606 and H. R. 4730. There are now two different Wagner-Murray-Dingell bills in Congress, but it is presumed that the last one, S. 1606, replaces S. 1050.

Some major changes were made in the new bill, probably for reasons of strategy. For example, the provisions for collecting contributions from employers, employees, and self-employed persons were eliminated completely. This was done so that the bill could be referred to the Committee on Education and

Labor, of which Senator Murray is chairman, and thus receive a favorable hearing in committee. Previous Wagner-Murray-Dingell bills were referred to the Senate Committee on Finance and were never reported out of committee. It seems obvious that a new bill or amendments to the present bill will need to be introduced to make provisions for compulsory contributions. Such amendments will probably be made at a later date.

A large portion of the first section was deleted completely. This section was almost identical with the provisions of the Hill-Burton Hospital and Health Center Construction Act. The reasons for removing this section are not entirely clear, but one reason might be the fact that the Hill-Burton bill is slated for passage; in fact, it has been adopted by the Senate. It is logical to assume that the authors would want to delete the provisions that will probably be adopted by Congress in another measure. A brief summary of the more important sections in the new bill follows:

1. Grants to States, counties, and health districts: (a) for the prevention treatment, and control of venereal disease and tuberculosis and (b) for the establishment and maintenance of adequate public health services.

2. Grants to the States for maternal and child-health services for "all mothers and children in the States or locality who elect to participate in the program."

3. Appropriations to enable each State to provide services for "all crippled children * * * who elect to participate."

4. Grants to States to provide medical care for needy persons.

5. Prepaid personal health service benefits (general medical, special medical, general dental, special dental, home nursing, laboratory and hospitalization benefits). Almost all persons would be entitled to receive personal health service benefits.

(a) The Surgeon General is directed to negotiate agreements with agencies, institutions, groups, and individuals "to utilize their services and facilities and to pay fair, reasonable, and equitable compensation for such services and facilities." (The Surgeon General can delegate this responsibility to others.)

(b) The Surgeon General shall appoint local committees to aid in the administration of the act. The members of such committees shall be selected from panels of names submitted by the professional organizations concerned with medical, dental, nursing, hospital, and laboratory services.

(c) A national advisory medical policy council would be appointed and would consist of the Surgeon General as chairman and 16 members selected from panels of names submitted by professional and other organizations concerned with medical, dental, nursing, hospital and laboratory services.

(d) Any dentist or physician may elect to participate in the plan and may select a method of payment based on salary, fee for service, per capita or a combination of these methods.

(e) Reimbursement for medical care for the needy would be provided under the same methods of payment to practitioners.

(f) 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 health services may be required by the physician, dentist, or nurse 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 may also limit the application of such fee to home calls or office visits and may fix the maximum total amount of such fee payments and may also provide for differences in the maximum size of such fees for urban and rural areas and with regard for differences among states and communities. (It is believed that this clause was inserted to control abuses or malingering.)

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 that dental benefits shall be restricted to such services as the Surgeon General may determine, provided the restricted services include at least examination (including X-ray survey) and diagnosis; prophylaxis; 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 treatment of acute diseases of the teeth, their supporting structures and fractures of the teeth or jaws. (It is not clear if carious lesions in teeth would be considered to be acute diseases of the teeth.)

With respect to general dental or special dental benefits, such determination may fix an age above which the restrictions on content shall apply. (It is important to note that the restriction in dental service could be limited to older age groups, thus making children eligible to receive complete service.)

(g) The act would create on the books of the United States Treasury a separate account to be known as "personal health service account." The act would also authorize the appropriation to the account of such sums as may be required to finance the benefits, payments, and reimbursements. From such appropriations, the Secretary of the Treasury would credit to the account an amount equal to 3 percent of the wages paid after June 30, 1946, with respect to employment.

From such appropriations, the Secretary of the Treasury would 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 health care.

(h) Provisions are made to finance medical education and research. Ten million dollars would be made available for the year 1946, \$15,000,000 for the year 1947 and for each calendar year thereafter an amount equal to 2 percent of the amount expended for health care.

The bill contains many qualifying phrases, making it very difficult to read. It also postpones important decisions on administrative detail until after the bill is enacted into law. It is therefore difficult, if not impossible, to determine how some of the provisions would be carried out and what would be the functions of Federal and State agencies in administering the prepaid personal health service.—Allen O. Gruebbel, D. D. S., *Executive Secretary*.

DENTISTS COMMITTEE FOR THE PASSAGE OF THE MURRAY-WAGNER BILL,
New York 21, N. Y., April 29, 1946.

Senator JAMES MURRAY,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: I understand that during the hearing on S. 1066, April 23, at which representatives of the American Dental Association and of this committee presented their views, the question of publication of informative articles about the bill in the *Journal of the American Dental Association* was mentioned. Our committee contended that the *Journal* did not publish such articles and Dr. Hillenbrand, editor of the *Journal*, was reported to have said that he had such an article ready for publication in the forthcoming (May) issue of the *Journal*.

I do not know whether or not the article mentioned is one I had submitted. I present, however, the facts relating to articles I have submitted to the *Journal of the American Dental Association* and respectfully request that this information appear in the record of the hearings.

Over the past year I have submitted two articles and two "letters to the editor" to Dr. Hillenbrand. These article and letters dealt with various aspects of the problem of providing dental care on wide base for our population and were designed to offset some of the announced official views of the American Dental Association on the subject and at the same time stimulate the thinking of dentists in this area of dental activity. Of these offerings the first one has been published, the second accepted but not yet published, the third virtually rejected and then withdrawn by me for publication elsewhere, and the fourth rejected outright. The time table, which is significant, is as follows:

Letter to the editor—submitted April 25, 1945, published July 1945.

Article, *Methods of Payment for Dental Care*, submitted May 23, 1945, accepted August 30, 1945, proof read September 29, 1945, not published as of this date.

Article, *Dental Health Legislation—A Discussion and a Suggestion*, submitted February 7, 1946, indicated as doubtful of acceptance February 18, 1946, withdrawn by verbal agreement, February 27, 1946, accepted for publication by Dental Items of Interest with promise of early publication.

Letter to the editor—Submitted March 28, 1946, rejected April 17, 1946.

Yours sincerely,

JOHN OPPIE MCCALL, D. D. S., *Chairman*.

DENTISTS COMMITTEE FOR THE
PASSAGE OF THE MURRAY-WAGNER BILL,
New York 21, N. Y., April 30, 1946.

Senator JAMES MURRAY,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: Please consider this letter a postscript to the one mailed to you yesterday regarding publication of articles dealing with national health legislation in the *Journal of the American Dental Association*.

The May issue of this Journal has just been delivered and I find that my article referred to in yesterday's letter as having been proofread is not in the May issue. There is an article on this subject in the Journal by Dr. Harold W. Oppie. This is evidently the article mentioned by Dr. Hillenbrand at the hearings and which I referred to in my letter. This article is essentially a review and is not an interpretation of either the present Wagner bill or its predecessors.

Yours sincerely,

JOHN OPIE MCCALL, D. D. S., *Chairman.*

Senator DONNELL. Is there anything further you desire to say?

Dr. FLAGSTAD. I hope that the entire letter written will be published in the proceedings. He read a certain portion of it. I thought they solicited membership under a false pretense. They solicited membership on the fact that they had not had a democratic expression of opinion, and my contention is that they solicited membership on the fact that they believed in compulsory health insurance.

I have no argument on that philosophy. I have an argument when they accuse the American Dental Association as not being fair in its point of view.

Senator DONNELL. Thank you, Doctor.

The committee will be in recess until tomorrow morning at 10 o'clock to convene again in this same room.

(Thereupon, at 1:20 p. m., Tuesday, April 23, 1946, the committee recessed to reconvene Wednesday, April 24, 1946, at 10 a. m.)

NATIONAL HEALTH PROGRAM

WEDNESDAY, APRIL 24, 1946

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

The committee met at 10 a. m., pursuant to adjournment, Hon. Claude Pepper (acting chairman), presiding.

Present: Senators Murray, Pepper, Smith, and Donnell.

Senator PEPPER. The committee will come to order, please.

I am told that Miss Marion W. Sheahan, president of the National Organization for Public Health Nursing, Inc., is not here this morning.

The next witness is Katherine J. Densford, the president of the American Nurses' Association.

Is Miss Densford here?

STATEMENT OF KATHARINE J. DENSFORD, REGISTERED NURSE, PRESIDENT, AMERICAN NURSES' ASSOCIATION

Senator PEPPER. We will thank you to give your name and address and organization you represent; and then your statement.

Miss DENSFORD. My name is Katherine J. Densford, director of the school of nursing in the University of Minnesota, and president of the American Nurses' Association.

Senator PEPPER. We are glad to have you here, Miss Densford.

Miss DENSFORD. You would like the statement now?

Senator PEPPER. Yes, please.

THE AMERICAN NURSES' ASSOCIATION

Miss DENSFORD. The American Nurses' Association, of which I am the president, is the national membership organization of graduate registered professional nurses in this country, having a membership of over 181,000.

It has a constituent association in each of the 48 States, the District of Columbia, Puerto Rico, and Hawaii. These constituent units are composed of approximately 524 district nurses' associations. The association was organized in 1896 and has been functioning actively ever since that date for the following purposes:

* * * to promote the professional and educational advancement of nurses in every proper way; to elevate the standard of nursing education; to establish and maintain a code of ethics among nurses; * * * to disseminate information on the subject of nursing by publications in official periodicals or otherwise; to bring into communication with each other various nurses and associations * * * of nurses throughout the United States of America * * * to the end that the public may receive better nursing care.

The opinions which I am about to express do not necessarily reflect my personal views but are the opinions of the association as made known through boards of directors and other representatives of State nurses' associations.

The house of delegates of the American Nurses' Association on June 7, 1944, adopted a recommendation which favors—

The expansion of health-insurance plans and providing for nursing service, including nursing care in the home. It is believed that, in addition to voluntary effort, governmental assistance is necessary for attaining adequate distribution of health services.

In order to secure definite action regarding specific legislation on the subject of a national health program now pending before Congress, it would be necessary to present the matter to the American Nurses Association house of delegates, which will convene September 23, 1946.

The American Nurses' Association has made continuous study of all proposed legislation dealing with such matters and has, through its official publication, the American Journal of Nursing, and otherwise, kept its constituent associations and members abreast of developments.

HEALTH INSURANCE MUST INCLUDE NURSING CARE

No program of health care or of health insurance, whether voluntary or compulsory, can be considered complete unless the program includes necessary nursing care. Any such program should contain provisions adequate to insure that the nursing services rendered will be of high professional quality.

If a Federal health insurance program is adopted, the administrator, namely, the Surgeon General of the United States Public Health Service, should, of course, be a duly licensed physician, and the program relating to nursing service and nursing education should be administered through Federal and State councils composed predominantly of qualified graduate registered professional nurses.

An example of a somewhat similar Federal council may be found in sections 622 (a), 623 (b), and 633 (b) of the proposed Hospital Survey and Construction Act (S. 191) as passed by the Senate.

NECESSARY SAFEGUARDS TO NURSING EDUCATION

Any program of health care or health insurance, whether administered by Government or by any private agency, containing provisions relating to nursing education should contain safeguards to insure that such nursing education will be of a high standard and will be adequate to qualify the graduates of these nursing education programs to render competent nursing service.

The American Nurses' Association continues, as always, to be in favor of maintaining and improving the health service for all the people of the United States of America, and will continue to support all sound measures for achieving this goal.

Attached hereto are statements which are being filed by the National League of Nursing Education and the National Organization for Public Health Nursing.

Thank you, Mr. Chairman.

Senator PEPPER. Are there any questions, Senator?

Senator DONNELL. I would like to ask a few questions.

Senator PEPPER. Yes, sir; go right ahead.

Senator DONNELL. Miss Densford, you refer in the concluding paragraph of your statement to other statements which are being filed. Do you have copies of those other statements so that we might know just what those are that are being filed?

Miss DENSFORD. They are extra copies of the testimony to be presented for filing only from the National Organization for Public Health Nursing.

(The document referred to is as follows:)

STATEMENT TO BE FILED AT HEARINGS OF NATIONAL HEALTH ACT OF 1945 (S. 1606)
BY THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

I. The National Organization for Public Health Nursing is an organization that functions through 21 State branches and 350 public health nursing agencies. Its membership includes approximately 11,000 nurses and 1,000 others whose interests are intimately related to nursing.

For 35 years the chief purposes of the organization have been to develop and improve the standards for community nursing service and to expand these services to include more communities. The national office acts as a medium for the expression of nursing opinion and as a clearing house to collect and distribute nursing experience.

II. Public health nursing emphasizes the importance and value of integrated family health service. Such a service includes (a) skilled nursing care in the home to provide treatment prescribed by the physician in cases of illness and instruction to the mother or another member of the family in how to give nursing care between the nurse's visits; (b) instruction to mothers concerning the need of continuous care for themselves and their families; (c) other educational efforts such as the prevention and control of specific diseases.

III. The interest of the National Organization for Public Health Nursing in a national health program and the policy of the organization toward such a program was expressed in the following digest of resolutions adopted in 1944:

(a) There is a need for the expansion of health insurance plans to include nursing services and, particularly, nursing services in the home.

(b) There is need for a national health plan that will make nursing services available to all types of communities—urban and rural—and to all people, regardless of economic status, creed, or race.

(c) There is need for a nursing program in each community that serves to coordinate the nursing activities of all existing health agencies.

(d) To provide reasonably adequate public health nursing service a ratio of approximately one nurse to 2,000 population is needed. This standard would call for an expansion of existing personnel approximately 21,000 to 65,000 public health nurses.

(e) The pressing need of personnel requires added facilities for recruitment, training, and postgraduate education.

IV. It is in the light of the above interests and actions that the National Organization for Public Health Nursing has analyzed Senate bill 1606. For the deliberations of the committee the following pertinent facts are summarized:

(a) Nursing service is one of the essential parts of an adequate health program and should be as readily available as medical care.

(b) In applying the recommended ratio of 1 public health nurse to 2,000 people throughout the United States, variations of the ratio should be based upon the needs of each community.

(c) State or local agencies administering medical care programs should be responsible for the provision of the basic nursing services in adequate amounts and kinds by (1) employing nurses, full time or part time, on the staff of the local official agency administering the medical service, or (2) contracting with voluntary public health nursing agencies and with individual graduate nurses for the purchase of nursing care.

(d) The State agency administering medical service should be responsible for quality of nursing care whether given directly or through contract with a local agency.

(e) In the local administration of nursing services the guidance of professional and lay committees should be sought.

(f) Adequate administration of the nursing services will require adequate professional supervision of the work of the individual nurse in order to develop and maintain high standards of efficiency.

(g) Resources for specialized education in pediatric, maternity, mental hygiene, and orthopedic nursing should be established on a Nation-wide basis to prepare nurses for direct service, for consultation, supervision, and teaching. Provisions should be made for research in administration of nursing services for mothers and children, of nursing education both basic and postgraduate (including professional and practical nurses), and of techniques of nursing care. All educational projects should meet standards established by the administrative agency with the advice of national professional organizations.

(h) Preliminary to the organization and distribution of nursing services, studies in communities should be made and should determine the following: (1) the need of qualified public health nurses; (2) the need of professional nurses without public health training; (3) the need of practical nurses and other auxiliary workers. Assignment of public health and other nursing tasks to auxiliary workers should be made in order to provide efficient service at the most economical cost.

V. In presenting the foregoing the National Organization for Public Health Nursing expresses both its interest and concern. For many years the organization has expressed its continuing interest in a national health program. Its present concern is with the magnitude of the tasks that face the organization and its membership and with the positive contributions that it may make to the movement toward adequate health services for all the people.

Senator DONNELL. There are two: One by the National League of Nursing Education—

Miss DENSFORD. Yes, Mr. Chairman. The National League of Nursing Education has a place on the docket a little later in May, so that you will have the president of that organization with you at that time, and perhaps you would like to defer questions on that particular organization until the president is able to appear with you.

Senator DONNELL. Very well. Is the statement to which you refer in this concluding paragraph as being filed by the National League of Nursing Education being filed today?

Miss DENSFORD. It is being filed today; yes.

Senator DONNELL. It is being filed right now?

Miss DENSFORD. Yes.

Senator DONNELL. Do you have a copy of that?

Miss DENSFORD. There is only the copy that I believe has gone to the secretary.

Senator DONNELL. At any rate, the representative of that organization will be here in May?

Miss DENSFORD. That is right. There are representatives of that organization here this morning, but they would like, if it were convenient, to have the questioning come at the time their president is able to appear.

Senator DONNELL. Now, the statement of the National Organization for Public Health Nursing—I have now before me a copy of that. Is that organization also to have a representative here, or is that your organization?

Miss DENSFORD. No. The organization which I represent is the American Nurses Association.

Senator DONNELL. I see. Do you know if the National Organization for Public Health Nursing is to have a witness here in person?

Miss DENSFORD. There is representation from that organization here this morning, and members of that organization will be glad to answer any questions. There is no special request for appearance before the

committee by that organization, however, since the president, Miss Marion Sheahan, was unable to attend this morning.

Senator DONNELL. Now, Miss Densford, I observe that the American Nurses Association has a very large membership of 181,000.

Miss DENSFORD. Yes, sir.

Senator DONNELL. And I notice also that that organization utilizes the house-of-delegates plan of official pronouncement; is that right?

Miss DENSFORD. Yes; that is right.

Senator DONNELL. And the next meeting of the house of delegates will occur in September of this year?

Miss DENSFORD. That is right.

Senator DONNELL. The house of delegates of the American Nurses Association has not yet passed specifically on S. 1606; that is correct, is it not?

Miss DENSFORD. That is right.

Senator DONNELL. Now, you mentioned, too, Miss Densford, that the opinions which you were about to express and did subsequently express do not necessarily reflect your personal views.

Do you have any objection to giving your personal views, or would you rather confine your testimony solely to the views in your representative capacity?

Miss DENSFORD. Since I am here, Mr. Chairman, as a representative of the American Nurses Association, it might seem preferable to express opinions here only of the association, if there is no objection.

Senator DONNELL. That is all right. I will not ask for your personal opinion, if you prefer to express those of the American Nurses Association.

I observe in the action taken by the house of delegates of the American Nurses Association, June 7, 1944, it is stated:

The expansion of health insurance plans and providing for nursing service including nursing care in the home.

That does not seem to be a complete sentence. Is there some part of that sentence omitted?

Miss DENSFORD. Perhaps, Mr. Chairman, if the first part of that paragraph is read—

The house of delegates adopted a recommendation which favors the expansion of health insurance plans and providing for nursing service including nursing care in the home.

Senator DONNELL. I see that now. That is quite all right.

Now, in the next sentence it is stated: "It is believed that in addition to voluntary effort, governmental assistance is necessary for attaining adequate distribution of health services," that is also included in the official action?

Miss DENSFORD. That is right.

Senator DONNELL. I see. Tell me, if you will, Miss Densford, whether or not there is any interim organization of the American Nurses Association, such as the board of trustees, that has expressed itself with respect to S. 1606 specifically?

Miss DENSFORD. We have an interim organization, of course. Our board of directors does function, but it has not taken action on S. 1606.

Senator DONNELL. It has not. I see. Yes, ma'am. That is all, Miss Densford.

Senator PEPPER. Senator Smith?

Senator SMITH. I have nothing, sir.

Senator DONNELL. Pardon me. There is one further point I would like to question on.

Miss Densford, you mentioned in the course of your testimony that if a Federal health insurance program is adopted, "the administrator, namely, the Surgeon General of the United States Public Health Service, should of course be a duly licensed physician." That represents the views of the American Nurses Association, does it? That is from page 2 of your mimeographed statement.

Miss DENSFORD. Yes; that does.

Senator DONNELL. Yes, ma'am. I call your attention in that connection that under section 203 (a) of S. 1606, while it provides that the Surgeon General of the Public Health Service shall perform the duties imposed upon him by the act, that immediately following that statement is the language, "under the supervision and direction of the Federal Security Administrator," and so forth.

Now, the Federal Security Administrator at the present time—Mr. Miller—is not a physician, as I understand it.

Do you know if I am correct in that?

Miss DENSFORD. I believe you are correct.

Senator DONNELL. You do regard it as essential that the administration of this system, if it is to be adopted, should be under a duly licensed physician?

Miss DENSFORD. As stated in the testimony, Mr. Chairman.

Senator DONNELL. Yes, ma'am. That is all.

Senator PEPPER. Well, Miss Densford, you did not mean to say—

Miss DENSFORD. May I clarify that?

Senator PEPPER. Yes.

Miss DENSFORD. If a Federal health insurance program is adopted, the Administrator, namely, the Surgeon General of the United States Public Health Service, should be a duly licensed physician.

Senator PEPPER. That is right.

Miss DENSFORD. That is the position.

Senator PEPPER. You mean the officer in more or less direct charge of the program?

Miss DENSFORD. That is right.

Senator SMITH. Just one question. Miss Densford, does this imply that you are supporting the compulsory health insurance plan, compulsory contributions?

Miss DENSFORD. Mr. Chairman, before Senator Smith was able to be here, the statement as given here indicated that the house of delegates, on page 1 of my testimony, the house of delegates of the American Nurses Association on June 7, 1944, adopted a recommendation which favors—

The expansion of health insurance plans and providing for nursing service including nursing care in the home. It is believed that in addition to voluntary effort, governmental assistance is necessary for attaining adequate distribution of health services.

That is the only action, Senator, that has been taken by the American Nurses Association, with no specific action taken regarding any specific bill.

Senator SMITH. I see. They are not necessarily endorsing this bill but just the general principle of Government assistance to the health program?

Miss DENSFORD. The American Nurses Association has not taken action regarding S. 1606. The only action it has taken is quoted here.

Senator DONNELL. It has taken no action affirmatively in favor of compulsory health insurance?

Miss DENSFORD. Neither affirmatively nor negatively. There has been no action.

Senator SMITH. You did not take any position one way or the other? You are neither for it nor against it.

Miss DENSFORD. That is right. The Association has not taken a position either favoring or opposed. The house of delegates will meet in September of this year, which would be the earliest time that any provision could be considered by the American Nurses Association officially.

NUMBER OF NURSES

Senator PEPPER. Miss Densford, has the American Nurses Association made any calculation, if the people had adequate nursing care, to determine about how many nurses would be required to give that adequate nursing care to the people of the United States?

Miss DENSFORD. There are studies of various sorts that have been made. I should hesitate, without reviewing those studies, to answer any question directly. I would be glad to submit the information.

Senator PEPPER. Have you made any study as to how many nurses will be necessary per thousand population, or per 5,000, or 10,000 population? In other words, there should be one nurse if the people are to get adequate nursing care, and there should be one nurse for about how many people?

Miss DENSFORD. We are not in a position at the moment, I think, Mr. Chairman, to give you that information. We can tell you how many nurses there are in parts of the country in relation to the population.

Senator PEPPER. Suppose you give us that. Tell us how many nurses there were in the country before the nursing training program was developed out of the war which went into effect.

Miss DENSFORD. In some parts of the country you would have one nurse for approximately—

Senator PEPPER. In the country as a whole.

Miss DENSFORD (continuing). Three hundred population, which would go up to 1 nurse to a much larger population of thousands, and I would hesitate to quote those figures, Mr. Chairman, without having the text here.

Senator PEPPER. Is it your opinion that the people of the United States have been receiving adequate nursing care?

Miss DENSFORD. In the judgment of, I would believe, any profession, the people of no country have received adequate professional care of any particular type, whether it be nursing or any other.

Senator PEPPER. And you think that is true of the United States?

Miss DENSFORD. Yes, I would believe that is true of this country as of any other.

INCOME OF NURSES

Senator PEPPER. Generally speaking, the nurses, in order to have a decent income, charge how much a day for their service, for an 8-hour day?

MISS DENSFORD. The rate of charge varies, depending upon economic conditions within the part of the country in which the nurse is living.

Senator PEPPER. Well, what would you say ordinarily a family has to pay if they require the services of a nurse, and can get one?

MISS DENSFORD. The rate would probably range from around \$4 to \$5 to \$8 or perhaps a little more per day.

Senator PEPPER. That is for an 8-hour day?

MISS DENSFORD. In most parts of the country it would be.

Senator PEPPER. If they had to have a nurse with a patient, for example, all the time, that would be from \$15 to \$24 or \$25 for the 24-hour day?

MISS DENSFORD. Well, if a nurse were in a part of a country in which she was giving care for an 8-hour period only, it would range then from \$12 to \$24 or so, I should think.

Senator PEPPER. I know, but if it were the kind of care that would require a nurse for each of the three 8-hour periods, it would be three times the five?

MISS DENSFORD. Three times the \$4 to three times the \$8, which would range from \$12 to about \$24.

Senator PEPPER. Now, do you share in my opinion that it is almost as essential, if not as essential, for a patient to have a nurse as it is to have a doctor to get good medical care?

MISS DENSFORD. It would seem to a nurse that it is essential if the patient needs nursing care that the patient have nursing care. You could not, I believe, make a general statement, because there are conditions in which only a physician might be needed. There are others in which the physician would delegate most of the care to the nurse and other workers.

Senator PEPPER. Now, can you tell us, is it not true that the physician who is treating a patient finds it preferable and highly desirable to have a nurse as his assistant in the care of a case?

MISS DENSFORD. Generally speaking, the physician would wish to have some nursing assistance.

Senator PEPPER. And in case of a serious illness, it would be highly desirable that the physician have a nurse for his assistance in the administration of medicines and in the care of the patient?

MISS DENSFORD. That is right. That is not to say in the case of every physician taking care of a patient he needs the nurse. It would depend entirely upon the physician.

Senator PEPPER. It depends on the circumstances?

MISS DENSFORD. That is right.

Senator PEPPER. You would think, also, that it is in the public interest that home-nursing facilities, as I believe you said in your statement, and as the house of delegates said, that home-nursing services should be available to the people.

MISS DENSFORD. We should like to see, according to the statement as presented here, an extension of service.

Senator PEPPER. What you would like to see, leaving up to the public officials the matter of determining what should be the public policy, you would like to see the people of the country get adequate nursing services, including home-nursing services?

MISS DENSFORD. That is right, as stated here.

Senator PEPPER. Yes. And you would like to see the nurses of the country get a decent compensation for their services?

Miss DENSFORD. Yes.

Senator PEPPER. Well, now, do you happen to have the figures as to the number of nurses, graduate nurses and nurses in training, how that has increased during the war?

Miss DENSFORD. We can give those to you without difficulty.

It is in your folder.

Mr. Chairman, you have a pamphlet entitled "Facts About Nursing."

Senator PEPPER. Yes.

Miss DENSFORD. If you will look at page 11, I believe it is. I will have to do a little looking myself.

On page 7, Mr. Chairman, you will find a listing of the ratio of nurses to population, for which you asked a moment ago.

Senator PEPPER. Yes.

Miss DENSFORD. One nurse to 357 people in 1940.

Senator PEPPER. One nurse to 357 people in 1940; yes.

Miss DENSFORD. And 1 to 416 in 1930. And 1 to 708 in 1920; 1 to 1,116 in 1910; 1 to 6,389 in 1900.

Senator PEPPER. Well, we have improved considerably in furnishing nurses' services to the people since 1900, have we not?

Miss DENSFORD. Yes. You asked for the increase in numbers of nurses, total number. The total number of nurses classified June 30, 1945, in the United States, was 283,895.

Senator PEPPER. Now, that is 1945?

Miss DENSFORD. That is right.

Senator PEPPER. Do you happen to have the number in 1940?

Miss DENSFORD. I did not come with the Census Bureau, but I will be glad to look. On page 7.

Senator PEPPER. That is right. You have that there?

Miss DENSFORD. You will find the total number as 371,066.

Senator PEPPER. And did you have more nurses in 1940 than you did in 1945?

Miss DENSFORD. The one that I gave you in 1945 was the total number that we had classified by the procurement and assignment service.

Senator PEPPER. That was not the whole number, was it?

Miss DENSFORD. No; probably not.

Senator PEPPER. As a matter fact, was not an immense nursing training program carried on during the war in order to provide additional nurses, especially for the armed services?

Miss DENSFORD. Yes.

Senator PEPPER. And for the country?

Miss DENSFORD. Yes.

Senator PEPPER. It was my impression that we must have a considerably larger number of nurses now than we had before the war. Do you not think that is true?

Miss DENSFORD. Quite.

Senator PEPPER. My thought was that I doubt very seriously whether or not that these worthy people who have been trained to be nurses for the people of the country, and who are capable of rendering very necessary and very important medical service to the people, unless

there is some far more comprehensive plan of affording medical care to the people, they will probably have to drop out of this profession for which they have been so recently trained, because I assume that there would have been more nurses before the war if there had been more need for nursing services, if people could have paid for them; so I was wondering if it is not an argument in favor of a more complete system of medical care for the people than we now have, that we not let these newly trained nurses now qualified for nursing service, not have them drop out of the profession, but we try to keep them and make it possible, no doubt, for more to come in and give more nursing care to the people of the country.

MISS DENSFORD. There are other factors, Mr. Chairman, such as public health nursing, which has already set up a ratio of need of 1 nurse to 2,000 of the people, and there are other factors in the care of special types of illness, as psychiatry, venereal disease, and so on, which will, we believe, increase the numbers of nurses needed.

Testimony regarding the need in the latter two fields will come when the president of the National League of Nurses is able to appear before you.

I would like to ask here, Miss Fisher of the National Organization for Public Health Nursing, she might wish to make some comment regarding the public health ratio of the personnel, if the Chairman so wishes.

SENATOR DONNELL. Mr. Chairman, before Miss Fisher does so, might I have the liberty of asking a few further questions, after you finish your interrogation?

SENATOR PEPPER. Surely. I just wanted to make it clear that the nurses association believes that the people of the United States should have more nursing service than they are now getting, including home nursing service that is not now being afforded in a necessary amount.

MISS DENSFORD. That would, I am sure, be accepted by the profession.

SENATOR PEPPER. Thank you.

SENATOR DONNELL. Miss Densford, I wanted to return for a moment to the action of the House of Delegates on June 7, 1944, and I think there was then pending S. 1161, which was the Wagner-Murray-Dingell parent bill, going back of S. 1050 to 1161 also.

Do you know whether or not the House of Delegates passed on 1161?

MISS DENSFORD. The House of Delegates did not pass upon any specific legislation, Mr. Senator.

SENATOR DONNELL. Yes, ma'am.

One other question: In the action of the House of Delegates, it says: "The expansion of health insurance plans" et cetera. At the time of that action, June 7, 1944, there was extensive voluntary health insurance throughout the country, Blue Cross, et cetera, was there not?

MISS DENSFORD. That is right.

SENATOR DONNELL. And some of that, at any rate, referred to nursing, did it not? That is to say, to health insurance voluntary plans, they included certain nursing items, did they not?

MISS DENSFORD. In rather small measure, I would judge, Senator.

SENATOR DONNELL. But there was some of it. And your association favored the expansion of health insurance plans as indicated in this quotation?

Miss DENSFORD. That is right.

Senator DONNELL. I quote:

The expansion of health insurance plans—

There was no mention in either this resolution or any other resolution of your House of Delegates of compulsory nursing service or compulsory health insurance? That is right, is it not?

Miss DENSFORD. There was no action taken regarding any specific type of legislation.

Senator DONNELL. And particularly no action taken either affirming or to the contrary with respect to compulsory health insurance? I am right, am I not, in that?

Miss DENSFORD. Neither compulsory nor voluntary. Neither for nor against.

Senator DONNELL. Neither for nor against compulsory insurance?

Miss DENSFORD. That is right.

Senator DONNELL. Now, Miss Densford, today under our prevailing practice, if a person becomes ill, who is the person that decides on nursing service, whether or not it should be given, and the extent of that nursing service; does the doctor ordinarily make that decision?

Miss DENSFORD. In most instances.

Senator DONNELL. In most instances. Yes, ma'am.

Now, I observe in this bill, S. 1606, at page 58, paragraph 210 (b), it is provided that—

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—

so that under this bill, instead of the local physician, the physician at home, determining it, the decision rests with the Surgeon General. You are familiar with that provision, are you not?

Miss DENSFORD. Yes.

Senator DONNELL. And then I call your attention further on the same page to this language, quoting at lines 21 and following:

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.

I call your attention, Miss Densford, to the fact that as distinguished from our present-day practice, where in large part the physician attending the patient decides the content of nursing services to be rendered, this act would undertake to vest that authority, under the provision I have read, in the Surgeon General of the United States.

You are familiar with this provision, are you not?

Miss DENSFORD. I have read the bill and I am familiar with it.

Senator DONNELL. Yes, ma'am. Let me ask you this: Under this bill as pointed out earlier in my questioning to you, while it is provided in 203 (a) that the Surgeon General shall perform the duties imposed upon him by the act, it is distinctly stated that it shall be "under the supervision and direction of the Federal Security Administrator."

I want to ask for your personal opinion, if you are willing to give it: Do you regard it as advisable that in the first place such extensive powers as I have indicated with respect to nursing benefits shall be transferred from the attending physician up to the Surgeon General or his deputy, and in the second place, if it is advisable that it be vested in him, or if it seems most practical to do that, is it advisable, in your judgment, that he shall, in turn, in the administration and determination of those questions as to what home-nursing benefit shall be given, shall be under the supervision and direction of a man who does not have to be a physician; namely, the Federal Security Administrator?

Do you regard that as advisable?

Miss DENSFORD. Mr. Chairman, the Senator has posed some very pertinent questions. It rather seems to me, however, if it meets with your approval, that one can hardly express a personal opinion regarding those. The association which I represent, and that is the only association for my being here—

Senator DONNELL. Yes, ma'am.

Miss DENSFORD. Has not taken action either in favor of such a policy or in opposition to it.

Senator DONNELL. I see. Yes.

Miss DENSFORD. And it would not seem that I could officially speak.

Senator DONNELL. That is all right, Miss Densford; I can appreciate your position on that matter. That is all, Miss Densford.

Senator PEPPER. Miss Densford, Senator Donnell has called your attention, on page 58 of the pending bill, to the authority of the Administrator to limit in a practical way the quantity and volume of home nursing service. Now, you realize that the effect of that language is a matter of interpretation. But you understand that the two provisions are set into the context of a bill, which is trying to make medical, dental to a degree, and nursing care as fully as it may be provided, available to as many people in the United States as possible, and that there is a limit to the number of nurses who are available for home services, and if you had a limited number of nurses and you had nursing care by some kind of financial arrangement available to everyone who needed it, that it might be necessary for the Administrator to limit, according to some general principles, after consultation with his advisory council, to limit the number of nurses serving in the home to certain kinds of cases, certain types of patients, maybe certain sorts of illness, maybe have certain general limitations of time. You can understand why the law would give authority to an Administrator to impose such practical limitations as that, can you not?

Miss DENSFORD. The comments are pertinent also to this situation.

Senator PEPPER. Very well.

Miss DENSFORD. And the bill and our consideration of it by the American Nurses Association.

Senator PEPPER. I quite understand your desire to confine your testimony as the house of delegates did, to a statement that there is a need for greater medical care than the people are now getting, and a need for more home nursing service than the people are now getting, and you are leaving it up to such as the Senators here and other Members of Congress to determine the manner in which that medical care shall be provided. Is that not correct?

Miss DENSFORD. At present.

Senator PEPPER. Do you recall that during the years 1932 and 1938 there were many nursing schools in the country closed down because of unemployment among nurses in practice.

Miss DENSFORD. Mr. Chairman, there would be many factors that would contribute to that situation, and as I have said, the president of the National League of Nursing Education, which is concerned primarily with the education of nurses and with the development of schools and the guidance of program of preparation, both for graduate nurses and undergraduates, will appear before you, and I would believe that you might prefer having an answer to the questions having to do with the educational program come from her.

Senator PEPPER. Very well. Are you aware of the fact that of all the private plans that are in effect now by the voluntary method to give insurance coverage, that of the people who are covered by these voluntary insurance plans, only 44.2 percent are eligible to receive home-nursing service?

Miss DENSFORD. I had not known the exact percentage. I am glad to have that figure. Thank you.

Senator PEPPER. Thank you so much.

Senator DONNELL. Pardon me. By your response to Senator Pepper's question as to leaving it up to the Congress to determine the method of extension of nursing care, I take it you are not expressing an opinion either for or against compulsory health insurance. Am I right in that?

Miss DENSFORD. That is right; either in favor of or opposed to.

Senator PEPPER. There is one other set of figures I would like to call your attention to, which this committee disclosed in connection with an examination of the Fair Labor Standards Act: that of the people in all communities of the country, of the people who are on relief, only 1.2 percent of them received private nursing care, and 11.8 received any visiting nursing care at all.

In the income group of less than \$1,000, 2.9 percent received any private nursing care, and 6 percent receiving visiting nursing care.

Between \$1,000 and \$2,000, 3.9 percent received private nursing care, 6 percent received visiting nursing care.

Between \$2,000 and \$3,000 annual income, 6.4 percent private nursing care, and 4.6 percent visiting nursing care.

From \$3,000 to \$4,000 annual income, 9.2 percent received private nursing care, and 3.3 percent received visiting nursing care.

Of \$5,000 or more, 16.6 percent received private nursing care, and 2.7 percent received visiting nursing care.

Now, they tend to indicate that at the present time and under the present system that people who get nursing care, especially private nursing care, which I consider of the more desirable character, that it is the people with the higher income that get the private nursing care rather than the people in the lower income group.

Miss DENSFORD. There is a correlation between the care and the provisions.

Senator PEPPER. All right. Thank you so much.

Senator DONNELL. May I ask you, Senator Pepper, to read into the record, please, the date at which these statistics you read applied and existed.

Senator PEPPER (reading):

Source: Britten, R. H., Collins, S. D., and Fitzgerald, J. S., United States Public Health Service, Public Health Reports, Washington, D. C., volume 55, No. 11, March 15, 1940, pages 444-470. (Based on data from the National Health Survey 1935-36.)

Senator DONNELL. I wanted to make it clear that that was 1935-36 data on which these figures were based.

Senator PEPPER. Yes. That is correct.

Miss DENSFORD. Mr. Chairman, I wonder if I might have the privilege of submitting the figures for which you asked and have them included in your report.

Senator PEPPER. We would be very pleased to have them. Thank you.

(The figures and information referred to are as follows:)

STATEMENT OF RUTH SLEEPER, PRESIDENT, NATIONAL LEAGUE OF NURSING EDUCATION ON S. 1606 BEFORE THE SENATE COMMITTEE ON EDUCATION AND LABOR

In principle the concerns of the National League of Nursing Education are those expressed in S. 1606—the promotion of health, the prevention of disease, and the proper care of all persons of all ages when ill. In actual functioning the National League of Nursing Education is a nursing education for nursing service association. Its major activities have included:

1. Development and promotion of standards for all types of nursing education.
2. Operation of a program of accreditation for undergraduate professional schools of nursing.
3. Operation of a testing service for nursing education and nursing service counseling.
4. Promotion of a consultation service on all phases of nursing education.
5. Studies related to nursing education and nursing service.

The National League of Nursing Education has 8,950 members with representation in 47 States, District of Columbia, Alaska, Hawaii, and Puerto Rico.

It is desired to make clear the specific interests of the organization I represent in the legislation proposed in S. 1606. These interests are concerned with the technical and educational aspects of the bill as they relate to the training of qualified nursing personnel. The National League of Nursing Education therefore asks the privilege of presenting, in relation to such training, certain facts of fundamental importance in the administration of a national-health program as outlined in S. 1606 in the event that this bill becomes law.

There are, at present, approximately 1,300 State-accredited professional schools of nursing in 47 States and the District of Columbia. In relatively few States is training in either tuberculosis nursing or venereal disease nursing required or recommended in order to take the State licensing examinations to practice as a registered professional nurse. Twenty-two percent only (286) of the 1,300 schools offer tuberculosis nursing experience. This means that of the approximate 32,000 students who will be graduated from schools of nursing in 1943, only about 7,000 will have had any experience in the nursing care of tuberculous patients.¹

The number of professional nurses needed in tuberculosis hospitals and sanatoria in order to provide a good quality of nursing care was recently estimated as 14,500.² Although an approximate 7,000 nurses who have had tuberculosis training will be graduated during 1946, it cannot be expected that even half of them will enter the hospital tuberculosis field.

The discrepancy between tuberculosis nursing needs and the number of nurses who have had instruction and training in that field is due to a multiplicity of causes. A major cause is the lack of the proper facilities, instructional and physical, which are essential to teach good tuberculosis nursing and to safeguard students' health.

¹ Unpublished study, National League of Nursing Education, 1946.

² Estimate made (March 1946) by Department of Studies, National League of Nursing Education, and Esta McNett, Assistant Director, Nurse Specialist in Tuberculosis Nursing Division, Veterans' Administration, Washington, D. C.

Less specific information is available on the needs and resources for venereal disease nursing. It is safe to say that the number of nurses who have had training in the care of venereal-disease patients will be considerably smaller than the number who have had training in tuberculosis nursing.

In maternity nursing and nursing of children every professional graduate nurse will have had some kind of training, since such training is a requirement for admission to the State licensing examinations. But unfortunately in many State-accredited schools of nursing, both the maternity experience and the experience in the care of children are too narrow in scope to prepare nurses to fulfill the nursing responsibilities contained in S. 1606. Specifically, in a large number of schools, the training in maternity nursing is limited to the hospitalization period of mothers and does not include prenatal nursing or post partum nursing after the mother leaves the hospital, which are important health services in the maternity cycle. Evidence in support of this statement is the fact that 48 percent, or 624, of the 1,300 schools report that their students receive outpatient experience, the field which large provides prenatal and post partum experience.³

The limitations of the training for the care of children are not unlike those of the training for maternity nursing. In too many undergraduate schools the nursing of children is narrowed to the hospitalization period. As indicated in the preceding paragraph, only 48 percent of the schools provide outpatient experience, and it is in the outpatient clinics where students have the opportunity to participate in well-baby and preschool clinics. Only two-fifths of the schools give their students training in acute communicable disease nursing, an important phase in the preparation for the care of children.³ The number of schools which provide experience in the nursing care of either premature infants or crippled children is not known. It is probable that the number is small for both services. A sound training in the nursing of children should provide for an understanding of their emotional, mental, and spiritual needs as well as the knowledge and skills required for their physical care during illness.

The reason for the inadequate professional undergraduate training in many schools of nursing is deep rooted. Fundamentally, it is economic. There are relatively few schools of nursing controlled by educational institutions (less than 50). The remaining 1,250 are hospital-owned schools. As such, they provide service for the hospital, and in providing this service, it is by no means always possible to prepare the student for the broad nursing functions which are implicit in the national-health program of S. 1606. Student service and its economic relationship to the hospital are discussed in exhibit 1.

Professional graduate nurses, realizing the inadequacies of their undergraduate nursing education, have sought and are seeking to enlarge and enrich it by post-graduate nursing work. But the programs which provide special kinds of clinical training for graduate nurses are exceedingly limited, one reason being the lack of qualified instructional personnel and another the lack of proper field facilities. Moreover, the expense of operating these programs is prohibitive without financial aid from sources outside the institution.

The picture I have presented to you on nursing education, both undergraduate and graduate, reveals the major weaknesses of the system. There are undergraduate schools of nursing operated on a high educational level, but they are too few. More programs soundly conceived are needed for graduate nurses.

The estimated 14,500 professional nurses needed to staff tuberculosis hospitals and sanatoria in the United States include 2,189 for supervisory positions (p. 1). In December 1945, similar data were compiled for maternity nursing and nursing in the care of children. It was estimated that approximately 7,000 professional nurses are needed to instruct students in maternity nursing and to supervise the care of maternity patients; that 3,500 professional nurses are needed for teaching and supervising the nursing care of children.⁴ There are indications that the shortages that were reported in supervisory and teaching positions during the war are continuing—though exactly how the supply of personnel, in numbers and in quality, differs from the needs is not known and is difficult to ascertain.

During the school year 1945-46, enrollment of professional graduate nurses reported for advanced or supplementary work in clinical nursing specialties was as follows: In tuberculosis nursing, 5 institutions reported an enrollment of 36 students; in venereal-disease nursing, 1 institution reported 7 students; in ma-

³ Unpublished study, National League of Nursing Education, 1946.

⁴ Estimates made (December 1945) by department of studies, National League of Nursing Education, collaborating with the Nursing Unit, Children's Bureau, U. S. Department of Labor, Washington, D. C.

ternity nursing, 15 institutions reported 152 students; in nursing in the care of children, 13 institutions reported 144 students; in medical nursing, 13 institutions reported 282 students; and in surgical nursing, 14 institutions reported an enrollment of 343 students.

With your permission, I should now like to discuss methods for strengthening professional nursing standards in order that nursing may function most effectively in the administration of S. 1606, should the bill become law. These methods involve the development and expansion of nursing education programs by the use of grant-in-aid funds for special educational and research projects and scholarships, and by the utilization of national nursing organizations, educational and nursing service institutions, and agencies for these several purposes.

Fundamental to the improvement in the training of students, both undergraduate and graduate, in all branches of nursing is the extension and development of clinical practice fields and the securing of qualified administrative, instructional, and supervisory personnel.

Since title I and title II both provide for the training of additional nursing personnel in order that such personnel be available for the more extensive health services proposed in S. 1606, special studies or projects which should be carried on are listed below. Some work has already been begun on all of these projects by the national professional nursing organizations; more should and would be done were the necessary funds available.

1. Survey of clinical facilities to determine their suitability as practice fields for training both undergraduate and graduate nursing personnel.

2. Curriculum studies related to the training of undergraduate nurses and especially to the training designed for graduate nurses.

3. Expansion of the present existing programs on accreditation of professional nursing schools.

4. Expansion of testing services—those for use of schools of nursing, State boards of nurse examiners, and merit systems.

5. Intensive and comprehensive studies of nursing service, both as related to quality and quantity of nursing care.

6. Survey of present personnel policies and practices in nursing education institutions and nursing services to determine how such can be improved.

7. Surveys basic to estimating the numbers of graduate nurses needed in hospitals and other institutions, clinics, public-health agencies, and nursing education programs—such surveys to be made in terms of different types of personnel.

8. Extension of the recruitment program for all types of well-qualified nursing personnel needed in a national health program.

Throughout the bill S. 1606, reference is made to standards for training personnel. Such standards, we believe, should be secured direct from the appropriate professional nursing-education organizations. If these organizations do not have the standards that are indicated, then it is urgently important that grants-in-aid be made to the appropriate professional organizations, as well as to the appropriate educational institutions and nursing-service agencies—Government and the student who should meet the requirements of the institution.

The National League of Nursing Education believes that all scholarships should be arranged, insofar as possible, directly between the educational institution and the student who should meet the requirements of the institution.⁵

In order to meet current as well as future Nation-wide service demands, it is essential that:

1. Grants-in-aid be provided to selected institutions to improve clinical courses in undergraduate nursing education.

2. Grants-in-aid be provided to improve, expand, and develop new programs for graduate nurses who are preparing to become teachers or administrators in schools of nursing and administrators or supervisors in all types of nursing services.

The league also believes that, in general, all grants-in-aid for special research projects in nursing education and nursing service to national professional organizations, educational institutions, and nursing service agencies should be granted through direct allocation to the institution or agency concerned and not through a State health department.⁵

Since nurses are essential in large numbers to the operation of the provisions of S. 1606, it would be most important that:

1. Appropriate nurse representation be included in every proposed advisory council—Federal, State, and local.

⁵ This principle has been approved by the National Nursing Council. See exhibit 2.

2. Such nurses be proposed by the appropriate National, State, or local professional organizations.

3. Preparation of these nurses be such that each can interpret the needs for nursing service and nursing education, both undergraduate and graduate, in their respective fields.

4. Nursing regulations in the specific fields be safeguarded by providing that each nurse representative on a council have the advice and support of an advisory technical committee composed of nurses.

While the intent of part A of title I, grants to States for health services, is clear, we venture to suggest that part A apply not only to nurses in the public-health field but to nurses in hospitals and sanatoria operating tuberculosis or venereal disease nursing services and also to nurses in educational institutions designed for the preparation of undergraduate nurses and graduate nurses in these two specific fields.

Other amendments we desire to present are the following:

Page 41, line 24, delete the word "medical" and substitute the word "health." The same revision should be made wherever reference is made to the National Advisory Medical Council.

Page 45, lines 2 and 3, delete the words "legally qualified" and substitute the words "meeting requirements in regulations for administration of act as proposed by representatives of the appropriate national nursing organizations on advisory council."

Page 64, line 21, insert after the words "dental practitioners" the words "or nurses."

In conclusion, may I say again that the National League of Nursing Education is deeply concerned with the implications for nursing contained in S. 1606, should this bill become law.

EXHIBIT 1

ECONOMIC IMPLICATIONS OF S. 1606 WITH REFERENCE TO HOSPITAL NURSING AND NURSING EDUCATION

In a comprehensive national health program, such as proposed in S. 1606, which emphasizes standards of service and well-trained personnel to make effective these standards, there are economic factors in hospital nursing which merit review and deliberation.

Section 204 of title II specifically refers to "standards to apply to participating hospitals" (p. 44, line 8) and "studies and surveys of personal health services and of the quality and adequacy of such services" (p. 44, lines 14 and 15). One highly important factor in the rendering of service in a hospital is that of nursing. A good quality of nursing requires a well-trained personnel with enough nursing time to make it possible to give good care.

Since the intent of the bill appears to be to provide service of good quality, provision for sufficient nursing time becomes of paramount importance. Has such provision been given its due consideration in the prescribed remuneration method for hospitalization as outlined on page 68, lines 2-9? Or would some other remuneration arrangement, such as payment of actual costs per diem care as stated by each hospital and as evidenced by an accounting system agreed upon by the administering agency and the hospital, safeguard more effectively the quality of the nursing care the patients receive and the health of the nursing personnel?

The policy of a 48-hour week has been pretty well established for graduate nurses¹ and also for student nurses, although there are schools of nursing in this country which, as late as January 1, 1946, reported student schedules of 60 hours or more weekly, exclusive of classes. One of the inevitable results in a hospital where the expense incurred for patient care exceeds the payment received for that care is the lengthening of the weekly hour schedule of the nursing personnel. The seriousness of this practice, both in relation to the quality of care received by the patients and the physical fatigue imposed on the nursing personnel, was pointed out in a nursing time study carried on in Bellevue Hospital, New York, N. Y.²

¹ Personnel Practices for General Staff Nurses, American Nurses' Association, New York, 1944.

² B. Pfefferkorn and M. Rottman, Clinical Education in Nursing, The Macmillan Co., New York, 1932, p. 55.

More than 1,300 of the 6,600 hospitals in this country either operate or are connected with professional schools of nursing. In these hospitals—where approximately half of all the patients in non-Federal general hospitals are cared for—student nurses provide by far the major proportion of the nursing care.

Exactly how much of the nursing service in the Nation is student service is not known. But since there are now approximately 135,000 nursing students, with about 80 percent of this number providing from 24 to 48 hours, or even more than 48 hours, of service weekly, it is an incontestable fact that students provide a considerable bulk of the hospital nursing care given to patients. While the dollar value of this service has never been estimated on a national scale, the following data may give some indication of the economic value of student service to hospitals.

In a comprehensive study of methods for analyzing nursing education and nursing service costs, these costs were studied in three hospitals, all three of which conducted their own schools of nursing. These three schools were generally regarded as good schools. In one of them the annual net contribution per student, in terms of nursing service rendered to the hospital, was \$41.81, in another \$81.35, and in the third \$241.40. The total net contribution by these schools to their respective hospitals in student service for the year was \$2,675.86; \$10,250.81; and \$21,146.13, respectively. These contributions were over and above any expense incurred by the hospitals in the conduct of their schools.³

It is not intended to imply that every one of the 1,300 professional schools of nursing represents a financial asset to its associated hospital. Much more extensive analyses would be needed to support such a statement. But from the evidence available, it is likely that the majority of schools of nursing make definite economic contributions, varying in amount and depending on the educational program offered, to their associated hospitals.

To summarize briefly: In a national health program which emphasizes standards of service and well-trained personnel, financial provision should be made for enough nursing time to safeguard patient care and to assure reasonable hour schedules for the nursing personnel. Because so large a proportion of nursing service is provided by students, the economics of undergraduate student service and its relation to their total training for a broad community service is a matter which well deserves attention in a national health program of the sweeping dimensions proposed in S. 1606.

EXHIBIT 2

EXCERPTS FROM THE STATEMENT OF THE NATIONAL NURSING COUNCIL ON BASIC POLICY IN REGARD TO FEDERAL AID TO NURSING EDUCATION,¹ JANUARY 21, 1946

Nursing is a profession essential to the health and well-being of citizens of the United States, yet the burden of the education of nurses has traditionally been left largely to private institutions. For the most part, young women who wished to become nurses have paid their tuition partly in cash but chiefly in service to the hospital while their schooling was in progress. War pressures for unprecedented numbers of nurses brought about establishment of the Division of Nurse Education in the United States Public Health Service with its extensive scholarship aid both for basic and advanced nursing education and formation of the United States Cadet Nurse Corps. Public Law 74 under which the United States Cadet Nurse Corps is administered is a war measure. The aid it affords will cease when students admitted before October 15, 1945, have completed their courses.

Sweeping changes are needed in many schools of nursing to make of them genuine educational institutions.

² Administrative Cost Analysis for Nursing Service and Nursing Education. A study sponsored by the American Hospital Association and the National League of Nursing Education in cooperation with the American Nurses' Association. 1940, p. 103.

¹ Member organizations of the National Nursing Council are: American Nurses' Association, National League of Nursing Education, National Organization for Public Health Nursing, Association of Collegiate Schools of Nursing, National Association of Colored Graduate Nurses, American Red Cross Nursing Service, Council of Federal Nursing Services, International Council of Nurses, Division of Nursing—U. S. Public Health Service, American Hospital Association, National Association for Practical Nurse Education, American Medical Association, Nursing Unit—U. S. Children's Bureau, American Association of Industrial Nurses.

SCHOLARSHIPS

Scholarships should be arranged so far as possible directly between the educational institution and the student who should meet requirements of the institution.

Such scholarships should be arranged:

1. For qualified students in basic professional nursing education in schools which meet criteria set by appropriate national professional nursing organizations.
2. For qualified students in advanced programs in universities and colleges where programs and courses meet criteria set by appropriate national professional nursing organizations.
3. For qualified students in practical nurse education in schools which meet criteria set by appropriate national nursing organizations.

GRANTS

Grants should be made:

1. To universities and colleges for development of advanced programs in nursing education which meet criteria set by appropriate national professional nursing organizations. It is especially important that facilities be developed in certain clinical fields such as tuberculosis, pediatric, and psychiatric nursing including mental hygiene and also for administrative, supervisory, and teaching positions in educational institutions and nursing services.
2. To schools of basic professional nursing education only if selection of schools is based on criteria set by appropriate national professional nursing organizations.
3. To schools of practical nurse education only if selection of schools is based on criteria set by appropriate national nursing organizations.
4. For research and experimentation in nursing as it relates to education of professional and practical nurses, carried on either by a Government agency administering the Federal-aid program or by allocation of funds to national professional nursing organizations and to educational institutions.
5. To make possible the assignment of Federal nursing education personnel for furtherance of studies and demonstrations and educational program development.
6. For promotion of nursing education in geographic areas where there is special need and local funds are limited; these special grants to be distributed at the discretion of the Federal administering agency to educational institutions and agencies which meet criteria set by appropriate professional national nursing organizations.

ADVISORY COMMITTEE

In the administration of all these programs it is believed that an advisory committee should be formed with representatives recommended by the appropriate professional nursing organizations.

[American Journal of Nursing, December 1943, p. 1061, vol. 43, No. 12]

HEALTH INSURANCE STUDIED BY ANA

American Nurses Association headquarters is a busy place. As announced elsewhere, the association has just published a study of organization, control, and financing of nurses' professional registries. It is an opportune moment, as it may be assumed that registry boards and committees are making plans for the time, sooner or later, when the armed forces will no longer need so many nurses.

The article on page 1066 is based on data collected, tabulated, and analyzed in the American Nurses Association office for the men nurses section.

An outline of the Status of Nursing in Relation to Health Insurance has just been released to the members of the American Nurses Association and National Organization for Public Health Nursing committee to study health insurance, and to the headquarters of State nurses associations and State presidents. It will undoubtedly stimulate further study. To quote from the outline, health insurance means:

"The provision of curative care in illness through insurance (or prepayment plans) and this may include any or several of the following: services of a physician; hospitalization; medicines; surgery; appliances, such as casts, braces, et cetera; use of x-ray and/or other mechanical equipment for treatment or tests; and services of the pathological laboratory."

Nurses are interested in health insurance from two diametrically opposite points of view, viz, as consumers and as practitioners who may be called upon to render some part of the service required by other consumers. The nurse as consumer, it will be recalled, was discussed in some detail in relation to group hospitalization plans by C. Rufus Rorem in the July 1941 Journal.¹ The participation of private (special) duty nurses in programs for providing care for patients was discussed briefly, but negatively.

The concept of provision for nursing care through the application of the insurance principle is by no means new. It goes back to the initial experiment of the Metropolitan Life Insurance Co., in 1909. At the present time, to quote again from the American Nurses Association Outline.

Some 70 companies offering health and accident policies issue a variety of policies which provide for nursing care in full, in part, or in lieu of hospital costs or surgical fees and with other provisos.

The Outline points out that studies of health insurance have been made by American Nurses Association committees at intervals since the initial one in 1917. They seem to parallel major activities in the general field of social insurance. An American Nurses Association committee was set up in 1935. This was the year the Social Security Act was adopted, an event which was followed, successively, by the National Health Survey and the National Health Conference. The American Nurses Association and National Organization for Public Health Nurses merged their interests and formed a joint committee in 1936 and the committee prepared a study guide on health insurance in 1937. In 1941 a study of the functioning of health insurance plans was made. Special effort was made to secure information on provisions for special duty nursing. Further data were secured in July of this year. The outline points out that with some 70 types of insurance or prepayment plans (including that provided by the Harmon Association for the Advancement of Nursing):

Insurance or prepayment plans to cover illness in varying degrees should be available to the majority of nurses.

The second conclusion is:

Provision for special nursing under prepayment plans is apparently not feasible on an actuarial basis at the present charges made for most prepayment health insurance plans.

Presumably a plan to provide special duty nursing could be set up on a sound actuarial basis, but the costs would make the service unattractive and the complexities of special duty nursing would create very difficult administrative problems:

[Reprinted from the American Journal of Nursing, vol. 44, No. 12, December 1944]

IS PREPAID NURSING CARE POSSIBLE?

Nursing service in prepayment medical care organizations

By Margaret C. Klem*

Many nurses, recalling the lack of employment opportunities in the 1930's are asking, "What of the future?" what are the prospects of individual security when the war ends and the thousands of nurses newly trained to meet war needs are demobilized from service with the armed forces? How many registered nurses can earn an adequate living in the United States?

¹ Rorem, C. Rufus: Nurses and Hospital Service Plans, American Journal of Nursing, vol. 41, p. 783 (July) 1941.

*Miss Klem is Chief, Medical Economics Section, Bureau of Research and Statistics, Social Security Board, and the author or coauthor of many articles and reports in the field of medical nursing, and health economics. Her most recent article for the Journal, Who Purchase Private Duty Nursing Services?, appeared in October 1939. The opinions expressed in this article are those of the writer, and do not represent the official views of the Social Security Board.

On good authority, much of this apprehension is unfounded. According to Dr. Mountin,¹ there never has been a true surplus of nurses. He estimates that approximately 485,600 full-time graduate nurses will be needed to serve the country's probable postwar population of 138 million; and that by the end of 1946, after allowing for withdrawals, probably not more than 300,000 nurses will be engaged in active practice. In spite of the war-accelerated program of nursing education, the number of available nurses will thus fall far short of the estimated need.

When the war ends, doubtless many nurses overseas will remain abroad and help in the postwar rehabilitation programs of foreign public health departments. A greatly increased demand for public health nurses is anticipated in this country also. The public health field will, therefore, afford jobs for a large number of nurses—perhaps twice as many as are now engaged in this type of work.² "A better and wider distribution of graduate nurses" is anticipated in other fields of service. Also, private duty nursing in hospitals will probably be replaced to a great extent by general staff nursing service. "We may expect for the registered nurse greater economic security than in the past."³

Another widening field for nurses, as well as service to the public, is in full-time employment of nurses with prepayment organizations furnishing hospital and medical care. Hospitalization plans in general are increasing their benefits to members and will, perhaps, include special nursing care in hospitals. Prepayment medical care organizations which have employed visiting nurses speak highly of the value of their services. It seems probable that had it not been for the wartime shortage of nurses, many more of these organizations would have utilized their services.

The nursing profession has had a long-standing interest in prepayment medical care plans—both as prospective members of such plans and as workers in the health field. As far back as 1917, American Nurses Association committees were studying health insurance and its possible effect upon the profession. In 1936, the American Nurses Association and the National Organization for Public Health Nursing united their activities in this field and formed the joint committee of the American Nurses Association and National Organization for Public Health Nursing to study health insurance and its implications for nurses. In 1941, this joint committee made a detailed study of health-insurance plans, with special emphasis on provisions for special duty nursing. The general conclusions of the study were summarized as follows:

"Routine nursing service by the general staff in a hospital is the usual nursing care at present provided to subscribers of prepayment plans for medical care and hospitalization. Services of special private duty nurses in the hospitals are provided by a few associations if the physician in charge of a patient deems such service necessary."

In the same year, a statement on health insurance prepared by the joint committee and approved by the boards of directors of the American Nurses Association and the National Organization of Public Health Nursing declared that nursing service was a necessary part of any comprehensive medical-care program.

Two years later, the joint committee pointed out that a plan including special nursing care might be set up on a sound actuarial basis, but that the necessary additional cost might prevent general acceptance of such service. In the committee's opinion, a war period might not be the most propitious time to attempt an experiment including special nursing care, but nurses should familiarize themselves with the plans providing care for the sick.

CURRENT EXPERIMENTATION

Today the nursing organizations are more interested in action than in continued study. The Joint Committee of the American Nurses Association and National Organization Public Health Nursing on prepayment plans for health services has replaced the joint committee to study health insurance and its implications for nursing. Principles of a suggested program in which nursing

¹ Mountin, Joseph W.: Suggestions to Nurses on Postwar Adjustments, *American Journal of Nursing*, vol. 44, p. 321 (April), 1944.

² Bryan, Leah Blaisdell: Problems in Public Health Nursing Education, *Public Health Nursing*, vol. 36, p. 448 (September), 1944.

³ Folendorf, Gertrude R.: What of Nursing in 1950?, *Modern Hospitals*, vol. 61, p. 67 (September), 1943.

services may be added to existing health or hospital or medical insurance plans have been approved. The program would provide all types of nursing service when it is most needed; that is, special private nursing service in the hospital or in the home for a serious condition or for illness requiring continuous nursing care and a visiting nurse service in the home for a condition or illness requiring part-time skilled nursing care.⁴ The services proposed for inclusion in the contract are as follows for each individual covered: A maximum of 12 visits of 1 hour each in the home by a visiting nurse, and 9 periods of 8 hours each of special private duty nursing service in the hospital or home. The organization would pay \$1.25 for each visit by a visiting nurse, and \$5 for each 8-hour period of special private duty service. The total expense of these two services should not exceed \$60 per year for each individual. The cost of such service is estimated at approximately 40 cents a month for each individual subscriber and 90 cents a month for each family.

Some consideration is being given to the suggestion that the subscribers pay for the first nursing visit in the home and for the first three periods of special nursing service, after which the organization would pay the cost up to the \$60 maximum. It is recognized that some procedure must be established to limit the prenaid nursing service to the medical requirements rather than the wish of the patient.

SURVEY OF PREPAYMENT MEDICAL CARE ORGANIZATIONS

A recent report indicates the services provided and the medical personnel affiliated with more than 200 prepayment medical care plans in the United States and a few in Canada.⁵ The following paragraphs summarize data contained in this report and in the agreements between the organizations and their subscribers, with particular reference to the number of nurses associated with prepayment organizations, types of nursing services provided, persons eligible for care, and the influence of hospital ownership and the provision of care to workmen's compensation cases on the type of nursing service furnished.

About 3,300,000 persons were eligible for medical care under the 214 plans surveyed in the United States during the spring and summer of 1943 (table I). More than half the plans are associated with industry, and their membership accounts for almost half the total. Although a few of the industrial plans are financed entirely by the employer, about half are financed jointly by the employer and employee and, in nearly half, the entire cost is borne by the employees. The other types of plans which have a substantial membership are medical society plans and private group clinics.

NURSES ASSOCIATED WITH THE ORGANIZATIONS

In 1943, more than 2,000 full-time registered graduate nurses were employed by 117 of the 214 organizations included in the study. Some of the 2,000 nurses gave care in hospitals owned by the organization, a few gave visiting nurse service, but in general the duties of these nurses corresponded to those of nurses employed by physicians in private practice. In addition to the 2,000 nurses employed full time, there were many who provided special nursing service for the medical care organizations when the need arose. From the information available, it is impossible to estimate the equivalent full-time nursing service furnished by this group; 13 organizations which provided special nursing service employed no full-time nurses, while a few organizations called upon certain nurses so frequently that the services of these nurses were equivalent to part-time employment; other organizations used the nurses' registries and did not call certain nurses exclusively.

A striking difference among plans appears in the extent to which nurses are members of the staff. Almost all private group clinics and all industrial plans financed entirely by employer have staff nurses.

⁴ Randall, Marian G.: Nursing in Health Service Plans, Public Health Nursing, vol. 36, p. 314 (July), 1944.

⁵ Klem, Margaret C.: Prepayment Medical Care Organizations, Social Security Board, Bureau of Research and Statistics, Memorandum No. 55, ed. 2, June 1944. Available from the Government Printing Office, 30 cents each.

TABLE 1.—Number of persons eligible for medical care in prepayment medical care organizations, number of such organizations, number and percent employing nurses, and number of nurses employed, by type of organization

[Based on 214 organizations furnishing data in 1943]

Type of organization ¹	Number of persons eligible for medical care	Prepayment medical care organizations			Number of full-time nurses employed
		Total number	Employing nurses		
			Number	Percent of total	
Total.....	3,320,408	214	117	54.7	2,148
Industrial:					
Financed by employer.....	107,649	13	13	100.0	87
Financed jointly by employer and employee.....	583,402	53	34	64.2	² 507
Financed by employee.....	734,274	47	21	44.7	877
Medical society:					
Washington and Oregon.....	230,147	15	1	6.7	(³)
Other States.....	711,665	18	1	5.6	46
Private group clinic.....	490,980	24	22	91.7	314
Consumer sponsored:					
Financed partly by Department of Agriculture.....	35,587	6	4	66.7	5
Other.....	141,254	23	10	43.5	189
Governmental:					
War Food Administration and cooperating agencies.....	225,500	7	7	100.0	108
Other.....	17,795	5	3	60.0	14
Unclassified.....	42,155	3	1	33.3	1

¹ Industrial plans are those organized within an industrial establishment, whether initiated by the employers, the employees, or joint employer-employee action. Medical society plans are those organized by State or county medical societies on a State-wide or county basis. Private group clinics are organizations owned and managed by one or more physicians who as a rule do not also engage in private practice. Consumer-sponsored plans are organized by subscribers with services provided by salaried medical personnel. Governmental plans are, as a rule, compulsory plans established for the employees of specified governmental units.

² 1 organization also employs 1 part-time nurse.

³ Employs 8 part-time nurses.

In plans financed entirely by employers the medical care given is of two types: (1) first aid, general health supervision, and care for industrial accidents or injuries, and (2) medical care for nonindustrial cases limited in some plans to the employees and in others extended to their dependents also. In some plans financed jointly by the employer and employee, and in some financed entirely by the employee, care to industrial and nonindustrial cases is provided by the same medical staff. A variety of financial arrangements exists through which the employer pays for the care given to industrial cases. The nurses employed by industry to give only first aid, general health supervision, or care to industrial accidents and injuries are not included in the 1,471 nurses associated with industrial plans (table 1). No industrial organization was included in the study unless medical care was provided for nonindustrial accidents, injuries, and illnesses. Almost all of the 1,471 nurses represented in the study are included in the 13,305 nurses estimated to be employed by industry,⁶ but some whose duties are in no way connected with industrial cases are not represented in the estimate.

Medical society plans, as a rule, have no nurses associated with them since, in most instances, medical service is provided by physicians in individual practice. In only two instances do medical society plans employ nurses; one of these plans, in the State of Washington, employs eight part-time nurses to work in first-aid rooms during the canning season; the other, in California, provides care to residents of war-housing projects. In this second plan, part of the medical service is provided through clinics in housing projects.

Regional differences.—In which section of the country are nurses most likely to find employment in prepayment medical care organizations? Plans in the Pacific region included in the survey employed more than half the nurses associated with prepayment medical care organizations; the membership in this

⁶ Nursing Needs and Nursing Resources, American Journal of Nursing, vol. 44, pp. 1044-1045 (November), 1944.

region accounted for slightly less than one-third of the total. The east north central region, which had about 25 percent of the total membership, reported the second largest number of nurses, 12 percent of the total. The middle Atlantic region, with one-tenth of the total membership, accounted for less than one-twentieth of the employed nurses. New England reported less than 1 percent of the nurses and less than 1 percent of the total membership. The percentage of nurses employed by prepayment organizations in the other regions was from 4 to 8 percent of the total.

The region in which the largest number of nurses were employed (the Pacific) also accounted for the largest proportion of members and of physicians associated with prepayment medical care organizations;⁷ in the other eight census regions there was no exact correlation between membership and the number of physicians and nurses associated with prepayment plans.

Nurses employed in relation to membership.—During a year a nurse employed by a prepayment medical care organization may come in contact with about 1,200 persons if all persons eligible for care come to the office, clinic, or hospital during the period. In spite of the fact that some of the nurses employed by the organizations give care only in the office or clinic and others do visiting or special duty nursing, there is a fairly consistent ratio between the number of nurses employed and the number of persons eligible for care.⁸

In industrial plans financed entirely by the employer a nurse is employed for every 1,237 persons eligible for care. Among plans in which the employees pay the entire cost of the medical program, more nurses are employed in relation to membership—1 for each 760 persons to be served. The other type of plan in which the policies are determined by members, namely, consumer-sponsored plans (exclusive of those financed in part by the Department of Agriculture) also employ a relatively large number of nurses, 1 for each 857 persons eligible for care. The following table indicates the average number of persons per nurse in various types of organizations:

<i>Organization</i>	<i>Number of persons per nurse</i>
Industrial:	
Financed by employer.....	1,237
Financed jointly by employer and employee.....	1,217
Financed by employees.....	760
Medical society (California housing projects).....	1,133
Private group clinics.....	1,178
Consumer sponsored (excluding plans financed by Department of Agriculture).....	857

SPECIAL DUTY AND VISITING NURSE SERVICE

Special information on the provision or exclusion of special duty and visiting nurse service was obtained from the cooperating organizations. As indicated in table 2, prepayment plans differ widely in their policies toward the provision of such services. Of the 214 plans studied, 81 reported that they furnished special or visiting nurse service, or both. Special nursing, usually limited to care in the hospital, is available to members of 50 organizations; visiting nurse service is available to members of 43.

Most industrial organizations financed entirely by the employer provide either special or visiting nurse service, or both; 10 of the total of 13 such organizations provided visiting nurse service; 6 provided special duty service. Among the plans in which the employees bear the entire cost of the medical program, these two types of service are less common; of the 47 plans of this type, only 17 made either visiting nurse or special duty service (or both) available to their members, but, as will be shown later, these 17 had 69 percent of the total membership of employee-financed plans. Among the 53 organizations financed jointly by the employer and the employee, 19 provided special duty, visiting nurse care, or both types of service; 13 plans provided special duty service and 8 visiting nurse service.

⁷ Klem, Margaret C.: *Voluntary Medical Insurance Plans, Their Extent and Limitations, Medical Care*, vol. 4 (November), 1944.

⁸ Some organizations, which give care to persons not belonging to the plan as well as to members, have been excluded from this particular analysis.

TABLE 2.—Number of prepayment medical care organizations providing special and visiting nurse service, by type of organization and type of nursing service provided

[Based on 214 organizations furnishing data in 1943]

Type of organization	Total number of organizations	Number of organizations providing—		
		Special duty nurse service only	Visiting nurse service only	Both special duty and visiting nurse service
Total.....	214	38	31	12
Industrial:				
Financed by employer.....	13	1	5	5
Financed jointly by employer and employee.....	53	11	6	2
Financed by employee.....	47	10	4	3
Medical society:				
Washington and Oregon.....	15	6		(1)
Other States.....	18			
Private-group clinic.....	24	8		
Consumer sponsored: Financed partly by Department of Agriculture.....	6		4	
Other.....	23	1	2	1
Governmental:				
War Food Administration and cooperating agencies.....	7		7	
Other.....	5	1	3	
Unclassified.....	3			

¹ Special nursing and visiting nurse service provided to approximately 40,000 persons covered in 1 contract with an organization having a total membership of 80,000; the other 40,000 were eligible for special nursing service only.

Of the 24 private group clinics studied, one-third reported the provision of special duty service. No plans of this type provided visiting nurse care.

The plans developed by the War Food Administration and cooperating agencies for seasonal farm workers, domestic and foreign, recruited, transported, housed, or placed by these agencies, all provided visiting nurse service but no special duty service.

PERSONS ELIGIBLE FOR PREPAID SPECIAL AND VISITING NURSE SERVICE

The membership of the prepayment medical care organizations which provide special or visiting nurse service gives an indication of the extent to which these services are available on a prepayment basis. One-half of the membership of prepayment organizations is entitled to receive either special nursing service or visiting nursing service, or both. More than one-third of the 3,300,000 persons eligible for medical care in prepayment organizations could get special duty nursing either in the hospital or in the home upon the recommendation of the attending physician or the association's medical director. Six of every 10 persons belonging to plans financed entirely by employees and 7 of 10 belonging to plans financed jointly by the employer and employee, were entitled to such service through their prepayment plan. In plans financed solely by employers, slightly more than 1 out of 10 members could get special nursing service. In the medical society plans of Washington and Oregon, three-fourths of the membership was entitled to special nursing care under the prepayment contract. Except for private group clinics, in which about one-third of the subscribers and their dependents could get special nursing service, the other organizations, as a rule, made no provision for such care. It is of interest that the 1,200,000 persons who could receive special duty nursing under the prepayment plan were all members of plans providing relatively complete medical care.

The visiting nurse has not been used to any great extent by prepayment medical care organizations. In all, only 610,000, or about 18 percent of the members of all types of plans, can get visiting nurse care under their prepayment contracts. This group is made up almost entirely of persons belonging to governmental plans

sponsored by War Food Administration, all industrial plans, and consumer-sponsored plans financed largely by the Department of Agriculture.⁹

Both special nursing service and visiting nurse service were available to some members of the organizations studied. This group is small—comprising less than 145,000 persons and representing slightly more than 4 percent of the members of all plans. The persons eligible for both services in the Washington-Oregon Medical Society group all belong to one organization; moreover, this organization limits the provision of both types of nursing service to the employees of one industrial company. Outstanding among the organizations which provide both types of nursing service are certain industrial plants financed entirely by employees; the nearly 72,000 persons who belong to the employee-financed plans which provide these services represent 10 percent of all persons in employee-financed plans and over half of all persons entitled to both special duty and visiting nurse service under prepayment medical care contracts.

TABLE 3.—*Number and percent of persons eligible for special duty and visiting nurse service in prepayment medical care organizations, by type of organization and type of nursing service provided*

[Based on 214 organizations furnishing data in 1943]

Type of organization	Number of persons eligible for medical care	Number of persons eligible for special duty or visiting nurse service				Percent of persons eligible for special duty or visiting nurse service			
		Total	Special duty only	Visiting nurse only	Both special duty and visiting nurse	Total	Special duty only	Visiting nurse only	Both special duty and visiting nurse
Total.....	3,320,408	1,651,984	1,041,970	466,156	143,858	49.8	31.4	14.0	4.3
Industrial:									
Financed by employer.....	107,649	102,424	2,450	88,229	11,745	95.1	2.3	82.0	10.9
Financed jointly by employer and employee.....	583,402	442,428	383,258	46,420	12,750	75.8	65.7	8.0	2.2
Financed by employee.....	734,274	506,285	369,255	65,067	71,963	69.0	50.3	8.9	9.8
Medical society:									
Washington and Oregon.....	230,147	172,490	132,490		40,000	74.9	57.6		17.4
Other States.....	711,665								
Private group clinic.....	490,980	149,754	149,754			30.5	30.5		
Consumer sponsored:									
Financed partly by Department of Agriculture.....	35,587	29,436		29,436		82.7		82.7	
Other.....	141,254	20,709	4,578	8,731	7,400	14.7	3.2	6.2	5.2
Governmental:									
War Food Administration and cooperating agencies.....	225,500	225,500		225,500		100.0		100.0	
Other.....	17,795	2,958	185	2,773		16.6	1.0	15.6	
Unclassified.....	42,155								

HOSPITAL OWNERSHIP

Prepayment organizations that own or control hospitals are more likely to provide their members with special or visiting nurse services than are organizations that reported no owned or controlled hospital. Plans owning hospitals are relatively few, however—only 46 of the 214 studied. Of these 46 plans, 21 reported special nursing service, 11 visiting nurse service, and 17 provided neither service. Of the 168 organizations that neither owned nor controlled a hospital, only 52 provided their members with special nursing care, visiting nurse care, or both.

About two-thirds of the persons eligible for special nursing service on a prepayment basis belonged to organizations that owned or controlled hospitals. The majority of these persons were members of industrial plans financed entirely by the employee or jointly by the employer and employee. All persons eligible for

⁹ These plans were promoted by the Interbureau Coordinating Committee on Postwar Programs of the Department of Agriculture, and were developed partly as a result of the health-service programs of the Farm Security Administration. They should not be confused with Farm Security plans, which are limited in the main to rehabilitation borrowers and excluded from the study of prepayment medical-care organizations.

prepaid special nursing care through membership in consumer-sponsored organizations were members of two plans that owned hospitals.

While there apparently is a definite relationship between ownership of a hospital and provision of special nursing service, no such relationship appears in visiting nurse service. Although some 610,000 persons were eligible to receive visiting nurse service through prepayment plans, only 242,000—slightly less than two-fifths were members of plans that own hospitals. The majority of these persons were covered by plans financed by War Food Administration and cooperating agencies and by industrial plans which were financed by employees.

PROVISION OF CARE TO WORKMEN'S COMPENSATION CASES

The industrial medical care plans furnishing information indicated whether or not the medical staff which provided care under the prepayment plan also gave care to workmen's compensation cases. Of the 113 industrial plans reporting, 66 gave care to workmen's compensation cases and 47 did not. Almost all the nurses employed full-time by industrial organizations (1,433 of the total of 1,471) were employed by 56 of the plans which gave care to workmen's compensation cases. Furthermore, nearly all nurses employed in industrial plans are associated with organizations which give relatively complete medical service, that is, physician's care in the office, home, and hospital; and hospitalization.

EXPERIENCE OF A FEW ORGANIZATIONS

The study on which this article is based did not contain information on the cost of nursing service or the proportion of the membership dues spent for general nursing service, special nursing, or visiting nursing service. Some information of this type is available, however, in studies made by the American Nurses' Association. One such study indicates 3 organizations (with 3,000-9,000 subscribers) in which special nursing services of graduate registered nurses were provided, the cost to the plan for each subscriber receiving nursing care ranging from \$10 to \$30 a year. The average cost per year for all subscribers eligible for care ranged from 19 cents to \$3.77 per person.¹⁰

In another report¹¹ the experience of a Canadian organization is quoted, pointing to the administrative problems met by patients, doctors, and nurses in differentiating between essential and luxury nursing services. The contract provided for special nursing care for the seriously ill upon recommendation of the physician, but this service was discontinued in July 1942.

Two of the organizations, which cooperated in the study of prepayment medical care organizations, provided further details on nursing care in addition to those presented in the report cited earlier¹² and in the literature of the organizations. The Medical Department of the American Cast Iron Pipe Co., of Birmingham, Ala., provides relatively complete medical care, the entire cost of which is paid for by the company. The workers and their dependents are eligible to receive physician's care in the clinic, home, and hospital; hospitalization; and dental care. In this organization, 8 registered graduate nurses were employed to serve a total of 8,000 persons and, of this number, 2 devoted full time to visiting nursing service. The visiting nurses assist the doctors with home deliveries, instruct mothers in care of their babies, change surgical dressings, and give other treatment prescribed by the doctors. Negroes represent about half the total membership in this plan and, during 1943, the visits made to the homes of Negro employees numbered 1,575, and those to the homes of white employees, 1,605.

These visits include some made in connection with work of the personnel office. Many visits are made to the homes of workers who appear to be having difficulties at home. The company has found that an employee cannot do his best work when he is worried about the illness of his wife or child and feels that he should be home taking care of them. When the employee knows that the nurse will call at his home each day to see that everything is being done for the patients, his work suffers far less.

This medical organization also makes arrangements for private duty nursing if the doctor thinks it necessary and permits the employee to repay the cost of

¹⁰ Tattershall, Louise M: Report of Study of Functioning of Health Insurance Plans—1941. American Nurses' Association, New York 19. N. Y.

¹¹ Outline Re Status of Health Insurance in Relation to Nursing, prepared by Mary E. G. Bliss, secretary, joint committee of the American Nurses' Association and the National Organization for Public Health Nursing, to study health insurance and its implications for nursing, October 1943.

¹² See Klem, Margaret C.: Prepayment Medical Care Organizations, op. cit.

such service through pay-roll deduction. Dr. C. B. Bray, the medical director, writes that,

This procedure enables our employees to have the care of a special nurse without having to pay the entire cost at one time. The total amount paid to special nurses for the year 1943 was \$7,094.25, with a total of approximately 80 patients being served.

The Employees' Mutual Benefit Association of the Milwaukee Public Service Companies has a large medical department which also provides relatively complete care, that is, physician's care in the office, home, and hospital; surgery; maternity care; dental care; and hospitalization. The cost of the medical department is shared equally by the employer and the employees.

This organization employs five registered graduate nurses and emphasizes the value of their home visits. In addition to the usual calls for prenatal and postnatal cases the visiting nurse makes home visits to change surgical dressings, to instruct patients in the preparation of certain diets, and to follow up on difficult cases in which there is a possibility that the patient may not be following instructions. The medical director says that the extensive use of visiting nurses improves the service by saving the patient many trips to the clinic and relieving the doctor of certain work that he believes the nurse can do as well or better. In this organization, in which 18,000 persons in a prewar year were eligible for medical care, the average cost of the nursing service amounted to approximately 65 cents per year per person eligible. Dr. Ernest W. Miller, the medical director of this plan, believes that a large share of the success of the medical department is due to the excellent work done by the visiting nurses.

The experience of these and other prepayment medical care organizations indicates that there is a definite place for both special nurses and visiting nurses as well as for those employed in clinics, hospitals, and doctors' offices. In the past, the greatest opportunity for jobs with prepayment medical care organizations was in the industrial plans and the medical society plans in Washington and Oregon, which closely resemble the industrial plans in services provided and members served. These organizations have learned of the value of special-duty and visiting nursing service. In some private group clinics and consumer-sponsored organizations, also, the physicians have recognized the importance of nursing service, but because of the war are unable to add nurses to their staffs.

Organizations of all types might profit by the experience of those now providing special nursing and visiting nurse service and learn the value of the nurse in relieving the physicians of many burdens, in interpreting the rules and explaining the benefits of the plans to members, and in providing more extensive services for persons eligible for care. The direction and extent of development of voluntary prepayment medical care services after the war, should provide a clue to the employment opportunities for nurses in this form of medical care.

[Reprinted from the American Journal of Nursing, vol. 46, No. 4, April 1946]

PENDING HEALTH LEGISLATION

Health is a matter of more or less intelligent personal concern to every individual. It is a matter of more or less social and economic concern to all citizens and to all taxpayers. It is a matter of supreme importance to all the members of the professional and technical groups whose services are required for the care of the sick and for the execution of health programs and to those who are aware of their own need for medical and health services. Broadly speaking, the public is better informed on the state of the Nation's health, and on the uneven distribution of facilities and personnel, than ever before.

The implications for nursing of the pending health legislation now before Congress, regardless of the specific outcomes of congressional action, are extremely important. Readers will recall the digest, published in the January Journal,¹ of some of the bills now pending, viz.

S. 1606—A bill to provide for a national-health program.

S. 191—The Hill-Burton Hospital Construction Act.

S. 1318—The Maternal and Child Welfare Act (the Pepper bill).

H. R. 4512—The Priest Mental Hygiene bill.

Hearings on some of these bills, before congressional committees, will undoubtedly have been begun before this Journal can be put in the mails, and

¹ Becker, Harry J.: Pending Health Legislation, American Journal of Nursing, vol. 46, pp. 11-16 (January), 1946.

health legislation will become an increasingly important topic of general conversation as well as of concern to the health professions. The issues are extremely complex. There is danger in clichés and over-simplified statements. Many nurses will want to study the bills for themselves. They should be able to secure copies of them, possibly also of the National Health Act of 1945,² by writing to their Representatives in Congress. Busy people will find it difficult to keep up with the large volume of published material, but real effort should be made to follow the publications of the more closely related organizations.

In an editorial, Mr. Truman on Health, Hospitals, official publication of the American Hospital Association, discusses the national-health program and suggests that possibly the President and the three congressional sponsors would themselves see the wisdom of enactment of part of the program at this time. This association has repeatedly urged Federal aid for hospital construction, Government assumption of responsibility for the indigent, and support of voluntary prepayment plans.³

In its January issue (p. 65) Hospitals reported passage by the Senate of S. 191 "with no criticisms of its major aims." Action by the House of Representatives is still pending as this is written.

The American Journal of Public Health and the Nation's Health (the journal of the American Public Health Association) carried medical care in a national-health program, the association's official pronouncement on desirable content and methods of administration of a medical-care program as a sector of a national-health program, in the December 1944 issue.

The Journal of the American Medical Association, for February 23, 1946, carries the new American Medical Association Health Program and Prepayment Sickness Insurance Plans.⁴ From that issue we quote:

"The present problem of public relations in American medicine in this country is to convince the American people that a voluntary sickness system developed with features peculiar to the American way of life is better for the American people than a federally controlled compulsory sickness insurance system."⁵

Members of the American Nurses' Association who attended the 1944 biennial convention at Buffalo will recall that the house of delegates accepted a recommendation which "favors the expansion of health-insurance plans and providing for nursing service including nursing care in the home. It is believed that in addition to voluntary effort, governmental assistance is necessary for attaining adequate distribution of health services."⁶

That recommendation was presented by the chairman of the joint committee of the American Nurses' Association and the National Organization for Public Health Nursing to study health insurance. Under the aegis of the committee a full-time worker is now making a study of the inclusion of nursing in existing prepayment plans, which is to be presented at the biennial in September.

The movement to provide adequate health and medical care is of outstanding importance to all Americans. We suggest that, individually and collectively, nurses should inform themselves on the fundamental issues. Study of the major bills now before Congress, of official action taken by organizations representing the health professions and of citizen groups, is indicated.

American Nurses' Association membership

Total membership, December 31, 1945----- 181, 468

Estimated number of members engaged in special fields of nursing service (based on percentage of distribution of membership for 1944) :	
Private duty-----	58, 070
Institutional-----	63, 514
Public health-----	23, 590
Military-----	14, 518
Other fields of nursing-----	7, 259
Inactive-----	14, 517

² Senate Committee Print No. 1, Report to the Committee on Education and Labor, relating to the bill (S. 1606) to provide for a national health program.

³ Mr. Truman on Health, Hospitals, vol. 19, p. 64 (December), 1945.

⁴ Journal of American Medical Association, vol. 130, pp. 495-496 (February 23), 1946.

⁵ Fishbein, Morris: The Public Relations of American Medicine, Journal of American Medical Association, vol. 130, p. 511 (February 23), 1946.

⁶ The Biennial, American Journal of Nursing, vol. 44, p. 629 (July), 1944.

American Nurses' Association membership, December 31, 1945—181,468 nurses in the United States of America

The U. S. Census:

1940:

Total:

Number	371,066
Percent	100.0

Women:

Number	362,897
Percent	97.7

Men:

Number	8,169
Percent	2.3

Ratio of nurses to population, 1940—1 nurse to 357 people.

National Survey of registered nurses, USPHS, 1943 (did not include over 36,000 nurses serving with the armed forces):

United States of America:

Active	170,599
Inactive but available	38,746
Inactive but not available	49,829

Total	259,174
-------	---------

NEGRO NURSES

The U. S. Census:

1940:

Women	7,065
Men	127

Total	7,192
-------	-------

PROCUREMENT AND ASSIGNMENT SERVICES

Classification of nurses:

Number of classified nurses (June 30, 1945): Total, United States of America	283,895
Number of nurses enrolled in the American Red Cross service (June 30): Total, 1945	151,844
Military recruitment program: Number volunteered and certified for military service, total	103,869
World War II: Number of nurses assigned to military service December 1, 1942—June 30, 1945, total number serving or assigned	76,003

NURSING CARE IN PREPAYMENT MEDICAL CARE ORGANIZATIONS

(By Margaret C. Klem*)

Nursing associations throughout the United States are not only concerned with methods of providing adequate nursing services during the present emergency, but are also carefully studying the outlook for professional nurses in the postwar era. Developments in all fields of medical care are being followed with much interest. Important action indicating the trend of opinion within the nursing profession regarding health insurance was taken in June 1944 when the joint board of the National Organization for Public Health Nursing, the American Nurses' Association, and the National League of Nursing Education, went on record as favoring "the expansion of prepayment health insurance plans with the provision for nursing service, including nursing care in the home."¹

That local as well as national associations are following present trends in health insurance with interest and are voicing their desire to participate is evi-

*Miss Klem is Chief, Medical Economics Section, Division of Health and Disability Studies, Bureau of Research and Statistics, Social Security Board. The opinions expressed in this article are those of the writer and do not necessarily represent the views of the Social Security Board.

¹ Nursing Associations Endorse Health Insurance, Medical Care, August 1944, p. 249.

denced by action taken in California and in New York City where health insurance proposals have assumed major importance within the past year. In California, the executive director of the State Nurses' Association declared that members of the association believed that a health insurance plan should furnish nursing services when the services are deemed necessary by the physician in charge and that the association was prepared to offer an amendment to any health insurance bill coming before the California Legislature to provide for such services. The director declared further that the nursing profession should have a place on the board of the proposed health service authority or on the executive body of any other approved system.² In New York, while discussing Mayor LaGuardia's health insurance plan for Greater New York, the executive director of the Visiting Nurse Service of New York, in an address before the New York Counties Registered Nurse Association, similarly expressed the hope that nursing services would be included in the New York health insurance plan and suggested that professional nurses consider the value of such inclusion and look toward representation on the board of directors.³

Interest by the nursing profession in the provision of nursing services through insurance is not new. Studies of health insurance have been made by the National Organization for Public Health Nursing and American Nurses' Association committees at regular intervals for many years. Actually, nursing care has been provided through insurance since 1909 when the initial experiment was made by the Metropolitan Life Insurance Co. More than 70 companies now offering health and accident policies issue a variety of policies which provide some type of nursing service.⁴ There are also in operation in the United States more than 200 prepayment medical care organizations of which nearly half regularly employ registered professional nurses as members of their staffs. Approximately 45 percent of the 5,000,000 persons eligible for medical care through association with these organizations are entitled to receive the services of either special nurses or visiting nurses or both, and more than 2,000 registered professional nurses are regularly employed members of the staffs of these prepayment organizations which offer nursing services.

SURVEY OF PREPAYMENT MEDICAL CARE

In 1943 the Bureau of Research and Statistics of the Social Security Board prepared a digest of information received during the spring of that year from 214 prepayment medical care organizations. A new study, based on information received in January-May 1945, will soon be published.⁵ Nearly all organizations which furnished data for 1943 are included in the 1945 digest which also contains information on prepayment medical care organizations established since 1943. In the following pages information on nursing services received from the 229 organizations supplying data in 1945 is compared with similar data for 214 organizations in 1943. Organizations furnishing information have been classified by type as follows: industrial, medical society, private group clinic, consumer-sponsored, and Government.

Prepayment plans associated with industrial establishments are more numerous and their membership is larger than those of any other type. These plans are financed in three ways: by employers, by employees, and jointly by employers and employees.

Medical society plans are those which have been organized by either State or county medical societies. Medical services in plans of this type are provided by physicians in private practice who have chosen to participate in the plan. The majority of the new organizations furnishing information in 1945 were of the medical society type.

The term "private group clinic" has been used to designate organizations owned and managed by one or more physicians. Services are usually provided by physicians practicing as a group.

² Nurses Association Asks Health Plan, Examiner (San Francisco, Calif.), March 1, 1945.

³ New York Times, November 9, 1944.

⁴ Health Insurance Studied by American Nurses' Association, American Journal of Nursing, December 1943, p. 1061.

⁵ Klem, Margaret C.: Prepayment Medical Care Organizations, Social Security Board, Bureau of Research and Statistics, Memorandum No. 55, 3d ed. in press.

Consumer-sponsored plans are organized and directed by subscribers. They resemble somewhat industrial plans organized and financed by employees.

Government plans have been established by a Federal, county, or city governmental unit for its employees. Membership in organizations of this type is usually compulsory.

NURSES IN PREPAYMENT PLANS

In 1945, nearly half of the 229 organizations furnishing information reported that they employed registered professional nurses as full-time members of their staff. The total number of nurses employed by these 109 organizations was 2,092. A comparison with similar data received in 1943 (table 1) shows that there has been little change in either the number of nurses employed or in their distribution by type of organization. In each year from 65 to 70 percent were employed by industrial organizations, approximately 15 percent were associated with private group clinics; consumer-sponsored plans and Government plans sponsored by the War Food Administration employed from 5 to 10 percent each; while 2 percent or less were associated with medical society plans.

The majority of nurses employed by prepayment medical care organizations either perform duties corresponding to those of nurses employed by physicians in private practice or are associated with hospitals owned or controlled by the organization. A smaller number serve as visiting nurses.

A striking difference among plans appears in the extent to which nurses are members of the staff. Almost all private group clinics and industrial plans financed entirely by the employer have staff nurses. Medical society plans, which in most instances provide medical services through physicians in individual practice, reported very few nurses on their staffs in 1945. The outstanding exception is in California where the medical society plan furnishes care for residents of war-housing projects and provides the services of general practitioners and nurses through clinics established in the projects.

TABLE 1.—Number of prepayment medical care organizations employing nurses, number of nurses associated with each type of organization, 1945 and 1943¹

[Data furnished by 229 organizations in 1945 and by 214 organizations in 1943]

Type of organization	1945					1943				
	Persons eligible for medical care	Organizations		Nurses		Persons eligible for medical care	Organizations		Nurses	
		Total number	Number employing nurses	Number	Per cent		Total number	Number employing nurses	Number	Per cent
Total.....	4,975,850	229	109	2,092	100.0	3,320,408	214	117	2,148	100.0
Industrial:										
Financed by employer...	212,590	19	17	119	5.7	207,649	14	14	104	4.8
Financed jointly by employer and employee...	546,772	47	33	412	19.7	583,402	53	33	507	23.6
Financed by employee...	752,786	49	21	805	38.5	734,274	47	21	877	40.8
Medical society:										
Washington and Oregon...	954,100	22	1	9	.4	230,147	15	0	-----	-----
Other States.....	1,640,256	31	1	22	1.0	742,320	20	1	46	2.1
Private group clinic.....	406,330	21	17	339	16.2	390,980	23	22	297	13.8
Consumer-sponsored:										
Financed partly by Department of Agriculture.....	23,553	5	-----	-----	-----	35,587	6	4	5	.2
Other.....	326,561	27	13	209	10.0	152,754	24	11	190	8.8
Governmental:										
War Food Administration and cooperating agencies.....	97,300	6	6	177	8.5	225,500	7	7	108	5.0
Other.....	15,602	2	-----	-----	-----	17,795	5	4	14	.7

¹ Data for 1945 relates to January-May; that for 1943 is largely for the spring of that year.

TABLE 2.—Number of persons eligible for care under prepayment medical care organizations and number of nurses associated with such organizations, by census region 1945 and 1943¹

[Data furnished by 229 organizations in 1945 and by 214 organizations in 1943]

Census region	1945				1943			
	Persons eligible for medical care		Full-time registered professional nurses		Persons eligible for medical care		Full-time registered professional nurses	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total.....	4, 975, 850	100. 0	2, 092	100. 0	3, 320, 408	100. 0	2, 148	100. 0
New England.....	129, 236	2. 6	3	. 1	13, 097	4	2	. 1
Middle Atlantic.....	685, 061	13. 8	142	6. 8	350, 729	10. 6	100	4. 7
East North Central.....	1, 056, 646	21. 2	244	11. 7	793, 533	23. 9	258	12. 0
West North Central.....	378, 862	7. 6	185	8. 8	309, 910	9. 3	167	7. 8
South Atlantic.....	303, 633	6. 1	151	7. 2	204, 084	6. 1	167	7. 8
East South Central.....	277, 464	5. 6	114	5. 5	292, 287	8. 8	159	7. 4
West South Central.....	183, 948	3. 7	81	3. 9	198, 820	6. 0	84	3. 9
Mountain.....	143, 907	2. 9	101	4. 8	115, 029	3. 5	123	5. 7
Pacific.....	1, 810, 093	36. 4	1, 071	51. 2	1, 038, 327	31. 3	1, 038	50. 6
Hawaii.....	9, 000	0. 2			4, 592	. 1		

¹ Data for 1945 relates to January-May; that for 1943 is largely for the spring of that year.

The 177 nurses employed by Government organizations were associated with plans sponsored by the War Food Administration for seasonal farm workers recruited, transported, or placed by that agency. This figure represents the average number of nurses employed during a year, for the number varies greatly with the seasons. An annual average of 97,300 persons are eligible for medical care through these organizations. Services are provided at Government expense and all members are entitled to the services of visiting nurses. Nurses associated with these War Food Administration-sponsored organizations covering 6 areas of the country perform such duties as giving health education, organizing health clubs, making periodic sanitary inspections, holding nursing conferences, advising on nutrition, assisting at clinics held by physicians, arranging for hospitalizations when necessary, making contacts with physicians, maintaining clinics, and acting as a liaison with the local health departments and local voluntary agencies. Many of the persons eligible for services call on the nurses for treatment of minor ailments which do not need to be brought to the attention of the physician; in 1943, on the average, two visits to nurses for services of this type were made for each clinic visit to physicians.

Number of persons eligible for services and nursing staff.—Approximately 5,000,000 people were eligible for medical care in the 229 organizations furnishing information in 1945, an increase of more than 1,500,000 over the number eligible for services through the 214 organizations reporting in 1943. During the interval between the two studies several new medical society plans were organized; the number providing information increased from 35 in 1943 to 53 in 1945, and the increase in membership in plans of this type was almost 1,500,000. Changes since 1943 in membership in other types of organizations are relatively insignificant when compared to this increase.

Since medical society plans rarely employ nurses, their increase in membership and the present nursing shortage probably account for the fact that nursing staffs have not grown in proportion to membership. Persons eligible for care in industrial plans decreased by 13,000 and the number of their staff nurses decreased by 152. Private group clinics increased their membership by 16,000 and the number of staff nurses by 52. Consumer-sponsored plans, excluding those financed partly by the Department of Agriculture, more than doubled their membership but employed only 19 more nurses than in 1943. Governmental plans sponsored by the War Food Administration averaged 97,300 members, a decrease of 138,000 persons, but they increased their nursing staff by 69 nurses.

Regional distribution.—A comparison of the number and percent of nurses employed throughout the various sections of the United States shows that there

has been practically no change during the past 2 years (table 2). In 1945, as in 1943, 50 percent of the nurses employed by prepayment medical care organizations were associated with plans in the Pacific coast region; 12 percent were employed by organizations in the east north central States; other regions employed less than 9 percent each, while the New England States reported only 3 nurses.

The region in which the largest number of nurses were employed (the Pacific) also had the largest membership in prepayment medical care organizations. In this region the ratio of nurses to persons eligible for medical care was 1 to 1,700. The east north central States, with the second largest membership as well as the second largest number of nurses, had a ratio of only 1 nurse to every 4,300 persons eligible for medical care. In most regions the ratio averaged 1 nurse to 2,000 persons.

PERSONS ELIGIBLE FOR NURSING SERVICES

In 1945 about 2,200,000 persons, or 44 percent of the 5,000,000 eligible for medical care, were entitled to receive either special duty nursing or services of visiting nurses or both—an increase of 500,000 over the number eligible for these services in 1943. Approximately 1,100,000 or 50 percent of the persons eligible to receive these services in 1945 were associated with industrial organizations; more than 800,000, or 37 percent, were eligible through medical society plans in Washington and Oregon; 7 percent through private group clinics; 5 percent through Government plans sponsored by the War Food Administration; and 1 percent through consumer-sponsored plans.

A comparison of data furnished in 1945 and 1943 shows that the percentage of persons eligible for special duty nursing or services of visiting nurses or both varied to some extent when considered by type of plan (table 3). The most noticeable increase was in medical society plans in Washington and Oregon where 85 percent of all persons eligible for care could receive one or both of these services in 1945 as compared with 75 percent in 1943. A decline occurred for Government plans except for War Food Administration sponsored (which in 1943 agreed to provide nursing service to 16 percent of those eligible for medical care) due to the fact that in 1943 the largest number eligible for nursing service were in organizations operating in the national park areas. These plans have been discontinued temporarily because of the war. Industrial plans financed by employees provided special duty nursing or services of visiting nurses or both to 77 percent of their subscribers and dependents in 1945 and increased the number eligible for services from 516,000 in 1943 to 577,000 in 1945.

Special duty nursing.—In 1945 and in 1943 more than one-third of all persons eligible for medical care were entitled to receive special duty nursing. While medical society plans in Washington and Oregon agreed to provide such services to 85 percent of their membership, those plans in other States furnished neither special nor visiting nurse's care. Industrial plans financed by employees included special duty nursing among the services available to 73 percent of those eligible for medical care; jointly financed plans made such services available to 45 percent of their membership, and employer-financed plans to 28 percent. In private group clinics, 40 percent of the membership was eligible for this service. Governmental plans reported no special duty nursing. The largest increase in proportion of membership eligible for special duty nursing services was in the medical society plans in Washington and Oregon; such services were available for 75 percent of the membership in 1943 and for 85 percent in 1945. The greatest decrease was in the jointly financed industrial plans; the proportion of members eligible for special duty nursing services dropped from 68 percent in 1943 to 45 percent in 1945.

TABLE 3.—Number of persons eligible for medical care and percent eligible for special duty and visiting nurse service in prepayment medical care organizations, by type of organization, 1945 and 1943¹

[Data furnished by 229 organizations in 1945 and by 214 organizations in 1943]

Type of organization	1945					1943				
	Number of persons eligible for medical care	Percent eligible for special duty or visiting nurse service				Number of persons eligible for medical care	Percent eligible for special duty or visiting nurse service			
		Total	Special duty only	Visiting nurse only	Both special duty and visiting nurse		Total	Special duty only	Visiting nurse only	Both special duty and visiting nurse
Total.....	4, 975, 850	44.2	33.0	7.4	3.8	3, 320, 408	50.2	31.7	13.9	4.6
Industrial:										
Financed by employer.....	212, 590	45.6	4.3	17.8	23.5	207, 649	50.2	1.2	39.5	9.5
Financed jointly by employer and employee.....	546, 772	77.9	45.0	32.9	---	583, 402	76.1	65.7	8.2	2.2
Financed by employee.....	752, 786	76.7	60.8	4.0	11.9	734, 274	70.2	51.6	8.8	9.8
Medical society:										
Washington and Oregon.....	954, 100	84.6	80.4	---	4.2	230, 147	74.9	57.5	---	17.4
Other States.....	1, 640, 256	---	---	---	---	742, 320	---	---	---	---
Private group clinic.....	406, 330	39.6	39.6	---	---	384, 965	38.9	38.9	---	---
Consumer-sponsored:										
Financed partly by Department of Agriculture.....	23, 553	---	---	---	---	35, 587	8.3	---	8.3	---
Other.....	326, 561	9.6	---	7.3	2.3	152, 754	13.5	3.0	5.7	4.8
Governmental:										
War Food Administration and cooperating agencies.....	97, 300	100.0	---	100.0	---	225, 500	100.0	---	100.0	---
Other.....	15, 602	1.2	---	1.2	---	17, 795	16.6	1.0	15.6	---

¹ Data for 1945 relates to January-May; that for 1943 is largely for the spring of that year.

Although some organizations provide special duty nursing in the home, in most cases this care is given only in the hospital. Contracts usually set no special limit to the length of time such services can be furnished. Recommendations of the physician are, of course, a standard requirement for furnishing this form of service.

Services of visiting nurses.—The major change in the proportion of members eligible for one or both types of nursing service occurred in the group eligible to receive the services of a visiting nurse. In 1945, 557,000 or 11 percent of the persons eligible for medical care in prepayment organizations, were entitled to receive services by visiting nurses; in 1943, 619,000 persons or 18 percent of those eligible for medical care were entitled to this service. With the exception of consumer-sponsored plans, which made this service available to 10 percent of their membership, and medical society plans in Washington and Oregon where 4 percent may receive the service, all persons eligible for this type of care were associated with either industrial or government-sponsored plans. The War Food Administration in both 1943 and 1945 included care by visiting nurses among the services available to all those eligible for medical service through its plan. Several industrial plans furnishing this care in 1943 reported that in 1945 the service had been temporarily discontinued.

VOLUME OF NURSING SERVICES AND COSTS

In a few instances, organizations which gave information on nursing services also reported on the volume of care provided. One organization with 85,000 subscribers in 1945 reported that 24-hour special duty nursing was provided up to a maximum of 30 days in any one case. This service was paid for at the pre-

vailing rate of a dollar an hour. For the fiscal year ended June 30, 1944, the cost of providing this service averaged a little more than 1 percent of the organization's expenses. The annual cost of the service amounted to \$22,389 or approximately 26 cents per subscriber per year.

Another organization gave the following figures on costs of special duty nursing:

Year	Number of persons receiving care	Annual cost		
		Total	Average per case	Average per subscriber
1939.....	15	\$2,105	\$140.35	\$0.30
1940.....	10	1,676	168.65	.23
1941.....	13	1,604	123.42	.23
1942.....	19	1,056	55.59	.15
1943.....	20	1,697	84.84	.24

A third organization with approximately 48,000 subscribers reported an annual expenditure of \$7,344 for special duty nursing, or an average cost of 16 cents per subscriber per year.

In 1943, one organization serving 8,000 persons, both subscribers and dependents, employed two full-time visiting nurses. During that year these nurses made about 3,200 visits to the homes of subscribers, an average of 40 visits per year per 100 persons eligible for care. In a second plan with about 14,250 subscribers, an average of 44 visits per year per 100 subscribers were made. In this plan the average cost per visit was \$1.23.

A third organization, with approximately 10,000 subscribers, reported a yearly cost of \$5,000 for services of visiting nurses or about 50 cents per person eligible for care. Approximately 40 visits per 100 persons eligible for care were made over a year at an average cost of \$1.45 per visit. These visits were made to approximately one-third of the members eligible for this service. In addition to the visits reported above, members also received a total of 2,254 visits from the metropolitan visiting nurses association in the city where the plan operates. Through both organizations, a total of 6,335 visits were made, or an average of 63 visits per 100 persons eligible for care.

In the fourth organization, services of visiting nurses were available to approximately 9,000 employees in a war industry as part of a medical-care program financed entirely by the employers. During 1944, the company paid \$9,000 in salaries to the three regularly employed visiting nurses; other costs incurred in providing the services were not reported. During the year, visits averaged about 63 per 100 persons eligible for care.

Since each organization providing information on costs of nursing services used its own accounting method, there is little if any comparability among organizations, though it is clear that nursing services can be provided at reasonable cost. The directors of plans that give nursing services are enthusiastic about the benefits derived by the patients and the organizations. When the nursing shortage is relieved many organizations will doubtless increase their nursing staffs. Other organizations which have not employed nurses in the past have indicated their intention to do so when nurses are available. Salaries have increased greatly during the war years; the beginning salary in one organization for example has risen from \$1,200 to \$2,000. A few organizations providing information on salaries paid in 1945 indicated a range from an entrance salary of \$1,800 to a high of \$2,500-\$3,000 a year.

[Reprinted from the American Journal of Nursing, vol. 42, No. 7, July 1942]

REGISTERED NURSES IN THE UNITED STATES OF AMERICA

By Pearl McIver, R. N., Senior Public Health Nursing Consultant,

States Relations Division, United States Public Health Service

The 1940 Census of the United States reported 369,287 trained nurses in the United States. However, that figure includes students who were in training at the time the census was taken as well as those nurses who may have had training as nurses but who are not registered. Therefore, it is to be expected

that the figure given by the Census Bureau would be higher than the number secured through the National Inventory of Registered Nurses which was completed in 1941.

A total of 289,286 registered nurses returned questionnaires in the National Inventory of Registered Nurses. Of that number 173,055, or approximately 60 percent, were actively engaged in nursing practice at that time. About 25 percent of the questionnaires sent out were not returned. It is not known whether those not returned represent duplications because of a change of name through marriage, a failure to fill out the questionnaire because the nurse was not engaged in nursing work and did not intend to return to active practice, or simply lack of interest.

Of the 116,231 inactive nurses who returned their questionnaires, 25,252, or about 22 percent, stated that they were available for full-time duty if their country needed them.

The ratio of active to inactive nurses is slightly lower for the country as a whole than for the sample nine States published January, 1942. In the sample States, it was found that 66 percent of the total number of nurses who participated in the inventory were actively employed, whereas in the country as a whole 60 percent were actively employed.

The percentage of actively employed nurses who were engaged in institutional work (47.2 percent) was practically the same for the whole country as for the nine sample States. However, the percentage of actively employed nurses who were engaged in private duty was lower. The nine sample States showed that 34 percent of the nurses were engaged in private duty nursing, while the rate for the country as a whole was only 27 percent.

Slightly more than 10 percent of the actively employed nurses were doing public health work. About 8 percent were engaged in other types of nursing work including industrial nursing. The type of employment was unknown for the final 8 percent. Table 1 gives a summary of the total registered nurses who participated in the inventory by State and the type of position.

Nurses eligible for military duty.—Two of the primary requirements for military duty are that the nurses be under 40 years of age and unmarried. Of the 173,055 actively employed nurses 89,327, or 51.6 percent, were unmarried and under 40 years of age. Of those nurses who were not active in nursing work when the inventory was taken, 9,366 were unmarried and under 40 years of age. Therefore, if only those two requirements are considered, it would appear that there are almost 100,000 nurses who are eligible for military duty.

TABLE 1.—The national survey of registered nurses, 1941—Number of active and inactive nurses and the type of last nursing position for active nurses and for inactive nurses who were available for full-time work, by State

State	Grand total	Total		Active by type of present position						Inactive nurses, available full time by type of last active position						
		Active	Inactive	Institutional	Public Health	Private duty ¹	Industrial	Other	Unknown	Total	Institutional	Public Health	Private duty ¹	Industrial	Other	Unknown
Total.....	29,286	173,055	116,231	81,708	17,766	46,793	5,512	9,440	11,336	25,252	7,440	1,684	9,551	732	1,471	4,374
Alabama.....	2,659	1,387	1,272	605	191	224	58	99	210	458	78	23	240	12	18	87
Alaska.....	384	172	212	87	37	11	1	8	28	29	10	1	11	1	2	4
Arizona.....	1,246	676	570	299	85	113	17	70	92	153	49	11	46	4	8	35
Arkansas.....	1,479	986	493	420	121	233	12	88	112	159	42	14	61	5	12	25
California.....	23,930	12,664	11,266	6,258	951	2,076	326	1,191	1,862	2,322	756	97	820	65	120	464
Colorado.....	3,689	2,410	1,279	1,413	188	-641	40	121	7	321	163	24	100	7	9	18
Connecticut.....	7,928	5,087	2,841	2,097	486	1,807	189	200	308	461	127	55	169	16	22	72
Delaware.....	990	485	505	224	61	100	26	30	44	100	23	10	51	3	1	12
District of Columbia.....	2,733	1,910	823	985	152	379	79	122	193	195	30	3	62	5	16	79
Florida.....	2,255	1,655	610	604	145	614	35	80	177	172	51	14	50	2	13	42
Georgia.....	4,001	1,927	2,074	870	266	363	65	123	240	636	118	35	324	16	22	121
Hawaii.....	1,303	874	429	470	90	125	28	68	93	93	49	7	19	6	3	9
Idaho.....	995	591	404	278	48	170	5	51	39	100	39	7	33	2	3	16
Illinois.....	17,086	9,406	7,680	4,806	932	1,634	416	564	1,004	1,407	392	86	589	75	44	221
Indiana.....	6,979	4,294	2,685	1,860	456	1,457	236	249	36	486	215	49	162	22	22	16
Iowa.....	5,857	3,175	2,682	1,553	250	1,024	52	182	114	481	193	36	200	11	12	29
Kansas.....	3,705	2,074	1,631	1,007	170	550	26	146	175	363	128	23	131	5	12	64
Kentucky.....	2,551	1,575	976	795	291	315	39	87	48	252	90	23	106	10	10	13
Louisiana.....	4,761	3,324	1,437	1,654	283	1,138	67	147	41	416	126	34	223	7	12	14
Maine.....	3,071	1,530	1,541	603	130	577	43	60	117	282	76	19	125	10	6	46
Maryland.....	4,903	3,195	1,708	1,337	337	1,289	117	65	50	287	76	24	109	12	11	55
Massachusetts.....	14,827	9,846	4,981	4,547	1,070	3,575	301	322	31	745	281	90	289	29	25	31
Michigan.....	10,660	6,060	4,600	2,768	749	997	342	445	759	952	391	85	302	32	49	173
Minnesota.....	6,684	4,524	2,160	2,395	396	1,387	100	200	46	435	200	33	153	7	15	27
Mississippi.....	1,475	1,019	456	303	144	369	13	59	131	174	38	20	71	4	12	29
Missouri.....	6,723	4,390	2,333	2,061	428	1,364	140	188	209	457	178	52	155	12	14	46
Montana.....	2,133	1,117	1,016	566	73	334	13	82	49	239	106	8	92	1	10	22
Nebraska.....	2,159	1,047	1,112	554	87	164	18	105	119	238	69	14	111	3	14	27
Nevada.....	226	129	97	55	18	29	5	2	20	24	6	1	10	1	6	6
New Hampshire.....	2,248	1,396	852	614	152	474	28	57	71	143	28	15	81	3	3	13
New Jersey.....	9,866	6,496	3,369	2,793	943	2,002	290	309	159	577	208	55	165	22	36	91
New Mexico.....	1,038	586	452	287	82	64	9	39	105	121	44	5	33	4	3	32
New York.....	32,084	19,321	12,763	10,663	2,407	3,135	467	1,217	1,432	3,262	279	45	1,060	18	538	1,322
North Carolina.....	4,290	2,274	2,016	1,098	273	440	49	147	267	594	125	29	297	28	13	102
North Dakota.....	1,010	449	561	255	52	49	3	30	60	154	38	4	69	4	9	30
Ohio.....	14,655	9,994	4,664	4,905	960	3,125	458	428	118	879	368	95	285	42	36	53
Oklahoma.....	2,419	1,477	942	739	169	410	19	110	30	274	113	17	87	5	10	42

Oregon	3,349	2,075	1,274	997	154	562	49	156	157	266	97	11	97	9	12	40
Pennsylvania	29,512	16,948	12,564	7,094	1,341	6,300	565	750	898	2,593	869	186	1,009	91	97	341
Puerto Rico	901	703	198	281	247	59	28	19	89	70	13	16	19	3	1	18
Rhode Island	1,854	1,068	786	535	157	218	43	43	72	145	43	8	66	1	4	23
South Carolina	2,094	1,066	1,028	465	137	242	27	86	109	836	76	21	177	7	10	45
South Dakota	1,291	672	619	309	60	148	9	50	96	136	37	9	47	3	14	26
Tennessee	3,695	2,455	1,240	1,051	376	695	85	138	100	378	89	34	183	15	22	35
Texas	7,211	4,775	2,436	2,028	393	1,868	137	335	14	637	240	46	275	20	32	24
Utah	1,403	758	645	382	107	96	15	60	98	155	51	18	41	5	9	31
Vermont	1,644	603	1,041	245	75	183	4	30	66	215	33	13	119	9	4	37
Virginia	5,120	2,887	2,233	977	279	1,114	102	157	258	494	134	42	193	17	21	87
Washington	5,573	3,161	2,412	1,635	249	834	77	324	42	520	240	41	174	14	31	20
West Virginia	2,953	1,767	1,186	611	135	667	78	87	189	304	86	28	110	13	13	54
Wisconsin	7,906	4,205	2,801	2,103	362	904	153	193	490	501	188	46	125	14	32	96
Wyoming	666	390	276	177	21	95	8	27	62	61	21	2	25	4	9	

¹ Includes some nurses who were originally coded as inactive, but later were found to have had some active nursing experience.

TABLE 2.—Number and percentage of unmarried and under 42 years of age active nurses whose hospital on day of graduation averaged less than 50, 50-99, and 100 or more patients, by type of last nursing position¹

Type of last nursing position	Total known as to number of patients		Average daily number of patients in hospital with which school is connected					
			Under 50		50-99		100 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total.....	2 84, 870	100	4, 635	5. 5	17, 422	20. 5	62, 813	74. 0
Institutional.....	45, 995	100	2, 562	5. 6	9, 203	20 0	34, 230	74. 4
Public health.....	7, 044	100	234	3. 3	1, 846	26. 2	4, 964	70. 5
Private duty.....	20, 626	100	1, 189	5. 8	4, 050	19. 6	15, 387	74. 6
Industrial.....	2, 383	100	103	4. 3	422	17. 7	1, 858	78. 0
Other types.....	4, 237	100	243	5. 7	877	20. 7	3, 117	73. 6
Unknown.....	4, 585	100	304	6. 6	1, 024	22. 4	3, 257	71. 0

¹ For nurses participating in the National Inventory, 1941.

² Daily average number of patients in hospital with which school is connected unknown for 4,457 nurses who were unmarried and under 40 years of age.

However, the physical status of the nurse is another important requirement for military duty. Of the 9,366 inactive nurses who meet the requirements with regard to age and marital status, 1,629, or approximately 17 percent, were physically incapacitated when they filled out the inventory schedules. Many others, both active and inactive, would probably be rejected for military duty because of visual or dental defects, or other conditions which do not prevent them from holding civilian positions. The ratio of rejections for military duty because of physical defects may be as high as 20 percent.

Another factor which may prevent some of the nurses from being accepted for military duty is the daily average number of patients in the hospital connected with the nursing school from which they graduated. The daily average number of patients was known for 84,870 of the 89,327 unmarried nurses under 40 years of age who were active in nursing work (table 2). From table 2 it will be seen that 4,635, or 5.5 percent, graduated from schools connected with hospitals having a daily average of less than 50 patients.

Therefore, if from the total number of registered nurses who are unmarried and under 40 years of age deductions are made for physical disabilities and for those nurses whose schools of nursing do not meet the standards required for military service, the number of eligible nurses may be reduced to about 75,000.

TABLE 3.—Number and percentage of all active nurses, unmarried and under 40 years of age, by type of last nursing position¹

Type of last position	Active registered nurses			
	Total active		Unmarried, under 40	
	Number	Percent	Number	Percent
Total.....	173, 055	100	89, 327	51. 6
Institutional.....	81, 708	100	48, 227	59. 0
Public health.....	17, 766	100	7, 402	41. 7
Private duty.....	46, 793	100	21, 728	46. 4
Industrial.....	5, 512	100	2, 528	45. 9
Other types.....	9, 940	100	4, 548	45. 8
Unknown.....	11, 336	100	4, 834	43. 2

¹ For nurses participating in the National Inventory, 1941.

Occupational group.—Of the 89,327 nurses who are unmarried and under 40 years of age, 48,227, or about 54 percent, are in the institutional field. The second largest group of eligible nurses is found in the private duty field which has 21,728 nurses who are unmarried and under 40 years of age.

Table 3 presents an interesting picture of the percentage of the nurses in each occupational group who are unmarried. The lowest percentage of unmarried nurses is among the public health nurses and the highest percentage of un-

married nurses is in the institutional field. These percentages are influenced no doubt by the fact that a large number of the late graduates are found in the general staff phase of institutional work.

The marriage rate for all nurses under 40 years of age (48.4) is somewhat higher than for other groups of professional women.

How soon do nurses marry after graduation?—Slightly more than 14 percent of the nurses who graduated some time during the year 1940 were married before they returned their questionnaires in 1941. About 27 percent of those who graduated during 1939 were married before or early in 1941 and almost 37 percent of those graduated in 1938 were married before the 1941 inventory was taken.

Nurses usually become excellent homemakers and mothers, and they should not be discouraged from matrimony. However, during this present emergency if they marry early, is it expecting too much that they be asked to remain in active nursing work for at least 2 years after graduation?

The supply and distribution committee of the National Nursing Council for War Service has suggested "State quotas" of nurses for military service. The distribution of eligible nurses, as revealed by the National Inventory of Registered Nurses, indicates the foci on which State and local nursing councils may fruitfully concentrate their efforts in the interest of meeting their quotas.

[Reprinted from the American Journal of Nursing, vol. 45, No. 10, October 1945]

5,000 ARMY NURSES

What are their postwar plans? How old are they? How many expect to stay in nursing? What additional professional preparation do they want? The data which follow are a sampling of the American Nurses' Association postwar planning study compiled by the American Red Cross. They will be of very great value in the counseling program for nurse veterans.

To help nurse veterans to return to civilian life, the American Nurses' Association, early this year, sent 50,000 postwar planning questionnaires to nurses serving with the Army Nurse Corps and the Navy Nurse Corps. The American Red Cross has accepted responsibility for compiling the data on the returned questionnaires.

These data will be of the greatest value in the counseling program for nurse veterans and, in addition to the data secured on the "civilian postcard questionnaire," they will be of definite assistance in shaping the plans and programs of the American Nurses' Association Professional Counseling and Placement Service. It should be remembered that this preliminary report represents a sampling only and that final results based on the total returns may reveal quite different trends.

On September 1, this year, 31,000 questionnaires had been returned by Army nurses. Some questionnaires have already been returned by Navy nurses, but since the questionnaires were not sent to the Navy nurses until somewhat later than to Army nurses, this report refers to Army nurses only. Later reports will be made concerning Navy nurses. Those who are analyzing the returns have been impressed with the care and thought with which the replies have been made.

A sample 5,000 returned questionnaires have been tabulated. These are the highlights:

Professional plans:

- 100 percent total sample,
- 73 percent expect to remain in nursing upon release from the military,
- 21 percent do not expect to remain in nursing upon release from the military,
- 6 percent did not answer the question.

Age grouping:

- 100 percent total sample,
- 61 percent were under 30 years of age,
- 32 percent were 30, but under 40 years of age,
- 7 percent were 40 years of age or over.
- The median age is 28.5 years.

Army status:

- 100 percent total sample,
- 3 percent are regular Army nurses,
- 97 percent are reserve Army nurses or Army of the United States nurses.

Length of military service :

- 100 percent total sample,
- 7 percent have served 1 year or less,
- 28 percent have served 1 year but less than 2 years,
- 41 percent have served 2 years, but less than 3 years,
- 13 percent have served 3 years but less than 4 years,
- 5 percent have served 4 years or more.
- 6 percent did not answer the question.
- The median length of service is 2.4 years.
- 17 percent of the nurses expressed interest in remaining in the Army Nurse Corps.

Academic education :**High school :**

- 100 percent total sample,
- 97 percent are high school graduates,
- 2 percent have had 1 to 4 years of high school, but did not graduate,
- 1 percent did not answer the question.

College :

- 100 percent total sample,
- 5 percent are college graduates,
- 0.2 percent had 4 years or more of college, but did not graduate,
- 1.8 percent had 3 years of college,
- 5 percent had 2 years of college,
- 10 percent had 1 year of college,
- 78 percent did not answer the question.

Period of graduation from school of nursing :

- 100 percent total sample,
- 41 percent graduated during 1945-41,
- 29 percent graduated during 1940-36,
- 16 percent graduated during 1935-31,
- 9 percent graduated during 1930-26,
- 5 percent graduated during 1925 or before.
- The median time since graduation is 6.5 years.

Previous nonnursing experience :

- The nurses reported very little prewar nonnursing experience. The types of experience reported by as many as 1 percent of the nurses included:
- Stenographic 6 percent,
- Teaching 3 percent,
- Clerical work 1 percent.

Marital status :

- 3 percent were married,
- 3 percent have husbands in service and most of these will ask for release from the military when their husbands are released.

Location after release from Army Nurse Corps :**In prewar position :**

- 100 percent total sample,
- 17 percent expect to return to their prewar positions,
- 71 percent do not expect to return to their prewar positions,
- 12 percent did not answer the question.

In State of registration :

- 100 percent total sample,
- 68 percent expect to return to the State in which they were registered,
- 26 percent do not expect to return to the State in which they were registered,
- 6 percent did not answer the question.

In Veterans' Administration : 18 percent reported an interest in serving with the Veterans' Administration

Field of postwar service :

- 100 percent total sample,
- 14 percent indicated an interest in public health nursing,
- 37 percent indicated an interest in hospital nursing,
- 4 percent indicated an interest in teaching,
- 13 percent indicated an interest in industrial nursing,
- 5 percent indicated an interest in private duty,
- 1 percent indicated an interest in foreign service,
- 26 percent gave no field of preference.

Interest in additional professional preparation:

- 100 percent total sample,
- 12 percent desire additional preparation in public health nursing,
- 21 percent desire additional preparation in hospital nursing,
- 3.5 percent desire additional preparation in teaching,
- 7 percent desire additional preparation in industrial nursing,
- 1 percent desire additional preparation in private duty.
- 1 percent desire additional preparation in foreign service.
- 50 percent do not desire additional preparation,
- 4.5 percent did not answer the question.

Specific clinic services in which additional preparation was desired:

- 100 percent total sample,
- 15 percent desire additional preparation in surgery,
- 10 percent desire additional preparation in anesthesia,
- 7 percent desire additional preparation in pediatrics,
- 5 percent desire additional preparation in psychiatry,
- 5 percent desire additional preparation in orthopedics,
- 5 percent desire additional preparation in obstetrics,
- 3 percent desire additional preparation in medicine,
- 3 percent desire additional preparation in physiotherapy,
- 5 percent gave "other answer," such as "writing," "administration," "social services," et cetera,
- 42 percent did not answer the question.

The tabulation of the 31,000 Army Nurse Corps questionnaires already returned is under way and will soon be available in considerably more detail than this sample. It has been found that the nurses have divided themselves into three groups, namely: those who stated that they expected to remain in nursing upon release from the military; those who stated definitely at the time of filling in the questionnaire that they intended leaving the profession; and those nurses who did not answer the question as to their professional plans. Tabulations will be made for each of these groupings, as well as for all three groups together.

Navy Nurse Corps questionnaires are being edited, coded, and tabulated as fast as they are received by the American Red Cross Nursing Service.

When all questionnaires of both Corps have been received and processed the final tabulations will be forthcoming, it is hoped, by January 1, 1946.

[Reprinted from the American Journal of Nursing, vol. 45, No. 12, December 1945]

5,000 CIVILIAN NURSES

From the Research Department of the American Nurses' Association

In order to determine what plans nurses were making for their return to peacetime life, and as a counterpart of the questionnaire which was sent to nurses serving in the Army and Navy, a post-card questionnaire was formulated during May 1945 to be sent to all nurses in the United States who remained in civilian service. Each State nurses association was asked to devise its own plan for reaching every nurse registered in the State. Not all the questionnaires have been sent out by the States, and some States have sent out their questionnaires too recently to expect complete returns. However, a sampling was made of the returns from 5,000 nurses included in the more than 50,000 questionnaires which have been returned thus far, and a preliminary survey of the plans and needs of these 5,000 nurses is reported in the following tables:

TABLE 1.—Age distribution of nurses

Age group	Number	Percent
Total.....	5,000	100
Over 60.....	148	3
51-60.....	489	10
41-50.....	899	18
31-40.....	1,564	31
21-30.....	1,865	31
Not reported.....	335	7

Of the 5,000 nurses in this sampling, 62 percent were between the ages of 21 and 40; 28 percent were between 41 and 60; and 3 percent over 60.

TABLE 2.—Number of States in which registered

	Number	Percent
Total.....	5,000	100
Registered in—		
1 State.....	3,199	64
2 States.....	1,139	22
3 States.....	285	6
4 or more States ¹	89	2
Not reported.....	288	6

¹ 63 nurses in 4 States; 17 in 5 States; 7 in 6 States; 1 in 7 States; and 1 in 8 States.

TABLE 3.—Postwar plans

	Number	Percent
Total.....	5,000	100
Continue in present position.....	2,706	54
Change position.....	479	10
To Government service.....	142	3
To civilian service.....	337	7
Retire.....	1,050	21
Undecided.....	169	3
Others and not reported.....	596	12

The majority (54 percent) of the group have expressed their preference to continue in their present positions; 21 percent plan to retire. The remaining 25 percent are either contemplating a change of position or are undecided about their plans.

One-third of the nurses who plan to continue in their present positions or to change to other positions have indicated a desire for further preparation.

Table 4, following, presents the choice of 3,950 nurses for the various types of nursing service. The percentage of nurses who wish additional preparation in medicine, surgery, obstetrics, psychiatry, and pediatrics is given in table 5.

TABLE 4.—Type of service and additional preparation

Type of service	Number of nurses	Percent	Type of service	Number of nurses	Percent
Total.....	3,950	100	Psychiatry.....	182	5
Surgery.....	566	15	Pediatrics.....	179	5
Obstetrics.....	315	8	Other.....	137	3
Medicine.....	218	5	More than one choice.....	193	5
			No choice.....	2,160	54

TABLE 5.—Desire for additional preparation

Choice	Number of nurses	Percent	Choice	Number of nurses	Percent
Surgery.....	213	38	Pediatrics.....	93	52
Obstetrics.....	122	39	Psychiatry.....	77	42
Medicine.....	58	27			

From table 6 below it will be seen that the percentage of nurses who plan to continue in their present positions is highest (67 percent) in the age group 51-60 and that of those who wish to change to another position is highest (16 percent) in the 21-30 year age group. In this connection, it is interesting to note that the percentage of nurses planning to retire in the age group over 60 is only 1 percent higher than those who plan to retire in the youngest age group.

Of 5,000 nurses studied, the 3,950 who plan to continue nursing reported their preference for one or more fields of nursing. The percentage of nurses indicating need for additional training according to their chosen fields of nursing is presented in table 7 below. Fifty percent of the nurses who chose public-health nursing as their field of interest indicated that they needed additional preparation for work in that field; 33 percent of the nurses who prefer industrial nursing would like additional preparation; 62 percent of those who chose teaching in a school of nursing signified a desire for further preparation; et cetera.

TABLE 6.—Postwar plans by age groups

Age group	No.	Per-cent	Continue in present position		Change position to—				Retire		Unde-cided		Other and not reported	
					Government service		Civilian service							
			No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent
Total.....	5,000	100	2,703	54	142	3	337	7	1,050	21	169	3	596	12
Over 60.....	148	3	77	52	2	1	3	2	41	27	3	2	22	14
51-60.....	489	10	329	67	7	1	10	2	57	12	18	4	68	14
41-60.....	899	18	574	64	26	3	33	4	137	15	21	2	108	12
31-40.....	1,564	31	856	55	32	2	90	6	336	21	61	4	189	12
21-30.....	1,565	31	683	44	64	4	186	12	409	26	58	4	165	10
Not reported.....	335	7	187	56	11	3	15	5	70	21	8	2	44	13

TABLE 7.—Field of nursing interest and desire for additional preparation in field of interest

	Field of nursing interest		Additional preparation desired	
	Number of nurses	Percent	Number of nurses	Percent
Total.....	3,950	100		
Hospital nursing.....	1,011	26	174	17
Private duty.....	583	15	41	7
Public health.....	639	16	320	50
Industrial nursing.....	306	8	101	33
Teaching in school of nursing.....	272	7	171	62
Teaching postgraduate in university.....	5		1	20
Other.....	65	2	12	18
More than one choice of nursing field.....	107	2	32	30
No data.....	962	24		

TABLE 8.—Type of position desired by type of nursing service

Type of position	Type of service												More than one choice		No data	
	Medicine		Surgery		Obstet-ric		Pedi-at-ric		Psychi-at-ry		Other					
	Number	Per-cent	Number	Per-cent	Number	Per-cent	Number	Per-cent	Number	Per-cent	Number	Per-cent	Number	Per-cent	Number	Per-cent
General staff.....	55	10	142	27	67	12	41	8	22	4	26	5	132	25	50	9
Head nurse.....	36	13	107	38	43	14	22	7	20	7	13	4	38	13	13	4
Supervisor.....	44	7	156	27	103	18	44	7	45	8	35	6	120	21	33	6
Instructor.....	31	12	39	15	24	9	25	9	20	7	20	7	100	38	8	3
Administrator.....	17	7	16	7	13	6	17	7	15	6	13	6	140	59	4	2
More than one choice.....	5	4	11	10	12	11	5	4	11	10	1	1	33	30	32	30
Other.....	2	5	7	15	3	7	1	2			13	29	18	40	1	2
No choice.....	28	2	88	5	50	3	24	1	49	2	16	1	1,579	84	52	2

Table 8 above shows the type of position for which these nurses have indicated a preference and the nursing service in which they would like to hold positions. Thus, of the 535 nurses who would like to have general staff positions, 10 percent chose medical nursing as their preferred type of service, 27 percent surgical nursing, 12 percent obstetric nursing, 8 percent pediatric nursing, 4 percent psychiatric nursing, et cetera. In the supervisory positions, 27 percent would like the supervisory position in surgical nursing, 18 percent in obstetric nursing, et cetera.

This preliminary study is concerned only with the expressed postwar plans of 5,000 of the nurses who remained in civilian service. A further survey will be made which will include pertinent data regarding the background of these civilian nurses—their education and experience, and their present positions in nursing.

[Reprinted from the American Journal of Nursing, vol. 45, No. 11, November 1945]

SOCIAL SECURITY—THE WAGNER-MURRAY-DINGELL BILL (1945), SENATE BILL 1050, H. R. 3293

By Donald W. Smith

The new Wagner-Murray-Dingell bill (which should be distinguished from a somewhat similar bill referred to by the same name which was introduced in 1943 and was pending during 1943 and 1944, but never enacted) was introduced in both Houses of Congress on May 24, 1945, and was referred to the appropriate committees, where it is now pending. In this article I shall not attempt to set forth all the detailed provisions of the bill, but shall merely outline its general features.

The bill, which is described as the "Social Security Amendments of 1945," contains the following six principal divisions, each of which will be briefly summarized.

- I. Grants and Loans for Hospital and Health-Center Construction
- II. Grants to States for Public Health Services
- III. Grants to States for Maternal and Child Health and Welfare Services
- IV. Grants to States for Public Assistance
- V. A National System of Employment Offices
- VI. A National Social Insurance System

I. GRANTS AND LOANS FOR HOSPITAL AND HEALTH-CENTER CONSTRUCTION

The bill would amend the Public Health Service Act by adding a new title providing for grants and loans for the construction of hospitals and health centers (including nurses' homes and training facilities). This title would empower the Federal Government to donate to States, counties, health, or hospital districts, or to nonprofit organizations, from 25 to 50 percent¹ of the cost of such construction projects, and to extend a loan of an additional 25 percent of the cost. An appropriation of \$50,000,000 would be authorized for the year ending June 30, 1946, and an appropriation of \$100,000,000 a year for each of the next 9 years, in addition to separate appropriations for the States' expenses of administration. The new title would be administered by the Surgeon General of the United States Public Health Service and the Federal Security Administrator, with the advice of a National Advisory Hospital Construction Council (consisting of the Surgeon General of the Public Health Service and eight members appointed by him) and of conferences of representatives of State agencies. Construction projects would be in conformity either with a State plan approved by the Surgeon General and the Federal Security Administrator or with the Surgeon General's determination of needed hospital projects.

NOTE.—This article is the substance of an address delivered by Mr. Smith at a conference of members of the board of directors of the American Nurses' Association with representatives of State nurses' associations held in Chicago, Ill., on September 19, 1945. Mr. Smith is a member of the bar of the State of New York and is associated with counsel for the American Nurses' Association.

¹ In several places throughout this article, reference will be made to similar ranges of percentages contained in the bill. In each instance the bill provides that the exact percentage shall be computed on the basis of the per capita income of the State in which the project is to be located, with the result that States having the lowest per capita incomes would receive the highest percentage of Federal aid.

II. GRANTS TO STATES FOR PUBLIC HEALTH SERVICES

The bill would amend the Public Health Service Act to provide increased aid to States for public health services, including specifically venereal disease control, tuberculosis control, and general public health work (which in turn includes public health nursing). The bill would authorize the appropriation of a "sufficient sum" each year for each of these enumerated public health services. (The present maximum annual appropriation for general public health services is \$20,000,000 per year.) States wishing to qualify for grants would be required to present plans for the approval of the Surgeon General of the Public Health Service. If such plans were approved, the Federal Government would provide 25 to 75 percent² of the funds expended under each plan. The program of grants would be under the supervision of the Surgeon General and the Federal Security Administrator; and an appropriation of \$5,000,000 a year authorized for demonstrations, training of personnel, and administrative expenses. The Surgeon General would also be directed to consult with conferences of State health authorities.

III. GRANTS TO STATES FOR MATERNAL AND CHILD HEALTH AND WELFARE SERVICES

The bill would amend the Social Security Act to authorize the appropriation of a "sufficient sum" annually³ for grants to States for each of three services: (1) maternal and child health services, (2) services for crippled children, and (3) child-welfare services. This program would be under the supervision of the Chief of the Children's Bureau and the Secretary of Labor. The former is directed to consult with an advisory committee appointed by himself (with the approval of the Secretary of Labor) and with conferences of State officers. States wishing to participate would be required to submit plans for approval by the Chief of the Children's Bureau. The Federal Government would provide from 25 to 75 percent⁴ of the funds expended under each approved State plan.

IV. GRANTS TO THE STATES FOR PUBLIC ASSISTANCE

The bill would amend the Social Security Act by adding thereto a new title providing for a comprehensive program of public assistance. It would authorize the appropriation of a "sufficient sum" for grants to States for the purpose of aiding the needy, especially children, the aged, and the blind. States would be required to have plans approved by the Social Security Board; and the Federal Government would pay 50 to 75 percent⁵ of the sums expended under each approved State plan. The term "assistance" is defined as including medical care for needy individuals. Administration of the new title would be committed to the Social Security Board.

V. A NATIONAL SYSTEM OF EMPLOYMENT OFFICES

The bill would establish in the Social Security Board a new permanent United States Employment Service, similar in many ways to the present agency of the same name. The Social Security Board would be directed to consult with a National Advisory Employment Service Policy Council appointed by the Board and to establish local advisory councils as well.

VI. A NATIONAL SOCIAL INSURANCE SYSTEM

This part of the bill contains the provisions relating to "socialized medicine" or compulsory health insurance, and has perhaps attracted the greatest amount of attention. It would amend the Social Security Act to provide for three large groups of benefits, as follows:

Prepaid personal health service insurance.—The provisions for health service insurance are entirely new. The benefits available under such insurance are listed as:

1. General medical benefit (service by a general practitioner).
2. Special medical benefit (service by a specialist or consultant).
3. General dental benefit.
4. Special dental benefit.
5. Home-nursing benefit.
6. Laboratory benefit.
7. Hospitalization benefit.

² See footnote 1.

³ The appropriation for child-welfare services would be \$15,000,000 a year for each of the first 2 years.

⁴ See footnote 1.

⁵ See footnote 1.

The hospitalization benefit is limited to from \$3 to \$7 a day for the first 30 days in a period of hospitalization and from \$1.50 to \$4.50 for each day thereafter; and from \$1.50 to \$3.50 for each day in an institution for the care of the chronic sick. Hospitalization benefits would not be payable for confinement in a hospital or other institution for mental or nervous diseases or tuberculosis. The maximum number of days of hospitalization benefit for any individual in any benefit year would be 60, but this limitation might be increased by the Surgeon General to 120 days if he found that funds were adequate.

Of special interest to nurses are the provisions with respect to the proposed new "home-nursing benefit." This benefit is defined as: "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."

Subject to the above provision, any nurse legally qualified by a State to furnish such home-nursing benefit or any group of such qualified nurses would be declared ipso facto qualified to furnish the new benefit. Such benefit is "ordinarily" to be available only upon the advice of a legally qualified attending physician, but is to be also available when requested by one entitled to it and approved by a medical officer designated by the Surgeon General. Rates of compensation would be determined in accordance with the following provisions:

"Rates or amounts of payment for particular services or classes of services furnished as benefits under this part 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 * * * nurses, having regard for age, specialization, and type of community; and payments shall be commensurate with skill, experience and responsibility involved in furnishing service."

The bill provides that if the Surgeon General, with the approval of the Federal Security Administrator, should determine that such action were necessary in order to prevent abuses, he might permit nurses rendering the home-nursing benefit to charge their patients a fee for the first service or for each service in a period of sickness or course of treatment, and that he might fix the maximum size of such fee and/or the maximum total amount of such fees in a period of sickness or course of treatment, with provision for differentials between urban and rural areas or among different States or communities. The Surgeon General, "having regard for the adequacy of available personnel," would be authorized also, with the approval of the Federal Security Administrator, to restrict the home-nursing benefit to part-time care on an hourly or visit basis, or to limited types of cases, or to a maximum amount of service per case, "or otherwise, as may be practicable and necessary." The bill provides that permission to nurses to charge fees, as well as restrictions on the home-nursing benefit, would be withdrawn "as rapidly as the Surgeon General finds practicable."

The new health-insurance provisions would be administered by the Surgeon General and the Federal Security Administrator, the Surgeon General being directed to consult with the Social Security Board and with a new National Advisory Medical Policy Council consisting of himself and 16 members appointed by him. Health-insurance benefits would be available to (1) those currently insured, (2) their dependents, and (3) those entitled to retirement, survivors' or extended-disability benefits. There are also provisions for grants-in-aid for medical and nursing education.

Unemployment and temporary-disability-insurance benefits.—Unemployment insurance is a feature of the present Social Security Act, whereas the provisions in the Wagner-Murray-Dingell bill with respect to temporary disability insurance are entirely new. The bill would provide benefits ranging from \$5 a week to \$30 a week for a maximum of 26 weeks. However, the Board of Trustees (consisting of the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board, all ex officio), if they found that funds were adequate, would be empowered to increase the maximum number of weeks' benefits up to 52 weeks in a year. A maternity benefit for not more than 12 consecutive weeks would also be provided.

Retirement, survivors' and extended-disability-insurance benefits.—Retirement and survivors' benefits are features of the present Social Security Act; insurance against extended disability (disability which has continued for six consecutive months) would be new. The bill would increase the present minimum payments of \$10 per month and maximum payment of \$35 per month to \$20 and \$120, respectively. Persons with extended disability would receive benefits similar to retirement benefits, except that an additional \$25 a month for the cost of an attendant would be payable if the service of such an attendant were necessary by reason of the beneficiary's disability.

The bill would also establish several new benefits, namely, the disabled husband's insurance benefits, the disabled widower's insurance benefits, and benefits payable to a surviving divorced wife with children. Several of the present retirement and survivors' benefits would be liberalized, with respect to either the conditions under which benefits would be payable, or the amount of such benefits, or both.

CONTRIBUTIONS

The cost of a national social insurance system such as that proposed by the bill would obviously be enormous. The bill would therefore impose a separate tax (somewhat euphemistically termed a "contribution") upon both the employer and the employee, each equal to 4 percent of the first \$3,600 of the employee's compensation in each calendar year, or 8 percent in all. The so-called self-employed would pay a tax of only 5 percent of the first \$3,600 of the market value of their services, but they would not receive unemployment and temporary-disability benefits. The bill provides that States or subdivisions of States (such as municipalities) might elect to come within the system, in which event the employer and the employee would each pay a tax of 2½ percent, with similar exclusion from unemployment and temporary-disability benefits.

It is considered, however, that these taxes would not suffice to pay for the benefits provided in the bill, and that eventually it would be necessary either to increase the tax rates or to supplement the taxes by appropriations from general revenues. Accordingly, the bill authorizes the appropriation of such additional sums as may be required to finance the benefits and payments of the national social insurance system.

COVERAGE

The bill would effectuate several changes in the coverage of the present Social Security Act which would be of interest to nurses. Employees of nonprofit organizations would be brought within the national social insurance system, except for employees who do not receive more than \$45 in any calendar quarter year and students, who would continue to be exempted. Members of religious orders performing services in the exercise of duties required by their orders would continue to be exempt. Student nurses and interns would no longer be exempt as such, but might be eligible for exemption as students at nonprofit institutions. Domestic servants would also lose their exemption and would be brought within the system.

State and municipal employees would be eligible to come within the system provided (1) their employer entered into an agreement with the Social Security Board, (2) more than one-half of the eligible employees of the government unit concerned were in favor of the agreement, and (3) their employer had not established and maintained for them a separate benefit or retirement fund. Federal employees would continue to be exempt.

It is possible that the bill, if passed, would bring private duty nurses within the system. While the bill would continue the exemption of casual labor not in the course of the employer's trade or business, under which exemption private duty nurses have hitherto been excluded from Social Security benefits and taxes, it is possible that the Social Security Board might hold that such nurses more properly come within the new category of the self-employed (a term which the bill does not define), particularly in view of the nurse's status as a practitioner of a profession rather than as an ordinary employee. Private duty nurses may, therefore, wish to seek clarification of the bill in accordance with their own views on coverage.

CONCLUSION

There are two categories of questions which nursing profession should consider with reference to this bill. The first category, obviously, includes a careful consideration of the provisions relating to coverage or exemption definitions of home-nursing and other benefits, methods of administration, and various

other details. The second group of questions, however, concerns the wisdom or policy of the bill.

It is apparent that the bill would go far toward unifying the medical, dental, and nursing professions under the control of the Federal Government. The power of the Surgeon General of the United States Public Health Service to prescribe standards, rules, and regulations would be extremely broad and flexible. There is no requirement that the Surgeon General be a member of the medical or nursing professions. It is not likely that any of the other officials concerned, such as the Federal Security Administrator, the board of trustees, or the Social Security Board, would be members of such professions. While the National Advisory Medical Policy Council would contain representative of the medical, dental, and nursing professions, such representation would be at least partially offset by so-called public representatives; and, in any event, the Council would serve only in an advisory capacity. Indeed, this Council would not even be the highest advisory body, for the over-all consultative organization would be the National Advisory Social Security Policy Council, which would consist, like the present War Labor Board, of the representatives of "employers and employees in equal numbers and the public." One of the specific concerns of this latter Council would be the "administration of medical, hospitalization, and related benefits, especially in areas in which facilities and personnel are not adequate."

It is evident, therefore, that the nursing profession should determine most carefully whether the bill embodies the most desirable solution to the problem of providing the public with medical and nursing care. In making such determination, consideration should be given to the various alternative solutions which have been proposed by public and professional groups or which might recommend themselves to the profession. The question of the extent to which the profession deems it desirable to come under Federal control should be given particular consideration, and should be treated as a question of principle, irrespective of the high esteem in which the present incumbents of the various offices involved may be held. The decision of the Nation on the bill is one that will profoundly influence our country's history for generations to come, and to the formulation of a sound decision the well-informed opinion of the nursing profession can make a most valuable contribution.

AMERICAN NURSES' ASSOCIATION MEMORANDUM FOR BOARD OF DIRECTORS

PRINCIPAL CHANGES IN THE THIRD WAGNER-MURRAY-DINGELL BILL FROM THE SECOND WAGNER-MURRAY-DINGELL BILL

The second Wagner-Murray-Dingell bill (S. 1050, H. R. 3293, introduced on May 24, 1945) is discussed in an article which appeared in the November 1945 issue of the American Journal of Nursing. It is assumed that the reader has a copy of this article before her. This memorandum will outline the principal respects in which the third Wagner-Murray-Dingell bill (S. 1606, H. R. 4730, introduced November 19, 1945) differs from the second bill.

I. GRANTS AND LOANS FOR HOSPITAL AND HEALTH CENTER CONSTRUCTION

This part of the second bill has been omitted entirely from the third bill.

II. GRANTS TO STATES FOR PUBLIC HEALTH SERVICES

Under the second bill, the Federal Government would have provided 25 to 75 percent of the funds expended for general public health work. The third bill increases the minimum contribution of the Federal Government to 50 percent, so that the Federal Government would contribute from 50 to 75 percent of the funds expended.

The third bill also provides for agreements or cooperative working arrangements between or among the administrators of the various parts and titles of the bill, in order, presumably, to insure the better coordination of the entire program. While these provisions are repeated in each part of the bill, for the sake of brevity they will be mentioned only at this point in this memorandum.

III. GRANTS TO STATES FOR MATERNAL AND CHILD HEALTH AND WELFARE SERVICES

In the line with the concept of the new bill as purely a health bill, the provisions for child welfare services (i. e., services to dependent, neglected, and delinquent children) are omitted entirely.

The percentage of Federal contribution has likewise been increased from the original 25 to 75 percent to a new range of 50 to 75 percent.

IV. GRANTS TO STATES FOR PUBLIC ASSISTANCE

The third bill narrows this part of the second bill to a more limited provision for grants to the States for the medical care of needy persons. The third bill authorizes an appropriation of \$10,000,000 for the fiscal year ending June 30, 1946, and a "sufficient sum" thereafter.

There is a new provision in the third bill that the medical care under this part of the bill may be provided either.—

1. By the State or local public assistance agency administering the plan for medical care through—

(a) Money payments to the individuals claiming such care.

(b) Payments to the persons or institutions furnishing such care; or

(c) Direct provision of such care; or

2. In accordance with agreements (authorized by the Social Security Board) between such State or local agency and other State or local agencies, by such other agencies; or

3. Through arrangements of the State or local public agency with the Surgeon General on the basis of payments to the personal health services account (see under "contributions," below); or

4. Through such combination or modification of the first three methods as the Social Security Board may approve.

V. A NATIONAL SYSTEM OF EMPLOYMENT OFFICES

The third bill omits this part of the second bill entirely.

VI. A NATIONAL SOCIAL INSURANCE SYSTEM

The provisions of the third bill with respect to this subject are confined to the prepaid personal health service benefits. The third bill does not deal with unemployment, temporary disability, retirement, survivors', or extended disability insurance benefits.

The provisions with respect to the "local-area committees," which are to "aid" in the administration of the health service benefits, are more definite in the third bill than in the second. The members of such committees are to be appointed by the Surgeon General 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."

The aforesaid committees are to be consulted at frequent intervals, are to be kept informed by the local-area officers of the Public Health Service with respect to arrangements for the availability of benefits and the policies to be followed, and are authorized to make annual and special reports, together with their recommendations, if any, to the local-area officers or to the Surgeon General through his State or regional officers.

Inasmuch as the third bill omits the provisions of the second bill with respect to extended disability benefits, the provisions that beneficiaries of such insurance are entitled to prepaid personal health insurance benefits, even though they would not otherwise be entitled thereto, are likewise omitted.

CONTRIBUTIONS

The third bill does not contain any provisions whatsoever with respect to the tax or "contribution" which would have been imposed by the second bill.

The third bill would set up a "personal health services account." The bill would authorize appropriations to this account of such sums as might be required to finance the benefits, payments, and reimbursements provided in connection with prepaid personal health services. From such appropriations, the Secretary of the Treasury would be directed to credit to the account (1) amounts equivalent to 3 percent of compensation received by employees or the self-employed after June 30, 1946, (2) amounts estimated by the Surgeon General to have been expended in the preceding year for the provision of various benefits, including home-nursing benefits, and (3) sums received by way of reimbursement for the cost of medical services furnished to the needy (see IV, above). The total disbursements under the program are to be limited to the total of the above credits. The Secretary of the Treasury is directed to pay into the account from time to time such amount as he and the Surgeon General estimate will be expended during the period of 3 months. Adjustment for overestimates and underestimates are to be made in future payments.

It is obvious that the third bill does not even attempt to pay its own way, and that all the necessary funds would come from the general revenues of the United States Treasury, i. e., from income taxes and similar sources.

COVERAGE

The third bill omits the provisions of the second bill with respect to the coverage of State and municipal employees through voluntary agreements of their employers with the Social Security Board. However, in lieu thereof, the third bill contains a general provision that all the prepaid personal health service benefits may be furnished to anyone for any period for which equitable reimbursement to the account on behalf of such person has been made or for which reasonable assurance of such reimbursement has been given by public agencies of the United States, the States, or any of them or their political subdivisions. Such reimbursement is to be in accordance with agreements and working arrangements negotiated by the Surgeon General with the public agencies and in accordance with contracts into which the Surgeon General may enter. This general provision is to extend to (1) the needy persons entitled to medical care under IV, above, and (2) to injuries, diseases, and disabilities otherwise excluded because covered by workmen's compensation, if special reimbursement is made to the account.

While the effect of the above general provision is not clear, it would appear to authorize the extension of coverage to Federal, State, and municipal employees if their respective department heads negotiated contracts therefor with the Surgeon General.

DONALD W. SMITH.

Dated January 19, 1946.

EXHIBIT I.

Ratio of public health nurses to population—1940

Areas	Population 1940, United States census	Number of public health nurses	Ratio of population to nurses
Total, all areas.....	131,669,275	123,433	5,619.0
New England.....	8,437,290	2,783	3,031.7
Middle Atlantic.....	27,539,487	7,083	3,888.1
East North Central.....	26,626,342	5,360	4,967.8
West North Central.....	13,516,990	1,660	8,142.8
South Atlantic.....	17,823,151	2,269	7,855.1
East South Central.....	10,778,225	1,051	10,255.2
West South Central.....	13,064,525	931	14,032.8
Mountain.....	4,150,003	648	6,404.3
Pacific.....	9,733,262	1,648	5,906.1

¹ Including industrial nurses, but excluding nurses on staffs serving more than 1 State. Territories not included. Count made by U. S. Public Health Service as of Jan. 1, 1940. State showing most favorable ratio of population to public health nurses is Connecticut, in which State this ratio is 2,466.4; State showing least favorable ratio of population to public health nurses is Oklahoma, in which State this ratio is 16,453.8; State showing median ratio of population to public health nurses is Washington, in which State this ratio is 7,144.9.

See map (exhibit IV)

EXHIBIT II

RECOMMENDED QUALIFICATIONS FOR PUBLIC HEALTH NURSING PERSONNEL,
1940-45¹

Since the publication of Minimum Qualifications for Those Appointed to Positions in Public Health Nursing in 1936,² far-reaching developments have taken place that need to be considered in setting new goals for the next five years. The years 1935-40 have seen the greatest expansion of public health nursing in its history, due in large part to the health provisions of the Social Security Act. Despite the pressing need for nurses to fill available public health nursing positions, there has been an increasing appreciation by administrators of the importance of appointing nurses specifically prepared for the public health nursing field. The Social Security Act has assisted in this trend by making provision for many nurses to get the needed preparation as well as requiring through a later amendment that appointments be made under a merit system of personnel administration.

The completion of the revised Curriculum Guide for Schools of Nursing by the National League of Nursing Education in 1937 has given impetus to the enrichment of the undergraduate curriculum so that the nurse may be more adequately prepared to make her contribution to the health and social welfare of the community in whatever field she enters. However, since this requires a faculty prepared to assist in the integration of the health and social aspects of nursing throughout the curriculum, increasingly emphasis has been placed on the importance of faculty preparation in these areas by many schools. Also, it is apparent that the graduates from the schools which offer such an enriched curriculum, with a wide range of clinical experience including communicable and mental diseases, will be considered potentially the most promising for public health nursing service. The membership list of the Association of Collegiate Schools of Nursing and the National League of Nursing Education's list of accredited schools will be helpful in furnishing another basis for the selection of graduate nurses for public health nursing.

The growth of merit systems as a method of selecting personnel both in official and nonofficial agencies has made for greater understanding by agencies and by citizens of the need for specific requirements for the various positions in the field of public health nursing. The qualifications recommended here have been formulated in the light of these present trends in qualifications for public health nurses wherever they may be employed.

Determined effort to reduce further certain existing health problems, such as crippling in children, maternal and neonatal hazards, tuberculosis, and the venereal diseases, has made emphasis on special services in these areas necessary. Each of these is recognized as one part of the whole family health service, and as such is most adequately carried on by the field nurse who is responsible for all phases of the public health nursing program. The nurse, however, needs help from consultants who in addition to the necessary equipment as supervisors have had preparation in the special field in which they are engaged.

Mindful of these trends and realizing that the first principle underlying the improvement of service is the appointment of qualified personnel, the Education Committee of the National Organization of Public Health Nurses, recommends these qualifications for those appointed to public health nursing positions as the goal for 1945. They are based on the principles: (1) that one of the most essential requisites in public health nursing is the ability to work effectively with people, (2) that the public health nurse must be a competent nurse with sound basic theoretical and clinical preparation in nursing and with an understanding of its social and health aspects, (3) that additional study, including supervised field experience, is essential to prepare the graduate nurse for the specific functions of public health nursing, (4) that continued in-service education including qualified supervision (see II, A of outline) is necessary to further the development of the nurse's potentialities for improved service to the individual family and community, which is the goal of all public health nursing.

While the following qualifications may seem to stress academic preparation and professional experience, personality remains a major factor in successful

¹ Approved by the education committee of the National Organization for Public Health Nursing.

Reprints will be available free of charge from the organization, 1790 Broadway, New York, N. Y.

² Published in Public Health Nursing, March 1936, p. 172.

public health nursing service, and therefore must always be given due consideration. Also, good physical health as determined by a preemployment examination should be considered essential because without it the other qualifications are rendered less effective.

Improvement in the technique of personal interviews and the collection of credentials, through study of personnel methods in other fields, will help in developing more accurate methods for the selection of applicants with fundamental requisites. Tests and other measurements need to be studied as a means of determining individual abilities and capacities.

On the other hand, it is important for both the nurse and the employer to understand the purpose and value of theoretical preparation for public health nursing. University study should be an economical means to the end of greater competency in daily work and not an end in itself. It is a means for the nurse to review under guidance past and present practice in this field in order to become familiar with sound, workable principles and thereby avoid some of the trial-and-error learning common to all new workers. It is an opportunity to gain additional tools, both in content and method, which will make work in the field more pertinent and more productive.

Unusual competence in the work to which the nurse is assigned is the only sound basis for promotion to greater responsibility and the one most frequently used. Well utilized graduate study should assist in the development of such competence. The amount of study suggested in these recommended qualifications is believed to represent the minimum needed for each type of worker described.

While these qualifications apply specifically to new appointees, the importance of corresponding additional preparation for those already appointed should receive careful consideration in relation to each nurse. Under certain conditions, it might be desirable for agencies to adopt a policy urging those appointed within the last few years to meet within a specified period of time the recommended theoretical preparation for the respective positions.

I. STAFF NURSES *

A. For the nurse working on the staff of an official or private agency under the direct supervision of a nurse supervisor who meets the qualifications herein set forth

Duties

To carry on the direct nursing service of the agency in the home, clinic, conference, school, or industry.

Preparation

1. General education—High school graduation or its educational equivalent which meets college entrance requirements. Education on a college level is desirable.

2. Basic nursing education—Graduation from an accredited⁴ school of nursing connected with a hospital having a daily average of 100 patients, with the necessary affiliation, which gives the nurse a broad clinical experience in medical nursing, including acute communicable disease, tuberculosis, and the venereal diseases; psychiatric and pediatric nursing (including the care of children with orthopedic and cardiac conditions); and an understanding of the social and health aspects of nursing, both physical and mental, through an integrated program of instruction in classroom, ward, outpatient department, with appropriate use of community facilities.

3. State registration.

4. Postgraduate study—Completion of the year's program of study in public health nursing in a university program approved by the National Organization for Public Health Nursing, previous to or within 5 years after appointment.

B. For the nurse in an official or private agency not working under direct supervision

Duties

In addition to carrying on the direct nursing service of the agency as in A, to assist in organizing the service; to work with lay and professional groups; to carry on the activities in special institutions such as the school and industry.

* See recommended qualifications for public-health nurses in school and industry, Public Health Nursing, February 1938, p. 108; July 1939, p. 410. Reprints are available free of charge.

⁴ Accredited by the State board of nurse examiners.

Preparation:

1. General education—Same as listed for staff nurse under A.
2. Basic nursing education—Same as listed for staff nurse under A.
3. State registration.
4. Postgraduate study—Completion of the year's program of study in public health nursing in a university program approved by National Organization of Public Health Nurses, before appointment.
5. Experience.—At least 1 year's experience under qualified nursing supervision in a public health nursing agency in which family health is emphasized.

II. SUPERVISORS AND EXECUTIVES

*A. For the supervisor**Duties*

To supervise the staff nurses in an official or private agency and to assist in their growth and development; to plan and develop the nursing program for which she is responsible in relation to the total program of the agency; to correlate it with that of other agencies in the educational, social, and health fields; to study and evaluate the program within her own area.

Preparation

1. General education—College degree.
2. Basic nursing education—Same as listed for staff nurse under I—A.
3. State registration.
4. Postgraduate study—Same as listed for staff nurse under I. B., and in addition, a course in principles of supervision.
5. Experience—At least 2 years' experience, one of which was under direct, qualified nursing supervision in a public health nursing service in which family health is emphasized.

*B. For the consultant**Duties*

To assist in analyzing the needs and developing the service in the special field; to correlate this service with other services offered by the agency and with the programs of other agencies; to advise regarding policies, techniques, and procedures in the special field; to participate in the supervisory and staff-education program of the agency in cooperation with the other supervisory personnel.

Preparation

1. General education—College degree.
2. Basic nursing education—Same as listed for staff nurse under I-A.
3. State registration.
4. Postgraduate study—Same as listed for staff nurse under I-B, and in addition a course in principles of supervision and advanced preparation in the special field, including content in that field, courses in general education, and methods of making and using studies.
5. Experience—At least 2 years' experience, one of which was under direct, qualified nursing supervision in a public health nursing service in which family health is emphasized, and at least one year's experience as a generalized supervisor.

*C. For the educational director or instructor in public health nursing**Duties*

In public health nursing agencies—to plan and to direct the educational program for the new nurse, for the student, and for the staff as a whole, and to correlate and develop the resources of the agency and of related community services for teaching purposes.

In schools of nursing—to assist in directing, to correlate, and to participate in the efforts to give the undergraduate student the concept of the social and health aspects of nursing, both physical and mental, through an integrated program of instruction in classroom, ward, and out-patient department, with appropriate use of community facilities.

Preparation

1. General education—College degree.
2. Basic nursing education—Same as listed for staff nurse under I-A.
3. State registration.

4. Postgraduate study—Same as listed for staff nurse under I-B, and in addition, courses in principles of supervision and in the philosophy and principles of education.

5. Experience—At least 2 years' experience, one of which was under direct, qualified nursing supervision in a public health nursing service in which family health was emphasized and at least one year's experience as a supervisor in a public health nursing service.

D. For the director

Duties

To administer the nursing service of the official or private agency; to determine with the administrative official or the board the policies and program to be followed; to interpret the needs of the nursing service to the administrative officials, to the board, to committees, and to the community; to participate in community planning and action in health and social welfare.

Preparation

1. General education—College degree.
2. Basic nursing education—Same as listed for staff nurse under I-A.
3. State registration.
4. Postgraduate study—Same as listed for staff nurse under I-B, and in addition, courses in supervision and in principles of administration.
5. Experience—At least 3 years' experience, preferably in more than one type of agency—i.e., official and private—including experience in supervision.

E. For the director of a university program of study

Duties

To assume direct responsibility for the planning and administration of the program.

Preparation

1. General education—Graduate degree.
2. Basic nursing education—Same as listed for staff nurse under I-A.
3. State registration.
4. Postgraduate study—Completion of the year's postgraduate program of study in public health nursing in one of the university programs approved by the National Organization of Public Health Nurses, before appointment, and advanced university courses in general education and in supervision and administration in public health nursing.
5. Experience—A minimum of 5 years of public health nursing experience, preferably in more than one agency, one year of which should have been in a general public health nursing agency with direct, qualified supervision, emphasizing family health. This experience should include experience as a staff nurse and experience as a supervisor, executive, or educational director.

EXHIBIT III

PUBLIC HEALTH NURSING PROGRAM AND FUNCTIONS ¹

In preparing for community health services for the period of demobilization and full return to peace, the reevaluation of public health nursing functions is basic to any consideration of future program.

After several years of wartime modifications in public health nursing—some purely expedient to be discarded as soon as possible and others with constructive implications for the future—a restatement of guiding principles now seems appropriate.

PUBLIC HEALTH NURSING DEFINED

For purposes of this statement, a public health nurse is a graduate registered nurse having special preparation in public health nursing as outlined in the National Organization for Public Health Nursing Recommended Qualifications for Public Health Nursing Personnel, 1940-45.²

¹ Approved by the committee on nursing administration of the National Organization for Public Health Nursing.

² Public Health Nursing, January 1942, p. 24. Reprints available.

Public health nursing is an organized community resource for furthering public health measures designed to prevent and reduce sickness and to produce positive health. These measures include environmental planning for health and safety; opportunities for gaining knowledge and attitudes favorable to maintenance of health; facilities for diagnosis and for preventive and restorative treatment. The contribution of the public health nurse is essentially educational, whether her service is given in the form of nursing care to the sick or health guidance and instruction to the sick and well; whether she works in home, health center, clinic, school, or industrial plant; whether she is employed by a governmental or voluntary, health or nonhealth agency. Her services are available to all age groups in all economic and social circumstances—to those who can afford to pay full or partial fees as well as to those who cannot.

Broadly speaking, then, the functions of public health nurses are to help make known scientific facts about health; to help create positive attitudes toward the acquisition and maintenance of health; to encourage and teach the use of health and medical resources; to contribute toward the adjustment of social conditions to the end that the individual and the family will become resourceful in meeting their health needs. The public health nurse has a community responsibility in keeping before the attention of its citizens the needs and reasons for adequate funds, facilities, and services; in helping the community to understand and apply efficient, economical methods of administering and coordinating nursing services in order to obtain maximum benefits without duplications and inequalities.

PUBLIC HEALTH NURSING PROGRAM

Although many types of service are embodied in a public health nursing program, each requiring some differentiation in approach and content, this is entirely compatible with a generalized service whereby every public health nurse serving families directly gives all the kinds of public health nursing they need.

PUBLIC HEALTH NURSING FUNCTIONS

Essential to good quality in any public health nursing service are awareness and understanding on the part of the public health nurse of:

The total health and social movement to which she contributes.

The bearing of economic and social factors on individual and national health.

The motivations and individual variations in human behavior and their significance in the preservation and attainment of health.

Principles of mental hygiene and their application, for making nurse-patient and worker-to-worker relationships more productive for all concerned.

The relation of nutrition to health and to normal growth and development, including signs of poor nutrition.

The significance of adequate recording and reporting of conditions and services in continuity and completeness of care, in evaluating past and planning future activities; and in relating needs to program.

Functions applicable to all phases of a generalized public health nursing service are:

Studying health needs in relation to the physical and mental condition of the individual, his family situation, and his working environment.

Encouraging and helping to secure continuous health supervision.

Bringing people not receiving medical supervision or care when needed into touch with available resources.

Helping the individual plan his daily life in a way to enable him to make the most of medical advice and all other health services at his disposal.

Giving and arranging for home nursing when needed for all age groups and health conditions.

Teaching others to give this care—relatives, nonnurse helpers, midwives—under professional nursing supervision.

Aiding in the development of community resources for health education and for prevention and treatment of illness by contributing to general knowledge of needs and by sharing in community planning and action.

Differences in various phases of the public health nursing program grow out of the actual needs of each age group or health condition, not the availability of special funds or special agency interests, and do not imply specialized workers. They are reflected in the activities of the general public health nurse, as follows:

Maternity

Getting in touch with prospective mothers and assisting in securing medical and dental examination and supervision early in pregnancy and throughout the maternity cycle.

Assisting in planning and preparing for hospital or home confinement.

Helping to secure postpartum medical examination.

Giving or arranging for nursing care at delivery if at home, and for the postpartum period.

Teaching others by demonstration, and supervising care given by relatives, attendants, and midwives.

Helping the family to carry out specific medical advice for the mother's and baby's care.

Helping the family, if eligible, to utilize special provisions for maternal care such as those available through Federal and State Government.

*Child health supervision**The infant and preschool child*

Assisting in securing complete birth registration.

Assisting in securing medical supervision, dental examination and correction of defects for every child.

Giving or arranging for nursing care of sick children, teaching through demonstration, and supervising care given by relatives and attendants.

Assisting in the control of communicable diseases through teaching the recognition of early symptoms, the importance of isolation and the value of immunization.

Participating in programs for the prevention of handicaps and the care and education of handicapped children.

Assisting the family to carry out general and specific medical advice concerning feeding, with emphasis on breast feeding.

Assisting the family to carry out general and specific medical instruction concerning early child care and training.

The school child

Participating in developing school health education programs based on the needs of the pupils.

Assisting physicians in the examination of school children and interpreting findings and recommendations to teachers, parents, and children.

Teaching the value of adequate health supervision and helping in the use of health facilities.

Assisting in securing correction of defects.

Instructing teachers, parents, and pupils to observe and recognize normal health and deviations from it.

Assisting in the control of communicable disease through teaching the recognition of early symptoms, the importance of isolation, and the value of immunization.

Promoting the maintenance of a physically healthful school environment, including sanitation, seating, lighting, ventilation, school lunches, and other physical factors.

Promoting the maintenance of an emotionally and socially healthful school environment.

Arranging for the care of emergency and minor injuries and illnesses in accordance with medical standing orders.

Participating in a program for the prevention of handicaps and the care and education of handicapped children.

Coordinating public health nursing activities for school children with all other health forces of school, home, and community.

Participating in curriculum making, and giving group instruction in principles of healthful living and home care of the sick.³

Adult health supervision

Encouraging periodic health examinations.

Teaching the fundamentals of personal hygiene in order to assist in the prevention and retardation of diseases specific to adult life.

Assisting in securing early diagnosis and treatment of those diseases.

³ This requires qualifications in the field of education as well as public-health nursing.

Industrial nursing

Promoting positive health through teaching individuals and groups of workers personal hygiene and the prevention of disease and injuries.

Giving or providing for first aid under medical direction, and also for necessary subsequent care to sick or injured employees.

Assisting the physician with medical examination of employees.

Assisting in securing the correction of defects.

Coordinating the health service with the industrial relations program, which may include:

Assisting the safety department in the interpretation of its program.

Keeping adequate medical and health records of all cases including compensation cases.

Offering consultation service to the manager of the lunchroom.

Interpreting the plant sanitation program to employees.

Assisting in developing recreational facilities.

Making available to various department appropriate data from nursing records.

Coordinating the nursing service with the other health and social services in the community through:

Securing needed health and social service for the industrial worker and his family.

Developing working relations with the health department and other community agencies and securing their participation in promoting health within the plant.

*Communicable-disease control**Acute communicable diseases*

Promoting the complete reporting of reportable diseases.

Teaching the need of medical care and assisting the family to secure it.

Giving or arranging for home nursing care, teaching through demonstration, and supervising care given by relatives and attendants.

Assisting the family to carry out isolation technique and general and specific medical instructions.

Interpreting health department procedure to individuals and groups.

Assisting, under authority of the health department, in making epidemiological investigations.

Instructing parents, teachers, and other individuals and groups:

To recognize early symptoms and isolate suspected cases.

To carry out proper precautions to prevent the spread of infection.

To provide adequate convalescent care.

Helping to secure specific immunization.

Tuberculosis

Assisting in securing reporting of all cases.

Assisting in finding cases, especially those with early minimal lesions and their contacts, and securing medical examination and supervision.

Securing medical examination and supervision for all cases and contacts.

Assisting, under authority of the health department, in making epidemiological studies, and where feasible, in installing central case registries.

Helping to arrange for sanatorium and postsanatorium care.

Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and attendants where sanatorium care is not available or is refused by the patient.

Using State and local facilities for rehabilitation of the patient.

Teaching patient and family the importance of personal hygiene and the precautions to be taken to prevent the spread of infection.

Stressing the importance of early diagnosis and X-ray examination.

Interpreting the significance of the tuberculin test.

Helping patient and family with emotional and social adjustment to a long-term communicable disease.

Helping to inform the community regarding prevention, control, and treatment of tuberculosis.

Assisting in integrating services of clinics, sanatoria, private physicians, health department, and other related health and social agencies.

Veneral diseases

Assisting in finding cases and contacts and in securing medical examination and supervision.

Promoting continuity of treatment by helping the patient follow medical directions, and cooperating with other workers to this end.

Teaching patient and family the precautions to be taken to prevent the spread of infection.

Teaching scientific facts concerning these diseases to individuals and groups.

Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and nonnurse helpers.

Assisting, under authority of the health department, in making epidemiological investigations.

Promoting the reporting of cases.

Noncommunicable disease

Assisting in securing early medical diagnosis and treatment.

Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and attendants.

Assisting in arranging for and giving special care to patients with special types of disability such as orthopedic, arthritic, and cardiac conditions, diabetes, and cancer.

Assisting in planning convalescent care and rehabilitation of the patient.

Observing and assisting in adjustment of health situations in the homes of patients; teaching general hygiene and the prevention of disease; and bringing the family in touch with appropriate community health resources.

*Orthopedic service*⁴

Assisting in finding orthopedic cases.

Observing and helping others to recognize and eliminate environmental conditions or habits which might produce postural or other orthopedic defects.

Observing and helping eliminate conditions of bed patients which may cause contractures, foot drop, or spinal curvature.

Observing and teaching others to recognize orthopedic defects and helping to secure medical diagnosis and supervision.

Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and nonnurse helpers.

Giving or securing skilled physical therapy under medical direction to prevent deformities and secure maximum return of power to muscles and joints.⁵

Teaching patient and family the importance of self-reliance on the part of the crippled person, promoted by encouraging independence in daily activities and interest in useful occupations.

In addition to the activities related to various phases of a general public health nursing service as enumerated above, the public health nurse also contributes to public health measures in the fields of sanitation and vital statistics.

In the field of sanitation, her assistance may include:

Ascertaining the source of water supply and the means of excreta disposal in home and schools she visits, and referring them to the public health engineer for investigation when necessary.

Teaching the importance of correcting unsatisfactory sanitary conditions, and the methods of immediate protection pending their correction.

Observing ventilation and screening and teaching proper measures in relation to them.

Inquiring about the source of the milk supply, and teaching standard sanitary methods of milk production and handling, including pasteurization.

In the field of vital statistics:

Instructing as to the value of birth registration and the importance of accurate statements on birth certificates, and making sure that births are registered before closing maternity cases.

Cooperating with the registrar in reporting names of newborn babies known to her in localities where birth reporting is poor.

Reporting stillbirths or deaths of shortlived infants who may be buried without formalities.

⁴This service is discussed separately because of the special attention given to crippled children's services through Federal and State appropriations.

⁵Public-health nurses give this treatment only if they are also qualified physical therapy technicians.

Assisting with morbidity and mortality studies which are useful in determining needs for service and in formulating public health programs.

MEDICAL APPROVAL OF STANDING ORDERS

Medical approval for specific nursing procedures in the care of the sick and for general preventive and instructive services is basic to public health nursing practice. This approval is usually obtained in the form of standing orders endorsed by a medical group designated by the agency administering the public health nursing service. In case of nursing care of the sick, medical directions also come directly to the public health nurse from the patient's physician. Standing orders are used until special orders can be obtained and/or unless special orders are not given.

CITIZENS' COMMITTEE

Guidance from a citizens' or consumers' committee is essential to the best development of a community public health nursing service whether under official, nonofficial, or joint administration.

AMERICAN NURSES' ASSOCIATION, SPECIAL COMMITTEE ON FEDERAL LEGISLATION

Chairman, Miss Annabelle Petersen, R. N., Assistant to Director, Nursing Services, American Red Cross, Washington 13, D. C.

Miss Edith M. Beattie, R. N. (American Nurses' Association delegate on the Women's Joint Congressional Committee, and executive secretary, Graduate Nurses' Association of the District of Columbia), 1746 K Street NW., Washington 6, D. C.

Miss Janet Fish, R. N., 1624 Thirty-second Street NW., Washington 7, D. C.

Miss Mattie Gibson, R. N., superintendent, Children's Hospital, Washington 9, D. C.

Miss Ashby Taylor, R. N. (director of nurses, Children's Hospital, Washington, D. C., and president of the Graduate Nurses' Association of the District of Columbia), Children's Hospital, Washington 9, D. C.

Mrs. Katharine Miller, R. N., general secretary, Pennsylvania State Nurses' Association, 400 North Third Street, Harrisburg, Pa.

Miss Marguerite K. Jacobsen, R. N., assistant executive secretary, American Nurses' Association, 1790 Broadway, New York 19, N. Y.

Mrs. Eugenia Kennedy Spalding, R. N., assistant professor, school of nursing education, Catholic University of America, Washington 17, D. C.

Miss Blanche Pfefferkorn, R. N., director of studies, National League of Nursing Education, 1790 Broadway, New York 19, N. Y.

Miss Ruth Fisher, R. N., associate director for administration, National Organization for Public Health Nursing, 1790 Broadway, New York 19, N. Y.

Mrs. F. S. Dellenbaugh (former member of board of directors of National Organization for Public Health Nursing), Litchfield, Conn.

Miss Ella Casey, R. N. (chairman of membership committee, New York Industrial Nurses' Club), 916 Hudson Street, Hoboken, N. J.

EX-OFFICIO MEMBERS

Miss Katharine J. Densford, R. N., president, American Nurses' Association, school of nursing, University of Minnesota, Minneapolis 14, Minn.

Miss Ella Best, R. N., executive secretary, American Nurses' Association, 1790 Broadway, New York 19, N. Y.

MISS DENSFORD. And may I ask, too, whether there is any question you would like to put to the representative of the National Organization for Public Health Nursing, Miss Fisher, who is here to answer any question you may wish to ask her.

SENATOR PEPPER. I think you have covered the subject quite well, unless some other member has any question, or unless she wishes to present herself.

MISS DENSFORD. Thank you for the privilege of appearing.

SENATOR PEPPER. Thank you. We are very glad to have had you come.

The next witness is Mrs. Beatrice Jacobs of the executive board, League of Women Shoppers.

STATEMENT OF MRS. BEATRICE F. JACOBS, CHAIRMAN OF THE HEALTH AND EDUCATION COMMITTEE, THE LEAGUE OF WOMEN SHOPPERS, INC.

Senator PEPPER. We are pleased to have you here, Mrs. Jacobs. Will you give us, please, your name, address, the organization you represent, and your statement.

Mrs. JACOBS. Yes.

Senator PEPPER. Please.

Mrs. JACOBS. My name is Beatrice Jacobs. My address is 1498 West End Avenue, New York City, and I represent the League of Women Shoppers, Inc.

Senator PEPPER. You go right ahead, Mrs. Jacobs.

Mrs. JACOBS. Mr. Chairman and members of the Senate Education and Labor Committee:

It is my privilege to represent the League of Women Shoppers, a national consumers' organization. The purpose and activities of our organization have always been directed toward the improvement and protection of the American standard of living. Since good health is vital and essential to that standard, we support Senate bill 1606 which will do much to promote the physical and mental well-being of our population and so insure a higher standard of living for all Americans.

THE PROBLEM OF MEDICAL COSTS

Meeting medical costs has always been one of the greatest problems of our population. In 1935 the Public Health Service found more than 23,000,000 Americans—nearly one-fifth of our population—suffering physical impairment or chronic disease. A recent survey by the National Opinion Research Center of the University of Denver revealed that 31 percent of the people questioned put off seeing a doctor because of the cost, and 23 percent had had to borrow money to pay doctor or hospital bills. One has only to scan the pages of the *New York Times* during December of each year when the 100 neediest cases are printed. More than 50 percent of the cases cite hardships caused by illness and inadequate medical care. In many cases the chronic illness which afflicts the victim might have been prevented by early diagnosis and treatment.

These families however, harassed by economic insecurity, often neglect early symptoms, delay seeing a doctor because of the expense involved or the stigma attached to a public clinic and, when finally forced to consult a physician, learn that they will be incapacitated for several months or years. How many of these wrecked lives would be saved and how many families salvaged if adequate medical care were given at the proper time? Take the case of Gloria, a girl of 13, who showed by her pallor and listlessness signs of severe malnutrition. This malnutrition was caused by her refusal to eat because she feared the food was poisoned. She would awake night, scream and strain to hear "voices." Her mother was assured, however, that with proper psychological help, she would have a good chance of growing up

normally and of finding that happiness of which she had been so tragically deprived. Yet her mother's meager earnings of \$27.50 a week could not afford her the psychological care she required. And the intensive treatment she needed could not be given by the existing inadequate public facilities.

In the junior high school in which I recently taught there was the case of Alfred. He was a boy who, in spite of his high IQ was a persistent truant. He had attended school for only 6 days in a semester and was on the road to delinquency. And there was little Dominic, a listless dreamer who was considered by the Catholic charity authorities to be a potential dementia praecox case. In almost every class there were children who were unable to learn how to read, not because of any mental deficiency, but because they were deeply disturbed psychologically. Much as the Child Guidance Bureau realized the urgency of these cases, they could do nothing for Alfred or Dominic, or the dozens of others, for the Child Guidance Bureau is equipped to treat intensively only one or two children in each school and the quota of that school had been filled.

Must these children grow up to be delinquents or helpless psychotics, or shall they be given the chance to grow into normal, well-adjusted, useful citizens? Numerous, well-staffed psychological centers within easy reach of the children, could save them from the ravages of mental diseases. Individual psychologists whom the families might consult, under the provisions of the bill, could help these children adjust to society. Does this not seem a good investment for the country to make? Does it not seem, gentlemen, as profitable to save these human assets as it does to save the natural resources of our country?

Medical service should not be considered a luxury. Rather it is the right of every human being to enjoy good health. The income of the person, his race or color, or the fact that he resides in a less privileged community should not limit his opportunities to use all the resources of modern medicine. Yet, under the present set-up, we find that medical care is definitely correlated with income. Families with incomes of less than \$1,000 spend one-third of the amount on medical care that is spent by families whose incomes are in the \$3,000 to \$5,000 class. Yet illness in the lower income group is three times as frequent as it is in the higher income group. President Truman stated only recently that we have not been efficient—

in making available to all our people the benefits of medical progress—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 the rural areas do not get the same amount or quality of medical attention as those who live in cities.

In fact, over 40 percent of the Nation's counties are without a single satisfactory general hospital. Whereas the ration in New York City of doctor to patient is 1 to 700; in some Southern States the ratio is 1 to 2,100. Doctors naturally tend to practice where they are assured of an adequate income and where the hospital and medical facilities are sufficient to permit them to carry out their work effectively.

Only if public-health facilities, hospital accommodations and laboratory equipment are provided in rural areas, and if doctors are assured of a decent income by a prepaid plan can the people living there expect adequate medical service. The passage of this bill would help bring this about.

ADEQUATE MEDICAL CARE A GOVERNMENT RESPONSIBILITY

Our organization feels that it is the responsibility of the government to provide adequate medical care for its people, just as it is its responsibility to provide for them in old age by social security and to provide for them during periods of unemployment. No person whose health is not up to standard or whose children are being poorly cared for can enjoy the right to the "pursuit of happiness" which our Constitution guarantees. Furthermore, we feel that it is to the advantage of the country as a whole that people's health improve. In 1943 600,000,000 work days were lost because of illness, mostly common ailments which had been neglected. If these people felt that they could see a doctor at the first signs of illness without having to worry about the cost, much of this lost time could have been saved.

In 1940, the National Youth Administration examined 150,000 youths and found 1 in every 7 was in urgent need of some kind of medical or dental treatment. Their conclusion was that health defects limited the kind of work that one-third of American young people do. Certainly if proper medical care increased the number of persons able to do all kinds of work, and if a large number of lost work days could be avoided, the productive capacity and resulting prosperity of our country would be heightened.

Although the advances of medical science have been tremendous, most people cannot take advantage of these remarkable techniques because they cannot afford them. Many a doctor hesitates to recommend expensive X-ray examinations, costly laboratory tests, and other services even though he honestly feels that the patient's condition warrants them, for he realizes the cost would be too burdensome. Yet he cannot make a correct diagnosis without them.

BENEFITS FROM TITLE II

As a result, he often makes a superficial diagnosis with which he himself is not satisfied. Under the set up provided for in this law, all X-ray laboratory techniques, and hospital facilities would be available to the patient for they would be included in the insurance. Do you not think, gentlemen, that many of the degenerative diseases, such as cancer, diabetes, and heart ailments would be delayed or prevented by the use of these facilities? If they are available, why should all the people not be able to use them? Should the benefits of science be limited only to those able to afford them?

Title II of the bill has a double beneficial effect. For the patient it does away with the stigma of charity. It assures him the freedom to choose his own doctor, to change doctors at will, a choice never given to patients in a clinic, to have the services of a doctor at home or in his office. It provides hospitalization and makes available to him all the known modern medical facilities.

The doctor can join a panel or not, as he wishes. He can treat or refuse to treat a patient as he wishes. He will have for consultation specialists, laboratory technicians, surgeons—and his fee will be paid.

SUPPORT OF PEPPER AMENDMENT TO TITLE I

In title I, part B of S. 1606, dealing with maternal and child health services, we support the amendments offered by Senator Claude Pepper.

America, which has contributed so effectively to the discovery of atomic energy and which is in the forefront of industrial and scientific progress is pitifully lagging in medical care. When it has been found that 8,000,000 of our 22,000,000 young men were not suited for general military duty because of reasons of health, we must conclude that something is radically wrong with the medical care available to the average person. Yet this need not be so. A change of attitude is necessary. If the people of the country feel it is their right to enjoy good health, and they do feel that way, according to the University of Denver poll, and if they are willing to pay for it, the health and living standards of this country can be infinitely improved.

Why should we be in an atomic age of science and in a primitive age of medical care? Let us, through the Wagner-Murray-Dingell bill, emerge from the darkness of indifference to the light of responsibility.

Senator PEPPER. I think we are indebted to you for your very excellent statement. What you are obviously trying to emphasize is the great need which is unsatisfied at the present time.

Mrs. JACOBS. That is right, sir.

Senator PEPPER. To afford adequate medical care for the people of this country.

Mrs. JACOBS. That is right.

Senator PEPPER. You feel this bill, by creating a national insurance program in which people would be eligible to participate will go along way toward furnishing to the people the medical care which they have a right to have.

Mrs. JACOBS. I think so; yes.

Senator PEPPER. And that both in respect to the civilian population and in the military, the general discoveries that are made by all kinds of surveys and tests, is to show that a great many people in this country at the present time are going to a premature death, or are suffering unnecessary illness.

Mrs. JACOBS. That is right.

Senator PEPPER. With the consequent loss of time, as well as suffering, and heartache and the disrupting of the family, perhaps, because they are not getting the medical care that medical science is able to afford, provided the people were able to buy it.

Mrs. JACOBS. That is right.

Senator PEPPER. We want to give Senator Donnell an opportunity to ask questions.

Senator DONNELL. I understood you to say that your home is in New York City.

Mrs. JACOBS. That is right.

THE LEAGUE OF WOMEN SHOPPERS

Senator DONNELL. And are you the president of the League of Women Shoppers?

Mrs. JACOBS. I am the chairman of the health of education committee.

Senator DONNELL. How large an organization is that, the League of Women Shoppers, Inc.?

Mrs. JACOBS. We are a national organization that has branches throughout the country.

Senator DONNELL. Approximately how many?

Mrs. JACOBS. You mean the actual membership?

Senator DONNELL. Yes.

Mrs. JACOBS. I am not the membership chairman, so I do not know the exact figures. The Herald Tribune, the press, has rather recently put our figures as 40,000, nationally.

Senator DONNELL. According to the New York Herald?

Mrs. JACOBS. According to the New York Herald Tribune.

Senator DONNELL. Mrs. Jacobs, does the League of Women Shoppers have meetings or conventions?

Mrs. JACOBS. Yes, we do; we have a convention once a year.

Senator DONNELL. When was the most recent one held?

Mrs. JACOBS. The last convention was held last May.

Senator DONNELL. May of 1945?

Mrs. JACOBS. Yes.

Senator DONNELL. That was prior to the introduction of this S. 1606, in the Congress?

Mrs. JACOBS. Yes.

Senator DONNELL. So that of course you did not pass specifically on S. 1606 at that meeting.

Mrs. JACOBS. But we did in each chapter of the league. You see, we have executive boards of each chapter, and we can pass on the bills according to the individual chapters and the national executive board itself passed on the bill.

Senator DONNELL. I was coming to that in just a moment. The national meeting, however, obviously did not pass on S. 1606.

Mrs. JACOBS. The national executive board did pass on it.

Senator DONNELL. I am talking about the annual meeting held last year in May of 1945.

Mrs. JACOBS. No; it did not.

Senator DONNELL. Did the meeting held last May, 1945, pass on S. 1606, or S. 1161?

Mrs. JACOBS. We favored that; yes.

Senator DONNELL. Did you pass resolutions on that?

Mrs. JACOBS. I am not certain.

Senator DONNELL. On either of those bills?

Mrs. JACOBS. I am not certain we passed resolutions. We favored the bill; whether we passed resolutions or not, I am not certain.

Senator DONNELL. You act through regulations, do you not?

Mrs. JACOBS. Yes.

Senator DONNELL. You express the opinion through resolutions?

Mrs. JACOBS. Yes; we do.

Senator DONNELL. You do not know whether resolutions were adopted or not, do you, at the annual meeting of last May?

Mrs. JACOBS. At that annual meeting, I cannot say.

Senator DONNELL. You cannot say?

Mrs. JACOBS. No.

Senator DONNELL. Now, referring to these actions of the local organizations, how many local organizations do you have, approximately, through the country?

Mrs. JACOBS. Nine.

Senator DONNELL. Nine?

Mrs. JACOBS. Yes.

Senator DONNELL. In the larger cities, are they?

Mrs. JACOBS. Largely, yes, Denver and Columbus, Ohio, and cities of that size.

Senator DONNELL. Have all of those nine bodies passed specifically upon S. 1606?

Mrs. JACOBS. They have.

Senator DONNELL. When did that action take place?

Mrs. JACOBS. I do not know. They would be at various board meetings. I cannot give you the dates of those.

Senator DONNELL. Have you seen the resolutions adopted at any of those board meetings?

Mrs. JACOBS. I have not. They may be in the national office of our organization, but I have not personally seen them.

Senator DONNELL. You have not personally seen them?

Mrs. JACOBS. No.

Senator DONNELL. How did you learn that these various nine organizations had specifically acted on S. 1606?

Mrs. JACOBS. I was told that by the national executive board.

Senator DONNELL. By the national executive board?

Mrs. JACOBS. Yes.

Senator DONNELL. But you have not seen the resolutions?

Mrs. JACOBS. No; I have not seen them.

Senator DONNELL. Is there anyone else here today on behalf of your organization?

Mrs. JACOBS. There is.

Senator DONNELL. Do you know anyone here who has copies of those resolutions that were passed by these nine?

STATEMENT OF MRS. SOPHIE ANZEL

Mrs. ANZEL. I am a member of the League of Women Shoppers, and so far as I know, the national executive board determines what is to be supported, and anything that the national executive board decides upon is binding on the local leagues, regardless of whether they have originally passed a local resolution or not. They may have individually passed on them locally, but the national board speaks for League always as a whole throughout.

Senator DONNELL. I wonder if you would be kind enough to step forward so that we can hear you and you can hear us. Will you take this chair, please.

So that the record may show your name, would you be kind enough to give it?

Mrs. ANZEL. Mrs. Sophie Anzel.

Senator DONNELL. Where is your home?

Mrs. ANZEL. 150 West Eighty-seventh Street.

Senator DONNELL. New York City?

Mrs. ANZEL. New York.

Senator DONNELL. Mrs. Jacobs, you do not know, then, I take it, in view of what Mrs. Anzel said, if I understood her correctly, you do not know whether these nine component organizations over the country have passed resolutions on S. 1606?

Mrs. JACOBS. I do know that I was told that locally this bill was favored by the executive boards of all branches.

Senator DONNELL. Who told you that?

Senator PEPPER. Excuse me. Maybe Mrs. Jacobs could furnish information for the record, a statement by the national executive board, with respect to the date of the passage of these various resolutions by the district council, if they were passed. Would you be able to do that?

Mrs. JACOBS. Do you mean right now?

Senator PEPPER. When you go back.

Mrs. JACOBS. I could send them.

Senator DONNELL. I want to interrogate her on the matter a little further, too.

What was the name of the lady that told you that, you say, these nine organizations had passed resolutions with respect to S. 1606?

Mrs. JACOBS. Mrs. Bodin.

Senator DONNELL. How do you spell that?

Mrs. JACOBS. B-o-d-i-n.

Senator DONNELL. What is her full name?

Mrs. JACOBS. Vera Bodin.

Senator DONNELL. Where does she live?

Mrs. JACOBS. New York City.

Senator DONNELL. Do you know her street address?

Mrs. JACOBS. I do not know. It is on East Ninety-sixth Street, but I do not know the exact number.

Senator DONNELL. Your information came from her, and you have not seen the actual resolutions passed by any of those nine organizations. That is right, is it not?

Mrs. JACOBS. Yes.

Senator DONNELL. And I undertood that this lady said that she does not know whether they were passed by those organizations, those nine. Am I right?

Mrs. ANZEL. I was not so informed personally, but from my knowledge of the structure of the league, I know that the national executive board passes on issues, and those decisions are binding on the other local leagues.

Senator DONNELL. That is what I understood your statement to be.

Mrs. ANZEL. That is true, to the best of my understanding.

Senator DONNELL. I understood that to be your statement from which I infer that that may be correct, although we will check that, and I am sure you will have Mrs. Bodin furnish that. We will check whether this was actual action taken by the nine component organizations, or whether it was action taken by the national board. What is the name of that board?

Mrs. ANZEL. National League of Women Shoppers.

Senator DONNELL. You spoke of some national board.

Mrs. ANZEL. The executive board of the national league.

Senator DONNELL. How large a body is that executive board. Since Mrs. Jacobs is testifying, I will ask her, although if she wishes to collaborate with this other lady, that will be perfectly all right.

How large a board is this executive board?

Mrs. JACOBS. I could not say exactly.

Mrs. ANZEL. I am not a member of the board myself. I am a member of the New York board.

Senator DONNELL. You are a member of the New York board?

Mrs. ANZEL. I am not in possession of the facts.

Senator DONNELL. Very well. Would you, Mrs. Jacobs, furnish us also at the same time that you furnish us with this information about the nine component branches, the action taken by them, if any, would you also furnish us with a copy of whatever resolution has been passed by the national executive board of your organization, giving us the date at which the resolution was passed, and the place at which it was passed?

(The information is as follows:)

LEAGUE OF WOMEN SHOPPERS, INC.,
NEW YORK CHAPTER,
New York 10, N. Y., May 15, 1946.

Hon. JAMES E. MURRAY,
Senate Labor and Education Committee, Washington, D. C.

MY DEAR SENATOR MURRAY: When Mrs. Beatrice Jacobs testified at the hearings of your committee on April 24, she promised to send you a memorandum of the action taken by our organization on the Wagner-Murray-Dingell bill.

At a national executive board meeting of the League of Women Shoppers held on February 28 a resolution in support of the Wagner-Murray-Dingell bill was passed. Such action by the national executive board is binding upon all the chapters of the league.

Respectfully yours,

KATHERINE ARMATAGE.

Mrs. JACOBS. Yes.

Senator DONNELL. Do you know whether or not a copy of S. 1606 was sent out to your 40,000 members over the country?

Mrs. JACOBS. I do not know that.

Senator DONNELL. You do not know that. So you do not know whether the membership as a general whole, 40,000 persons, have actually examined the bill?

Mrs. JACOBS. No; but I will say that we have had many meetings, each chapter has had many meetings of its membership at which this was discussed, at which the speakers have been sent to discuss this bill, and at which the members were free to express their opinions on it.

Senator DONNELL. By chapters, do you mean these nine component organizations?

Mrs. JACOBS. That is right.

Senator DONNELL. Of course you have not attended those meetings, all of those meetings, have you?

Mrs. JACOBS. I could not throughout the country.

Senator DONNELL. You have attended, I take it, the meetings of the organization to which you belong.

Mrs. JACOBS. That is right.

Senator DONNELL. New York City, is that right?

Mrs. JACOBS. Yes.

Senator DONNELL. And has your local organization in New York City, the one to which you belong, has it passed any resolution with respect to S. 1606?

Mrs. JACOBS. It has.

Senator DONNELL. Were you there when it was passed?

Mrs. JACOBS. Yes.

Senator DONNELL. And when was that passed, as nearly as you can tell us?

Mrs. JACOBS. I do not remember exactly, a month or two ago. Do you remember exactly?

Mrs. ANZEL. I do not remember. I think it was in the fall of the year. I am not sure.

Senator DONNELL. When was that?

Mrs. ANZEL. Shortly after the bill was introduced.

Senator DONNELL. Are either of you ladies able to tell us whether a copy of S. 1606 was before the meeting of your particular local organization when action was taken?

Mrs. ANZEL. Yes; I believe it was.

Senator DONNELL. Are you sure of that?

Mrs. ANZEL. We attempt to get copies of bills before we pass any decision on it.

Senator DONNELL. Are you sure of whether a copy of S. 1606 was in your local organization when your action was taken by that local organization?

Mrs. JACOBS. It was, and Mrs. Bodin, a lawyer, helped to analyze it.

Senator DONNELL. Was the entire document read to your organization?

Mrs. JACOBS. No; the entire document was not.

Senator DONNELL. It was not?

Mrs. JACOBS. The analysis was.

Senator DONNELL. The analysis presented by Mrs. Bodin was presented to your organization?

Mrs. JACOBS. Yes.

Senator DONNELL. And that is what the local group acted upon, is it not?

Mrs. JACOBS. That is right.

FREE CHOICE OF A DOCTOR

Senator DONNELL. For instance, Mrs. Jacobs, you say in your statement over here that title II assures for the patient the freedom to choose his own doctor. Have you examined this bill personally to see whether that is a correct statement?

Mrs. JACOBS. I examined the bill and that was my understanding within limits, of course.

Senator DONNELL. Well, you do not say anything about the limits here in your statement. You say, and I am quoting, "It assures him the freedom to choose his own doctor."

Mrs. JACOBS. Still we consider that the present system assures the choice, do we not? I mean we assume now that that patient has the choice of a doctor. Well, that, too, even under the present set-up, is limited and still we do not always say that. It is limited by the fees of the doctor, by the high fees, and naturally every mother of a child would want to go to the best doctor available, but if his fees are \$15 in the office, instead of \$3, she has to choose the doctor that charges \$3, so it is limited in that respect. So it would be limited under this bill to that extent.

Senator DONNELL. The statement in your testimony here that the bill title II "assures him"—that is, the patient—"the freedom to choose his own doctor"—that is subject to some limitation?

Mrs. JACOBS. Yes; I would say somewhat the same as at the present time.

Senator DONNELL. Regardless of whether it is the same, it is subject to some limitations.

Mrs. JACOBS. Some limitations; yes.

Senator DONNELL. Your statement here, however, does not mention those limitations, does it?

Mrs. JACOBS. No; but I am telling you.

Senator DONNELL. I understand you are telling me, but it is not in the statement as you have had it typed here, and as you gave it to us this morning.

Let me call your attention to section 205 (j), appearing on page 50 of the bill, reading:

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.

You are familiar with that, are you not?

Mrs. JACOBS. Yes, I am.

Senator DONNELL. In other words, in a community in which a majority of the doctors who go into this governmental insurance plan decide upon the per capita basis of the payment the surgeon general says as to Dr. Jones that you may have 1,000 patients and no more, or some number that the Surgeon General fixes.

Mrs. JACOBS. I understand that.

Senator DONNELL. If that man happens to be the type of man that you speak of that everybody wants to go to, and his quota is filled up pretty rapidly, then if you or I came in there 5 days later and wanted to get on his list, we do not have the freedom of choice to get on it, do we?

Mrs. JACOBS. No.

Senator DONNELL. As you pointed out today, if a doctor has more than he can do, he cannot get on either.

Mrs. JACOBS. That is right.

Senator DONNELL. But today, Mrs. Jacobs, the freedom of decision as to whether or not the patient may get on his list is left not to the Surgeon General of the United States, but to the local physician himself, and to you; that is correct, is it not?

Mrs. JACOBS. Yes; that is true, but I am not sure that that is always so good. My experience has been that when a doctor does not limit his own practice, very often there is a great deal of negligence of the patient, and I think limitation of a practice is a good thing for the patient.

Senator DONNELL. I am not arguing with you on whether or not it is good or bad. The point I am making is that the bill does prescribe limitations.

Mrs. JACOBS. That is right.

Senator DONNELL. By law.

Mrs. JACOBS. I know.

Senator DONNELL. And vests in the Surgeon General the authority to provide those limitations.

Mrs. JACOBS. That is right.

Senator DONNELL. Whereas under the existing law today if a doctor in his own best judgment thinks he can receive a patient, he has the legal right to do it, is that right?

Mrs. JACOBS. I know it, yes.

Senator DONNELL. So to that extent, then, the freedom of choice by the patient of his physician is different under the bill from what it is today. That is correct, is it not?

Mrs. JACOBS. That is right, but I do not think there is any more freedom under one than under the other, really.

The CHAIRMAN. May I say right there, I would like to call attention to the fact that a very prominent and distinguished physician was here 2 days ago, and he pointed out that the freedom of choice is limited by the physician whose services are sought, by the method he employs in jacking up his fees.

Mrs. JACOBS. That is right.

The CHAIRMAN. He jacks up his fees so high.

Mrs. JACOBS. That is right.

The CHAIRMAN. The patient who desires the services is compelled to go to some other physician.

Mrs. JACOBS. That is right.

The CHAIRMAN. That is the existing system in the United States under the present system.

Mrs. JACOBS. That is just as much limitation to that.

Senator DONNELL. There is room as to whether there is just as much. At any rate, the point I am making, I am not criticizing your statement; I am analyzing it. When you tell us that this bill assures the patient the freedom to choose his own doctor, and that must be modified certainly by the limitation that I have expressed to you, in my questions, must it not?

Mrs. JACOBS. Yes; I think so.

Senator DONNELL. You think there exist limitations today?

Mrs. JACOBS. Yes; I do.

Senator DONNELL. But not limitations imposed by the law, are they?

Mrs. JACOBS. No.

Senator DONNELL. Mrs. Jacobs, I call your attention also to the fact that while the bill S. 1606 says that the Surgeon General may prescribe these maximum limits of number of potential beneficiaries, that it is also stated in this bill that 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. You are familiar with that, are you not?

Mrs. JACOBS. Yes.

Senator DONNELL. Section 203 (a), you know, as a matter of fact that the present Federal Security Administrator, and this is not said critically, is not a doctor. No one on this committee sitting here today is a doctor. But he is not a doctor, but the performance of the duties of the Surgeon General imposed upon him by this act under section 203 (a) and I quote exactly, are "under the supervision and direction of the Federal Security Administrator." That is correct, is it not?

Mrs. JACOBS. Yes.

Senator DONNELL. Therefore this limitation of the choice by a patient of his physician is not only subject, as I read this law 1606, to the right of the Surgeon General to prescribe maximum limits of potential beneficiaries, but is also subject to the fact that the Surgeon General himself is subject to the supervision and direction of the Federal Security Administrator. That is right, it is not?

Mrs. JACOBS. That is right.

Senator DONNELL. You say also in your statement that this bill assures the patient the freedom to change doctors at will. You say that, do you not?

Mrs. JACOBS. Yes.

Senator DONNELL. I quote exactly from it.

Suppose, Mrs. Jacobs that you have a physician, or rather you are on the list of Dr. Jones.

Mrs. JACOBS. Yes.

Senator DONNELL. And under this bill—

Mrs. JACOBS. Yes.

Senator DONNELL. 1606.

Mrs. JACOBS. Yes.

Senator DONNELL. And Dr. Jones does not suit you and you want to go over and change to Dr. Smith, but Dr. Smith's quota is already filled up, you cannot change over to Dr. Smith then, under the bill, can you?

Mrs. JACOBS. No; no more than you can at the present time because perhaps of the limitation of the size of the fees.

Senator DONNELL. Yes, but Dr. Smith is—

Senator PEPPER. And the number of patients he may have.

Senator DONNELL. But Dr. Smith is the man who today determines what his fees will be, and how much practice he can take, and some governmental officer, the Surgeon General down here in Washington, acting under the supervision and direction of the Federal Security Administrator, a nonmedical man, does not have anything to do with it today; does he?

Mrs. JACOBS. No.

Senator DONNELL. So that the power to change doctors at will, which you say is assured to the patient under this bill, is limited by the fact, or by the illustration that I have given at any rate; is it not?

Mrs. JACOBS. Yes, I think it is.

Senator DONNELL. I will not go into all of the details in this bill, but we might take up the question of consultation and specialists, and so forth, where the Surgeon General has the right to determine who shall be considered consultants and specialists.

Mrs. JACOBS. That is right.

Senator DONNELL. There are powers given in this bill to the Surgeon General which certainly restrict the presently existing legal rights of doctors. That is true; is it not? You will agree to that?

Mrs. JACOBS. I am sorry; I do not understand.

Senator DONNELL. The fact that the Surgeon General has the power to prescribe who shall be considered in these various categories, changes the presently existing law under which any doctor himself may decide for himself what he can practice, provided he complies with the legal standards of the State in which he is licensed. That is correct; is it not?

Mrs. JACOBS. Yes; that is.

Senator DONNELL. You mentioned in the course of your statement various statistics here, the Public Health Service. I observe that you go back to 1935, where you give the figures as to the number suffering physical impairment or chronic diseases, and then you give a survey by the University of Denver.

Do you know how many persons were surveyed by the University of Denver?

Mrs. JACOBS. No, I read about it.

Senator DONNELL. You read about it?

Mrs. JACOBS. Yes.

Senator DONNELL. Where did you read about it, please, in what document?

Mrs. JACOBS. In a pamphlet called For the People's Health.

Senator DONNELL. And who issues that pamphlet?

Mrs. JACOBS. The Physicians Forum.

Senator DONNELL. The Physicians Forum?

Mrs. JACOBS. Yes.

Senator DONNELL. That is the organization of which Dr. Boas is the president, is it not?

Mrs. JACOBS. Yes; that is right.

Senator DONNELL. That is where you got your information as to what the University of Denver research survey disclosed?

Mrs. JACOBS. That is right.

Senator DONNELL. May I ask you, Mrs. Jacobs, and this is without any offense intended, as I realize we all have to have assistance, did you have any assistance in the preparation of this testimony that you have given to us today?

Mrs. JACOBS. By whom?

Senator DONNELL. By anybody?

Mrs. JACOBS. I did it absolutely myself, except for the reading of certain material.

Senator DONNELL. And you have read certain material and have prepared this statement?

Mrs. JACOBS. Yes, alone.

Senator DONNELL. You did not have any consultation?

Mrs. JACOBS. None at all.

Senator DONNELL. With anybody on the Committee for the Nation's Health?

Mrs. JACOBS. No.

Senator DONNELL. You did not have any consultation with Dr. Boas?

Mrs. JACOBS. No; I do not know Dr. Boas.

Senator DONNELL. Do you know Mr. Michael Davis?

Mrs. JACOBS. Never heard of him.

Senator DONNELL. Have you ever heard of Mr. Isadore Falk?

Mrs. JACOBS. Never.

Senator DONNELL. Never heard of him?

Mrs. JACOBS. No.

Senator DONNELL. Are you familiar with the Committee on Research in Medical Economics?

Mrs. JACOBS. I do not know that organization.

Senator DONNELL. This committee to which I refer has an office at 1790 Broadway in New York City.

Mrs. JACOBS. I never heard of it.

Senator DONNELL. Your organization is located at 1133 Broadway, New York City, is it not?

Mrs. JACOBS. Yes.

Senator DONNELL. The League of Women Shoppers?

Mrs. JACOBS. Yes.

Senator DONNELL. Mrs. Jacobs, you speak about scanning this list in the New York Times during December of each year.

Mrs. JACOBS. Yes.

Senator DONNELL. I mean with respect to this December scanning, have you studied that over a period of years?

Mrs. JACOBS. Yes.

Senator DONNELL. Have you maintained a file on it?

Mrs. JACOBS. No.

Senator DONNELL. You have not?

Mrs. JACOBS. No.

Senator DONNELL. You say that your organization supports Senate bill 1606. Has there been any poll of any kind taken of the 40,000 members as to whether they favor it?

Mrs. JACOBS. No; as far as I know there has not. The way we work is through the executive boards.

Senator DONNELL. Through the executive boards?

Mrs. JACOBS. Yes; as I said we have many membership meetings at which this problem was discussed, and speakers addressed the members. The members were free to give their opinions, and then the executive board passed upon the bill.

Senator DONNELL. You came here today at the request of the executive board?

Mrs. JACOBS. That is right.

Senator DONNELL. How many of the members of that board live in New York City?

Mrs. JACOBS. Of the national board?

Senator DONNELL. Yes, ma'am; that is the board which requested you to come.

Mrs. JACOBS. Yes; I should say most of them, would you not?

Mrs. ANZEL. Well, they represent all of the cities as far as I know. Yes; every one of them has a representation on the board.

Senator DONNELL. Did this executive board hold a meeting in New York City at which it delegated the function of coming here to you?

Mrs. JACOBS. They did.

Senator DONNELL. When was that meeting held?

Mrs. JACOBS. I do not know.

Senator DONNELL. You were not present?

Mrs. JACOBS. I was not there. I was merely instructed to come here and represent them.

Senator DONNELL. You were instructed to come here and you did come here.

Mrs. JACOBS. Yes.

Senator DONNELL. And you personally prepared this statement?

Mrs. JACOBS. Personally.

Senator DONNELL. That board did not prepare it?

Mrs. JACOBS. Oh, no.

Senator DONNELL. How do you know that the board concurs in all of the statements that are in your statement?

Mrs. JACOBS. Because I submitted it to them.

Senator DONNELL. Submitted it to the board?

Mrs. JACOBS. Yes.

Senator DONNELL. When did you submit it to the board?

Mrs. JACOBS. To the chairman of the board.

Senator DONNELL. To the chairman of the board.

Mrs. JACOBS. Yes.

Senator DONNELL. Was the board in session at that time?

Mrs. JACOBS. The board was not in session.

Senator DONNELL. The board was not in session?

Mrs. JACOBS. No.

Senator DONNELL. Were its members called together, do you know, by the chairman, to pass upon your statement?

Mrs. JACOBS. I really do not know that.

Senator DONNELL. You prepared it and submitted that to Miss Bodin; is that right?

Mrs. JACOBS. I showed it to Miss Bodin.

Senator DONNELL. Did she read it all?

Mrs. JACOBS. Yes.

Senator DONNELL. And she approved it?

Mrs. JACOBS. Yes.

Senator DONNELL. And you brought it down and have given it to us as your own best judgment; is that right?

Mrs. JACOBS. That is right.

Senator DONNELL. Could I ask one more question, please?

There is attached to my copy of your statement here a release here for the newspapers dated for release April 24.

Did your organization prepare that release or did you prepare it?

Mrs. JACOBS. I prepared it.

Senator DONNELL. You prepared this?

Mrs. JACOBS. Yes.

Senator DONNELL. Who did the actual mimeographing, not the individual, but was it done by your organization?

Mrs. JACOBS. Somebody in the office.

Senator DONNELL. In the office of your organization?

Mrs. JACOBS. Yes.

Senator DONNELL. I see. Thank you.

Senator PEPPER. Mrs. Jacobs, is the majority of the board blondes or brunettes? [Laughter.]

Senator PEPPER. You say that unlike many of the Cabinet officers, and many of the United States Senators who make speeches, you prepared your own?

Mrs. JACOBS. Yes.

Senator PEPPER. All right. Thank you.

The CHAIRMAN. I suppose that in addition to discussing this problem of national health with the members of your organization, you have discussed it with people generally.

Mrs. JACOBS. Yes; I have.

The CHAIRMAN. With whom you come in contact?

Mrs. JACOBS. Yes.

The CHAIRMAN. What is the general attitude of the women of this country, as you have found in your discussions with reference to the need for a national health insurance system, such as we are proposing here?

Mrs. JACOBS. The opinions that I have gotten all seem to concur in the fact that it is very necessary, not only for the low-income groups to be insured, but for the middle-class people to be insured, because the hardships rendered by severe illness are so great that it often puts the family into debt for a long time.

The CHAIRMAN. The hardship that is suffered by the people in the middle class?

Mrs. JACOBS. Middle class, as well as the lower class.

The CHAIRMAN. It is just as severe as it is in the other classes.

Mrs. JACOBS. Yes.

The CHAIRMAN. It is often the basis upon which the family is sent on the road to bankruptcy and ruin.

Mrs. JACOBS. Very often that is the case.

The CHAIRMAN. You said that you have scanned the pages of the New York Times, which every year prints a list of the hundred neediest cases in New York City. I understand that analysis of those neediest cases has revealed the fact that most of them have been in that position because of serious illness in the family.

Mrs. JACOBS. That has been my conclusion; yes.

The CHAIRMAN. You have noted also, I suppose, references to polls taken in various parts of the country?

Mrs. JACOBS. I have.

The CHAIRMAN. In reference to this subject?

Mrs. JACOBS. Yes.

The CHAIRMAN. And the fact that generally the people are hoping that we may evolve some system in this country which may make medical care and hospitalization more available to the great masses of our people.

Mrs. JACOBS. Yes; according to the Denver poll it shows that very clearly, and other polls.

The CHAIRMAN. Thank you very much for your valuable assistance to us here in the study of this problem. We are under great obligation to you for your appearance here.

Senator DONNELL. There was referred to in the testimony of Dr. Peters yesterday an article in the New York Times of April 23, relative to the action taken by the Medical Society of the County of New York. I would like, if you please, to read this article into the record.

The CHAIRMAN. It may be considered as read. I do not think it is necessary to read it. We are not trying this case to a jury. Therefore, having the printed matter in the record, it will be considered as having been read.

Senator DONNELL. I would like to have this copy back. It is the only copy I have.

The CHAIRMAN. I have a copy of that which I had thought of offering myself. We will include it in the record.

(The article referred to is as follows:)

PHYSICIANS DIVIDED OVER HEALTH LAW

COUNTY SOCIETY VOTES AGAINST INSURANCE DESPITE VIGOROUS OPPOSITION

Overruling a vigorous protest by a militant minority, the Medical Society of the County of New York adopted a resolution last night opposing national compulsory health insurance at its monthly meeting at the Academy of Medicine, One Hundred and Third Street and Fifth Avenue.

The resolution, proposed by the Comita Minora, declared that the compulsory health insurance feature of the Wagner-Murray-Dingell bill was "contrary to our national spirit and traditions of self-government." It appealed to the public to support efforts of the medical profession to prevent the enactment of the measure into law.

Deterioration of the quality of medical care in this country and the consequent jeopardy of the health and welfare of millions would result from adoption of the National compulsory health insurance program, the society charged.

It also condemned the proposal on the ground that it would "obliterate local community initiative and responsibility in matters of health and medical care, promote the centralization of power, particularly the taxing and controlling power of the National Government and create a gigantic self-perpetuating bureaucratic machine that will inevitably become the master rather than the servant of the people."

The society also pointed out that in place of national compulsory health insurance, the medical profession and the voluntary hospital system were developing a Nation-wide program of voluntary hospital and medical care insurance locally administered on a nonprofit basis.

The resolution was adopted by a vote of 503 to 152. Those opposing the resolution held that the people of the country wanted the Wagner-Murray-Dingell bill and health insurance and that the medical profession was "unwise and narrow" in trying to keep the people from having what they wanted.

Compulsory Government medicine also was opposed last night in addresses before the National Physicians Committee for the Extension of Medical Service, meeting at the Waldorf-Astoria Hotel.

The speakers included Msgr. Alphonse N. Schwitalla, dean of the St. Louis University School of Medicine; Dr. Edward Cary of Dallas, Tex., former president, American Medical Association, and Dr. Morris Fishbein, editor of the Journal of the American Medical Association.

They were in agreement in their opposition to the Wagner-Murray-Dingell bill with its proposals for compulsory health insurance, and stressed that Government could assume protection of individual health only in emergencies and never by compulsion. Monsignor Schwitalla based his opposition also on basic theological considerations. The proposed Federal bill, according to the speakers, would be the beginning of the nationalization of medicine.

The CHAIRMAN. That concludes the hearing this morning. We will be here tomorrow morning, April 25, to hear further witnesses.

(At 11:25 a. m., the committee adjourned.)

×