

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 3

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NATIONAL HEALTH PROGRAM

THURSDAY, APRIL 25, 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, Donnell, and Thomas of Utah.

The CHAIRMAN. The hearing will now come to order.

I would like to insert in the record at this point the report to the Education and Labor Committee on the pending bill from the Secretary of Agriculture, the Honorable Clinton P. Anderson.

DEAR SENATOR MURRAY: In accordance with your request, I am submitting this report on S. 1606, the National Health Act of 1945. This legislation would implement to a large extent the proposal for a national health program made by President Truman on November 19, 1945.

ENDORSEMENT OF S. 1606

The Department of Agriculture is vitally interested in efforts to improve the health of our whole population and particularly the rural population. For many years the Department, through several of its bureaus and offices, has played an active part in attempting to help farm and rural people deal with difficult aspects of the problem of medical care and health services. Accordingly, we welcome consideration of legislation which would strengthen and expand public health services including maternal and child health programs, institute far more effective assistance to the States with respect to the medical care of needy persons, establish a sound program of prepaid personal health service benefits on an equitable basis and provide Federal aid for the education of professional health workers and for medical research.

While this proposed legislation would benefit people of the Nation generally, it would probably have its most far-reaching effects in the benefits that would accrue to the more rural States and to the rural population in general. The economic factor has been basic in today's serious maldistribution of health personnel and medical facilities and in the generally disadvantaged position held by farm and other rural people with respect to obtaining essential health services. Under this bill the resources of the whole Nation could be drawn upon to aid in meeting the needs of every segment of our population.

TITLE I

The establishment of a system of variable grants-in-aid to the States, through which the States having the lowest per capita incomes will get the maximum proportion of Federal aid, should go far toward enabling the less-wealthy States to build up organized health services to a level of effectiveness comparable to that which can be attained by the wealthier, more industrialized States. The provisions of title I which authorize appropriations sufficient to accomplish the objectives of the three parts of the title should serve as a stimulus to the rapid expansion of public health and maternal and child health services and the early establishment of effective programs within the States for the medical care of the needy. Since the principle of variable grants-in-aid is sound when applied to aid extended to the States by the Federal Government, the Congress might well consider imposing as a condition of eligibility governing such aid that the State

plan must, in turn, adopt a variable grant formula similar to the Federal, in its apportionment of State and Federal funds to the localities within the State, thus assuring equitable health benefits to its entire population, both urban and rural.

The desirability of extending organized public health services as rapidly as possible until every section of the United States has the protection of a well-staffed health department under the direction of a full-time health officer is apparent. Despite notable advances in this field, particularly since the passage of the Social Security Act in 1935, vast areas of our Nation still lack full-time health departments. As of 1942 there were 1,242 counties lacking this full-time essential service—most of them rural counties—with a total population of approximately 40,000,000 people. Even where health departments have been established, many are seriously understaffed and are in no position to offer the well-balanced preventive services needed by every community.

There are special reasons for establishing effective public health services in rural counties. The general pattern of death rates and of the incidence of illness among rural people reflects the lack in rural areas of the advances in public health which have characterized most large urban communities for many years. Due to the failure to apply known preventive techniques on a broad scale and due to deplorable deficiencies in rural sanitation, the toll of preventable diseases is much higher among rural people than among urban residents. The death rates for typhoid fever, diphtheria, malaria, and pellagra are higher, for example, and the same is true for pneumonia and influenza, diarrhea, and enteritis. According to Selective Service findings, the prevalence of syphilis among the whole rural male population of draft age is estimated to be actually higher than in the comparable group of urban males. The trend in tuberculosis moreover is such that, while once highly urban in occurrence, there are clear indications that this scourge is rapidly becoming predominantly rural. There are many indications such as these that the extension of public health services to the rural population is needed as urgently as the extension of therapeutic medical services.

The importance to our rural population of extending and improving maternal and child health services, including the program for crippled children, can readily be seen when one considers high rural birth rates and the fact that over half of all the children under 15 years of age in the United States live in rural communities. There is urgent need for extending the full benefits of modern medical science to the rural mothers and children. The maternal mortality rate is reported to be one-third higher among rural residents than among those in larger cities, and the infant mortality rate is one-fourth higher. In general, the highest mortality rates are found in the States with the lowest per capita incomes. This should be largely overcome through the variable grant-in-aid program which would enable such States to develop maternal and child health services comparable to those in the wealthier States.

Welfare medical services have been extremely deficient in the more rural States. These States, with their limited financial resources, have been under a special handicap with the 50 percent Federal matching grants-in-aid and in many areas with little or no State funds to supplement the Federal contribution. Furthermore, the present requirement that only such assistance expenditures would be matched by Federal funds as are paid in cash and unconditionally to the recipient—coupled with the Federal maxima—makes the effective use of Federal funds for medical care difficult. S. 1696 gives promise of greatly improving the situation, with grants-in-aid being provided on a variable matching basis, with aid being made available to all medically needy persons—and with elimination of the cash-grant rule. This program will benefit the rural population greatly, for larger segments of the rural population are in need of such service than is true of the urban population.

TITLE II

There would be many advantages in providing medical care to the needy through the general facilities and organization developed under title II of the bill for prepaid personal health service benefits. The States could pay insurance contributions in behalf of their needy citizens. Such a arrangement, which is permitted in the bill, would avoid the development of a dual system of medical care in which the system worked out for the needy might well be at a generally lower level of quality than for the rest of the population.

With respect to inclusion of farmers and farm workers in this program, the administrative techniques in collecting contributions from this group present no insurmountable difficulties. The Department of Agriculture, with the aid

and cooperation of the Social Security Board of the Federal Security Agency, has been working on these problems. It is my understanding that what appear to be workable methods are available in assessing incomes of farmers and collecting their contributions for the insurance program.

HEALTH PROBLEMS IN RURAL AREAS

The problem of medical care is an extremely serious one in rural communities. For 40 years or more there has been a trend toward the loss of physicians from country districts which can apparently be reversed only through the assurance of adequate purchasing power for medical care. The establishment of national compulsory health insurance should exert a powerful influence in this direction. Even before the war our 1,000 most rural counties had an average of 1,700 persons per physician compared to an average of 650 persons per physician in metropolitan centers. The situation today is far worse, and there are indications that many veteran physicians will not return to the rural communities where they formerly practiced. Meanwhile rural practitioners represent an aging group which is not being replenished by new graduates; young doctors are almost inevitably drawn to urban centers which offer better facilities and greater assurance of higher earnings. The shortage of dentists is even more acute and the same general situation prevails with respect to other health personnel.

The deficiencies in rural health facilities, particularly hospitals, are just as serious. Our most rural States have less than half the number of general hospital beds per 1,000 population found in our most urban States. About 40 percent of all the counties in the United States are entirely lacking in approved hospital facilities.

Resulting from these deficiencies in personnel and facilities and the underlying economic factors causing them is the generally inadequate medical care received by farm and rural people. Surveys have shown conclusively that of virtually every type of medical service, except perhaps the dubious benefits of midwives and patent medicines, rural people obtain less than urban. The relative financial burden of illness, nevertheless, is even greater for the rural population in that they spend a larger proportion of their income for the more limited care that they receive. A program which will presumably call for annual contributions of about 3 percent of net income would clearly be of advantage to the average farm family, since, according to a study by the Bureau of Human Nutrition and Home Economics in 1941, the average percentage of net cash income spent by farm families for medical services was 8.7. Actually, there is a wide variation according to income, for families making \$250 or less spent 21.2 percent of their net cash for medical care, while such expenditures accounted for only 3.3 percent of income in the \$3,000-\$5,000 bracket.

WEAKNESSES OF VOLUNTARY INSURANCE

The Department of Agriculture has had experience in the field of voluntary health insurance for farm families. The Farm Security Administration has sponsored voluntary prepaid medical service plans for its borrowers in over one-third of the counties in the United States. The Interbureau Committee on Post-War Programs sponsored a number of special programs open to all farm families in selected counties, now in their fourth year of operation. Although these programs have resulted in benefits to the families who have participated, they have revealed inherent weaknesses in applying the insurance principle on a voluntary basis to the problem of sickness costs and have furnished evidence of the need for universal coverage. In this connection I would like to call to your attention the report The Experimental Health Program of the United States Department of Agriculture, just published by the Committee on Education and Labor's Subcommittee on Wartime Health and Education.

ADVANTAGES OF A NATIONAL SYSTEM

The value of a Nation Wide program of health insurance is clear. The system contemplated by the bill would permit funds to be allotted on the basis of relative needs. If this problem were tackled by individual States, the less wealthy and chiefly rural States would be seriously handicapped through their lack of economic resources sufficient to operate an effective program. The establishment of a national system of health insurance would lead to the ultimate redistribu-

tion of health personnel on a reasonably equitable basis. It should provide the foundation, too, for the financial maintenance of health facilities so that their distribution would also be in relation to need. In this connection I might say that the Department of Agriculture is interested in S. 191, the Hospital Survey and Construction Act, which has already been passed by the Senate. As you and others have pointed out so clearly, however, S. 191 will fall short of the objectives in view unless it is accompanied by legislation such as S. 1606 to assure the maintenance of facilities, once they are constructed or enlarged. I need only cite the generally lower occupancy of rural hospitals today compared with urban institutions, despite the generally poorer supply of rural hospital beds. The farm and rural population lacks the medical purchasing power through its own resources to maintain adequate modern facilities.

The provisions of S. 1606 calling for decentralized administration appear to be sound. I am particularly glad to note the provisions for local area committees to serve in an advisory capacity to local administrative officials. I hope that some of the health insurance plans sponsored by the Department of Agriculture have resulted in educating numerous rural community leaders in this field and that there will be opportunities for many of these individuals to serve on the local area committees.

COVERAGE SHOULD BE UNIVERSAL

Legislation of this type should provide for as close to universal coverage of the population as possible. The Congress might well consider amending the bill to provide for the development of arrangements which would assure the inclusion of federal, state and local employees, and also railroad workers in the health insurance program.

I appreciate the need for temporary limitations in benefits when specialized personnel are lacking, as in the case of dentists or, to a lesser extent, nurses. The funds which would be made available for professional education should help to meet such shortages. As a minimum, the program from the outset should offer complete physician's services including services of specialists and consultants, hospitalization, preferably for an indefinite period, complete laboratory and all other essential auxiliary services. Consideration might well be given to providing certain drugs, especially those that are costly, and biologicals used both in the prevention and treatment of disease. If necessary supplementary funds from general revenues should be appropriated to make such benefits possible.

It would be highly desirable if provisions were made for unified administration of all aspects of the health program outlined in S. 1606. Such administration would insure full coordination between the public health and the therapeutic aspects of the over-all program.

URGENCY OF PROMPT ACTION

The need for the proposed legislation to be enacted on an early date is highlighted by the fact that we are already in a period where professional health personnel of all kinds are being rapidly demobilized from the armed forces. Unless measures are taken to attract physicians, dentists, and other health personnel to rural districts, we shall have lost an opportunity which may not recur. Our failure to take such steps, in fact, will have a tendency to set back the cause of better rural health for many years. Another cogent reason for early action on this legislation is the fact that war surplus hospital and medical equipment and supplies are becoming available in large quantities; the equitable distribution of such properties to rural and urban areas alike can only be assured through a national health program which will result in the establishment and maintenance of facilities in which the surplus materials can be utilized. These, and the daily unnecessary loss of thousands of lives, to say nothing of disability and reduced work capacity of our people, are among the reasons why the Department of Agriculture endorses the objectives of S. 1606.

The Bureau of the Budget advises that it has no objection to the submission of this report.

THE CHAIRMAN. The first witness will be Mr. Charles F. Brannan, Assistant Secretary of Agriculture.

Will you state your full name and your official position with the Department of Agriculture?

**STATEMENT OF CHARLES F. BRANNAN, ASSISTANT SECRETARY
OF AGRICULTURE**

MR. BRANNAN. My name is Charles F. Brannan. I am Assistant Secretary of the Department of Agriculture.

THE CHAIRMAN. Is the statement that you have this morning a statement prepared by yourself, or is it a statement by the Secretary of Agriculture?

MR. BRANNAN. The statement this morning is being made by me for and on behalf of the Department of Agriculture.

THE CHAIRMAN. Did you prepare the statement yourself?

MR. BRANNAN. The statement was prepared, Senator, under my direction.

THE CHAIRMAN. Under your direction?

MR. BRANNAN. Yes.

SENATOR DONNELL. What was the document that was offered for the record a few minutes ago from the Secretary of Agriculture?

THE CHAIRMAN. That was the report of the Department of Agriculture on the present bill.

MR. BRANNAN. And the two coincide in all respects.

SENATOR DONNELL. The statement you are about to give and the report you filed?

MR. BRANNAN. Yes.

THE CHAIRMAN. You may proceed with your statement.

MR. BRANNAN. Mr. Chairman, I appreciate the honor of appearing before this committee on a matter of such Nation-wide importance and of especial importance to its farmers. The Department of Agriculture has long been actively concerned with the health problems of rural people. We have been made keenly aware of the consequences of poor medical care among the farm families of America. We have come to a recognition of the inescapable need for a comprehensive health program, based on the lessons of the past, but bold in its plans for the future. The national health bill—S. 1606—contemplates the attainment of the major part of this objective. It is an essential part of a broad program of social security.

RURAL HEALTH NEEDS

The 57,000,000 Americans who live in rural areas have a tremendous stake in any program that serves the national interest. Forty-three percent of the Nation's population live in communities of less than 2,500 persons. Only about 400 of our 3,070 counties are really urban, and it surprises many to learn that such an urban State as New York has a greater farm population than the five rural States of North and South Dakota, Nebraska, Wyoming, and Montana combined. Indeed, rural America is the continuing source of city populations; the urban birth rate is far lower than that of farm families and it is only the farm-to-city migration that maintains the size and growth of our cities. Medical experts tell us that illness is most prevalent in the early and the waning years of life. It is, thus, significant in any evaluation of the rural benefits of a national health program to remember that more than half of all the Nation's children under 15 years of age, and a higher proportion of those persons over 65, live in rural areas.

Farm people, therefore, have a very direct interest in these proceedings. And the health and welfare of the rest of America can never be secure while rural health needs go unmet. If I can demonstrate today that our rural families have pressing health problems, that their geographical dispersion and economic insecurity lead to disadvantages in the search for medical care, and that the legislation under discussion promises to strike at the core of their problems—then, I shall feel that my coming before you will have accomplished its purpose.

Contrary to some opinion, rural life is not—as it well could be—the most healthful life. For many years farm and village areas have lagged behind, failing to make the progress in medical care and health services that has characterized the larger cities. As a result, the natural benefits of open air and simple living have become outweighed by the advantages of modern urban health and sanitation services. Rural America today resembles all too closely the urban America of 40 years ago so far as health is concerned. The greatest challenge we now face is that of overcoming the needless lag between scientific medical knowledge and its widespread application.

We must face the fact that the burden of ill health rests disproportionately upon rural families. This committee has been referred many times to the shocking revelations of the Selective Service physical examinations. These data have highlighted the poor state of rural health. Compared with the over-all rejection rate of 43 percent—alarming as it was—the rate for farmers as an occupational group was 53.4 percent. Farm youth in the significant 18-19 year-old group were turned down at a rate 40 percent higher than for all others, a figure based on physical defects alone.

In 1940 the Farm Security Administration made a survey of low-income farm families and discovered an average of more than three significant physical defects for each man, woman, and child examined. Anemia, malnutrition, defective vision, dental caries, hernias, child-birth injuries—such was the repeated pattern. Only four out of every hundred were free of significant defects.

We pride ourselves on America's conquest of the communicable diseases, but rural Americans still sicken and die far too often from preventable conditions. Typhoid fever claims three times as many rural as urban victims, and the death rate from diphteria is twice as high. The great scourges of malaria, hookworm disease, and pellagra still stalk the farms of the South. And the infections of syphilis and tuberculosis, generally conceded to be urban problems, are rapidly becoming more common among country-dwellers.

Perhaps the most sensitive indicator of health standards is the infant mortality rate. Rural areas have a rate one-fourth higher than that in large cities, and in addition have a material mortality rate that is one-third higher. Over 3,000 infants could have been saved in 1943 in Texas alone if this State had the infant death rate of urban Connecticut. That 9 more rural than urban infants die out of every 1,000 born alive is a reflection in part of the fact that less than half the births in rural areas occur in hospitals and many are unattended by a doctor or nurse.

In such a situation, there is no room for complacency, and with the possibilities of the national health bill before us, there can be no hesi-

tation. Such a burden of disease requires full public health facilities in every county, maternal and child care provisions that reach into every community, and a system of comprehensive personal medical services that assures to every family good care at the time it is needed. S. 1606 embodies these necessities. Under its provisions, rural people can anticipate the greatest relative benefits, since they now have the greatest accumulation of health deficiencies.

As to community health services, despite this burden of preventable illness and premature death, rural people are provided with less of every type of medical service and facility than are those in the cities. The public health provisions of title I of this bill will come as a boon to the 33,000,000 persons who resides in counties that lack the protection of full-time public health departments. Where such agencies do exist in rural areas, they are too often seriously inadequate, reflecting the weak financial status of so many rural communities.

The most urban States actually spend twice as much per capita annually for public health services as do the most rural States. With \$2 per person per year as the desired minimum for public health expenditures, we find the average rural State now able to spend only about 50 cents, counting funds from all sources. Farm people, therefore, will approve of the proposals in title I, part A, which would provide the greatest amount of Federal assistance for those States in the most need of public health services. Moreover, that segment of the Nation that has the highest birth rate, that has over half the children, and that has so many infant and maternal deaths cannot but welcome the far-reaching provisions of part B of the bill's first title, wherein protection for mothers and children is greatly expanded. The urgent need for both parts A and B is emphasized by findings such as the fact that in 1940 only one-third of farm children up to 8 years of age had been vaccinated against smallpox.

The voluntary health agencies that are helpful in the cities too seldom penetrate to the farmer, and rural sections and whole rural States cannot provide the kind of public welfare services that the industrial centers are able to establish. The Bureau of Human Nutrition and Home Economics has shown that less than 10 percent of any farm income group receives free medical care. Here, again, the less wealthy rural States are disadvantaged by the current 50-50 matching grant formula of Federal assistance.

The rural needy are further handicapped by existing State statutory maxima on cash benefits and by the present legal restrictions on the use of Federal funds for direct payment for medical services. While in 1942 the most urban State was spending \$2.92 per capita for general assistance, the most rural one could afford only 25 cents. Moreover, settlement laws now in effect in may States and localities prevent migratory seasonal farm workers and their families from receiving such welfare medical services as are available to local residents. In general, we should not be far wrong in stating that the man "on the county"—as the rural saying goes—is lucky if he gets any medical care at all.

TITLE I OF S. 1606

Title I, part C, of the bill, the section on care for the medically indigent, is obviously pertinent to rural needs. A variable amount

of Federal assistance to the States, based on their per capita incomes, will assure more equal health opportunities for all. To provide further for the most equitable distribution of funds to the rural sections of each State, I would strongly urge that in order to qualify for Federal aid, a State must agree to apply to its own political subdivisions the same principles of variable matching grants. Another commendable feature of this section of the bill is the requirement that State plans shall not impose residency restrictions as a condition of eligibility for welfare services. This gives assurance that the needy among the migratory farm labor force will not be denied care in the community to which they have migrated. Federal aid for the medical care of the indigent is another step forward in the effort to provide medical protection for all Americans. It is hardly necessary to point out that the hard-working country doctor would no longer have to care without recompense for the many poor folk in his community.

At this point I would make a further comment, which we in the Department have not deemed expedient to formulate as an amendment. As the bill now reads, it is merely permissible for State or local welfare departments to pay the cost of the premiums for their needy clients and thus provide for them the full quality medical services that are vouchsafed to the beneficiaries of the health insurance system of title II. I would urge, however, that this be made mandatory in the bill, so that all needy persons may be included under the umbrella of the national system of prepaid personal health services.

HOSPITAL CONSTRUCTION DEPENDS UPON MEDICAL PURCHASING POWER

The extensive hearings held by this committee on the Hill-Burton hospital survey and construction bill (S. 191) have acquainted you all with the inadequacy of the Nation's hospital facilities, and particularly with the great disparity between rural and urban areas in this regard. The most rural States have less than half the supply of hospital beds found in the most urban States. The big cities have a 60 percent higher hospitalization rate than do the farm areas. Moreover, cold figures conceal the fact that rural hospitals are usually small, ill-equipped, and—because they are so often privately owned—generally lack free beds. The graph in exhibit No. 1 clearly illustrates the direct relationship between shortage of hospital facilities and low rural financial resources.

There is clearly a need for a vast program of hospital and health center construction, as contemplated in S. 191. But, as your chairman has stressed repeatedly, newly constructed hospitals can rapidly become "white elephants" if erected in areas where they cannot be fully utilized. We cannot ignore the present-day paradox of low hospital-bed occupancy in precisely those areas that have the least hospital facilities. This is the unfortunate picture in low-income rural counties where individual resources are not sufficient to permit the full use of facilities that now exist.

The effective demand for hospital care is a function of medical purchasing power, and a construction program alone will not bring sick farmers into the hospital. The answer lies in a prepayment system that removes the economic barrier to hospitalization. The health insurance system proposed in title II of the bill would be the needed

guarantee of full usage of any facilities provided by S. 191. As a matter of fact, the hospital bill as it now reads, requires proof that a hospital can be maintained before grants are authorized for its construction.

This is sound, but it means that the poorer rural and other areas which might not now be able to guarantee maintenance would get very few if any—new hospitals. Again, it is obvious that a national health insurance system is essential to provide the community purchasing power that is necessary before many areas can even expect new facilities under the Hill-Burton bill.

MALDISTRIBUTION OF MEDICAL PERSONNEL

One cannot speak of hospitals without at once thinking of doctors. The need for physicians, and for dentists, nurses, and other medical workers, is desperate in rural areas. We are today facing the consequences of a long downhill trend in regard to the number of country doctors. The low economic status of so many rural communities is an effective deterrent to professional people, and the lack of adequate rural hospital facilities further contributes to the concentration of doctors in the cities. During the war this already serious problem was aggravated by the fact that rural States greatly exceeded their quotas for the armed services, and significant numbers of veteran doctors are not planning to return to their rural practices.

Despite the fact that 43 percent of the population is rural, only 18 percent of all professional medical and related personnel are in the farm and village localities. Our most rural counties had, before the war, an average of 1 doctor to every 1,700 persons, while the big-city ratio was 1 to 650. Although it is generally agreed that the minimum proportion should be 1 to 1,000, many farm counties have been struggling with ratios of 1 to 3,000, to 1 to 5,000, or even worse; indeed, the war left 81 counties in the Nation without any doctor at all.

The figures in exhibit No. 2 demonstrate the fact that the supply of physicians is directly related to the per capita wealth of the States.

The situation is getting worse instead of better. Too high a percentage of rural physicians are well advanced in years, with resulting decreased efficiency and less knowledge of modern methods. Far too few of the new medical graduates are going to rural areas. There are not enough farm youths who can afford to finance a medical education in the first place. Yet, we now face an unparalleled opportunity. For there are some 60,000 physicians and further numbers of dentists who are being demobilized from the services. Many of them intend to establish new practices. Some 20,000 of the younger men have never before engaged in civilian practice. Here is our chance—without the immediate necessity of producing more doctors—to attract to the rural areas the health workers so badly needed.

Title II of S. 1606, in conjunction with the hospital construction bill, enables us to capitalize on this opportunity. The national health insurance fund would assure adequate remuneration in rural communities and would attract doctors back to the country districts that might have been their natural choices. The facilities anticipated under S. 191 would be the added essential for a desirable professional environment. Studies of the potentialities of a national program have

indicated that the country doctors who are now in the lower medical income brackets can anticipate substantially greater financial security while enjoying the other benefits of this comprehensive plan.

There is little need to labor the point of shortages of personnel by similar analysis of the even greater need in rural areas for specialists, dentists, and trained nurses. It is sufficient to indicate the astounding fact that in 1941 only 1 out of every 10 counties in the Nation had an accredited pediatrician, and that throughout the four States of Idaho, New Hampshire, Nevada, and South Dakota there was not a single certified obstetrician.

MEDICAL COSTS MUST BE SCALED TO INCOME

Clearly the most fundamental deterrent to adequate medical care is its high cost to the individual. Comprehensive services of modern scientific caliber cannot be cheaply purchased at the time of sudden, unexpected illness—especially when it is the breadwinner who is stricken. Most farm families—and virtually all hired farm-workers—lack sufficient purchasing power to meet these high costs. In 1944—a year of unprecedented farm prosperity—income from farming represented only 8.5 percent of the national income, although the farm population was 18.6 percent of the total. The per capita net income of all nonfarm persons in the United States in 1943 was over $2\frac{1}{2}$ times that from farming. This urban-rural disparity is illustrated by the unequal amounts which city and farm families are able to spend for medical care. In 1941, median income urban families spent \$26.76 per person while corresponding farm families spent only \$14.37 per person—barely half as much. This is graphically portrayed in exhibit No. 3, where it is shown that the poorest farm families, who comprise the bulk of the population, spend the least for health care.

The lowest figures suggested for the average cost of good family medical care, about \$100 a year, are beyond the reach of some 80 percent of all farm families. So, lack of purchasing power results in continued deficiencies of medical care, which in turn is the forerunner of poor health. Then, inevitably, illness and poor health affect earning capacity and work efficiency, thereby further lowering income and the ability to purchase needed care. Thus the vicious circle completes itself.

The circle must be broken at some point. And the effective means is prepayment scaled to income—health insurance for all. In this way the catastrophic consequences of unexpected illness can be avoided. This, too, can the total resources of a rich Nation be so mobilized that every citizen will receive the benefit of modern medical care. With dollar barriers down, prevention of disease can become truly effective, early diagnosis of conditions amenable to scientific skills can become a reality for everyone, and full medical treatment need no longer depend on the size of the patient's pocketbook.

Local—even State—resources have proved inadequate to meet the economic requirements of health security. A program covering the whole Nation is clearly the means of bringing parity of services to farm families. The estimated 3 percent of income to be paid for the system of comprehensive health services as has been suggested in the

larger social-security bill, will come as a distinct and welcome advantage to farm families that spent in 1941—for quite inadequate medical services—an average percentage of their net cash income of actually 8.7! And the percentage spent by low-income farmers was higher yet.

ATTEMPTS OF DEPARTMENT OF AGRICULTURE TO SPONSOR VOLUNTARY INSURANCE

My conviction concerning the need for national health insurance is not based upon mere theory. We in the Department of Agriculture have had considerable experience with the problems of medical care for farm people over a period of many years. The Farm Security Administration, for example, has sponsored voluntary prepayment medical care plans for low-income borrower families ever since 1936. Field personnel were impressed early in the rural rehabilitation program with the fact that poor health was too frequently a cause of farm failures and loan defaults.

Accordingly, local prepayment plans offering medical, hospital and often dental care were organized in cooperation with State and local professional societies. These plans included, at their peak, over 600,000 persons in 43 States, extending into more than one-third of the counties in the Nation.

In a further effort to explore the possibilities of prepaid medical care as a method of helping farm families better to meet their health needs, the Department's interbureau committee on postwar programs undertook the establishment of six "experimental" projects open to all farm families in the counties selected. The facilities joining these plans, which offer more comprehensive services than most FSA plans, pay 6 percent of net cash income annually, and the difference between their aggregate payments and the over-all cost of the program is made up by a Federal grant of funds.

We should be utterly derelict in our responsibilities today were we to ignore the lessons of this large body of experience in health insurance. On the credit side, the prepayment plans certainly assist low-income farm families to meet basic medical costs during the period of their rehabilitation. More medical care is obtained than the families would have otherwise received. This is especially true in the subsidized experimental plans. There results a sense of security against the financial threat of illness that is hard to over-emphasize. The patients get earlier care and know the benefits of some services previously foregone. The participating physicians are for the most part satisfied and have testified to the receipt of greater payments than were received from the same families on an individual basis.

Interestingly enough, in the light of all the dire predictions, there has been exceedingly little evidence of abuse of the system by the members. Few patients have called doctors to their homes needlessly, but, on the contrary, have been encouraged to go earlier to the doctor's office with illnesses not yet in the advanced and disabling stages. I am persuaded by this experience that deterrent charges for first visits, as permitted by the bill ostensibly to prevent abuses, are not really warranted.

Perhaps the chief lesson we have learned is that health insurance is a perfectly feasible method of meeting the costs of medical care. The various advantages just mentioned are but reflections of this fundamental fact. In addition, scores of rural people have gained first-hand experience in the management of medical care plans that will be invaluable to insure wise local participation in a national program.

Aside from these good points, all of our plans have revealed the weaknesses and shortcomings that seem to be inherent in the voluntary approach to health insurance. To begin with, the number of participants remains small and the plans have never enjoyed the population coverage that is so essential to actuarial soundness. Too many of those who announce sympathy with the idea of health insurance just neglect to sign up, or tend to take a chance on the continuation of their good health. A significant proportion of the lowest-income families who need the most medical care are unable to meet even the modest premiums required. The turn-over of member families is surprisingly high, making for instability of administration, and resulting in the filling of the rolls with the poorest medical risks, since it is those who use the services most who tend to stay on.

Moreover, the high-income groups—and even the middle-income families—are either denied eligibility or are actively discouraged from participation by the physicians in the area. Because of these factors, individual premiums tend to be relatively high and even then the plans have sufficient funds for only quite limited types of services. This in turn means that members are often forced to spend additional funds outside of the plan for services not provided in their contracts.

In a voluntary program there is little incentive for preventive medical practice and little inducement to improve the quality of medical care. The voluntary plans are able to utilize only such limited facilities as are already available in the community. Little or nothing is accomplished toward attracting more doctors into the area or toward stimulating the establishment of new and needed facilities. I am firmly convinced that these factors of inadequate coverage, limited services, and adverse selection of risks are inevitable in any system of voluntary prepayment—even though the FSA plans have been a definite step forward.

As for the experimental plans, which represent a demonstration in tax-assisted voluntary health insurance, all of the same lessons have been driven home. Even though the members pay 6 percent of their net cash incomes, the most anyone could expect, and even though Government grants double the funds available, the amount and quality of the services provided in these rural counties have fallen far short of recognized standards. The conclusion seems inescapable that voluntary prepayment, no matter how generously subsidized, can never attain the goal of health security for rural America.

For all the shortcomings of these Department-sponsored plans, little else actually exists for the farmer. Blue Cross and medical society plans are geared to city incomes and to the existence of adequate hospitals. Less than 3 percent of farm people are covered even for Blue Cross hospitalization, and the medical society plans in 1945 covered only one-half of 1 percent of the population in the 28 predominantly

rural States. Where such plans do extend into rural areas, the chief reason for low farmer participation is simple—the costs are too high in relation to the services offered.

The Department-sponsored and many of the consumer-type plans, have provided for membership participation and control, but medical society and Blue Cross plans give no voice at all to the enrolling members. Finally, there is little to commend a system of numerous private plans with overlapping and duplication of administration.

Exhibits Nos. 4 and 5 demonstrate rather dramatically that the extent of these plans is negligible in rural areas—and that the more rural a State is, the less such coverage exists.

The consumer cooperative health programs open to farm people are commendable in their accomplishments, but they are few and far between. These include the Farmers Union Hospital at Elk City, Okla., the similar cooperative hospitals in Mooreland, Okla. and Amherst, Tex., and the Sandhills Regional Health Association in Nebraska. Hopefully, more are developing in Texas as a result of the recent enabling legislation in that State.

The fundamental solution of the problem of payment for medical services is the one proposed in title II of this bill—that of a single national plan of compulsory health insurance supplemented with general tax funds. Only a Nation-wide plan has the actuarial soundness to provide equally comprehensive medical care to those in the cities and those in the country, to those in rural as well as urban States, to the economically insecure as well as to the prosperous. Only such a national plan can offer complete medical care at rates within the reach of all. The limitations of the voluntary approach are overcome while exploiting to the full the principle of spreading of risks and sharing of costs.

One feature of the national health bill that is impressing farm people and country doctors is the fact that health insurance is a change only in the method of payment for medical care. The physician-patient relationship is actually enhanced by removal of financial worries. All farm families can call upon their doctor without the fear of debt or the stigma of charity. These are matters of no little moment in rural communities.

Most persons sincerely concerned with rural health problems are in agreement with the facts of unmet health needs. Further, there is little denial, even from those professional bodies that once opposed the whole idea, that prepayment insurance is a feasible method of financing medical care; yet, some persons still fail to recognize the need for national coverage. We have reviewed the experience of the Department in demonstrating the limitations of voluntary plans. We have seen that individual rural communities and poorer rural States are unable by themselves to finance an adequate program, despite the very real interest and the heroic efforts that so many of them have made.

The resources of the industrial urban States are in large measure derived from the manpower and produce of the farms and the market they provide. In return, rural citizens have the right to expect acceptance of the principle of nationally pooled contributions from which there can be provided needed medical services for everyone, regardless of local ability to pay.

ADMINISTRATION CAN BE DECENTRALIZED

This is not a call for Federal domination. We need a national program to equalize health opportunities for the entire population, but day-to-day administration under this bill will be decentralized and essentially local. To date the various States have done laudable jobs of health planning. Through State and local programs a great deal has already been accomplished toward the stamping out of disease and the organization of health and medical services. State hospital planning commissions, public health departments, public welfare agencies, and the like have made great steps forward. Such programs, however, need the full support of national resources to accomplish their missions effectively. The passage of the national health bill will in no way end the need for such State and local initiative and leadership. In fact, local participation in administration is essential to the best use of the facilities and services made possible under a national program.

Under the provisions of this bill, nonprofit health associations, group practice clinics, and cooperative hospitals—all so important to the farmer—can play an expanding role, acting as agents for their members in taking advantage of the increased opportunities under the national health program.

Local participation in the administration of S. 1606 is of vital importance. It is essential that there be fair rural representation on all State and local area advisory committees. Farm people are experienced in community management of cooperative ventures of many kinds. Those now active in REA cooperatives, AAA committees, Farm Security committees, Soil Conservation Service councils, and so on, are ready to play their parts.

Rural people are well accustomed to the channels that have been used for years in agricultural programs. Within the framework of national standards necessary to safeguard the use of Federal funds, the rural communities of America are ready to adapt the national blueprint to local specifications. To those who argue that a Federal plan is too rigid to serve properly the varying sections of the country, I would point out that local participation is clearly defined in the proposed legislation.

That an over-all national system of health insurance is essential to meet rural needs is emphasized by the extent of interstate migration of seasonal farm workers. This migration is a recognized feature of our agricultural economy, involving a labor force of some 700,000 to 1,500,000 persons. The Department since about 1937 has attempted to mitigate some of the most serious hazards faced by this group, through a program of housing, sanitation, and medical care. The Labor Branch of the Production and Marketing Administration has been financing and administering this health program, which has met the needs of the farm workers imported from other countries to meet current farm labor shortages and the needs of a segment at least of our own seasonal labor force.

Actually, we have hardly scratched the surface so far as the medical care needs of all domestic migrants are concerned. We welcome this bill, therefore, as a means of protecting the migrant and his family who, we assume, will ordinarily be found among the insured group.

It is important that those administering this program recognize the lessons gained from our experience that special medical facilities—including mobile clinics and even mobile professional personnel—will continue to be needed if migrants are to get adequate health care and if the resources of local communities in the paths of migration are not to be seriously overtaxed.

RURAL DEMAND FOR A NATIONAL HEALTH PROGRAM

There is a growing awareness among rural people that the problem of medical care need no longer go unsolved. A recent survey by the Bureau of Agricultural Economics revealed that three-fourths of all farmers are in favor of prepaying for medical care. The National Opinion Research Center reported in 1944 that 68 percent of those polled indicated a desire to have social security cover doctor and hospital bills. Last year Columbia University's "Poll of experts" discovered that a majority of health and medical specialists felt that national compulsory health insurance was the answer to the Nation's health needs.

Our major farm organizations have given increasing recognition to the need for extensive planning in the attack upon rural ill-health. The resolution on health adopted at the 1945 national convention of the American Farm Bureau Federation pointed out that "One of rural America's most urgent problems is to provide a program to bring about better facilities in rural areas for hospitals, medical care, and improved health."

The National Grange resolved at its last convention—

that because of the uneven and unpredictable cost of illness, it is of prime importance that rural people should spread the risks and share the costs of sickness by developing a comprehensive form of prepayment plan for hospital bills and health insurance,

and that—

since many rural families and rural areas are too poor to support doctors and hospital services even with any form of health insurance, public or private funds be combined with insurance funds to equalize the ability of these families and these areas to secure and maintain needed health services.

The National Farmers Union program for 1946, adopted at the annual convention just recently held, has this to state regarding health:

We highly commend President Truman for his courage and vision in calling for a universal, prepayment medical care program for all Americans, and call upon Congress to enact legislation putting that program into effect at the earliest possible date.

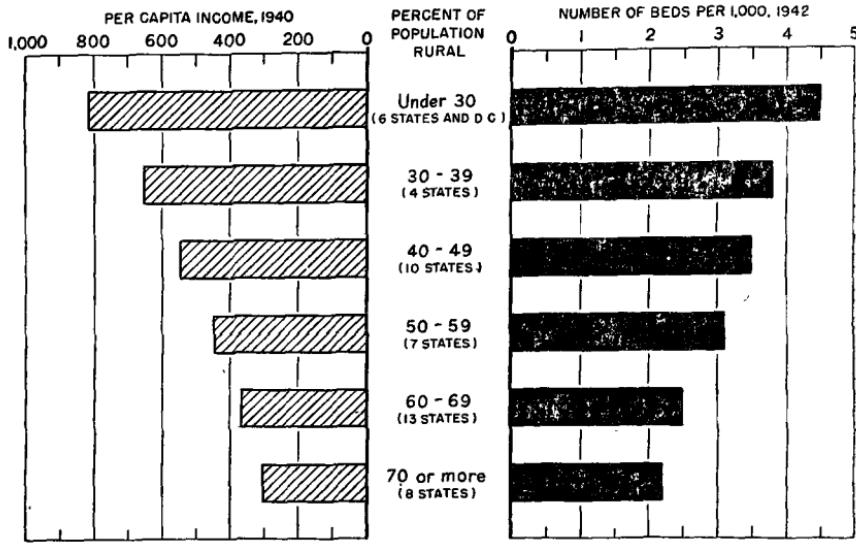
Indeed, numerous rural conferences, articles, in farm periodicals, and radio forums have increasingly demonstrated that rural America is aware of its needs and determined to bring about the kind of health program that will afford them, and the entire Nation, the opportunity to enjoy the fine medical services of which modern science is capable.

Rural families want community-wide public health services. They want good care for mothers and infants. They want a program of good quality medical care for the needy, and one that is a part of an over-all medical care system. Most of all, their limited medical purchasing power requires a national system of health insurance as the means of assuring comprehensive medical care to everyone. Such are

the major provisions of S. 1606, the national health bill. It has the full support of the Department of Agriculture, and I am confident that it has the backing of the farmers of America.

(The charts are as follows:)

**GENERAL HOSPITAL BEDS - STATES GROUPED BY PERCENTAGE OF POPULATION RURAL.
SHOWING HOSPITAL BED RATIOS AND THEIR RELATIONSHIP TO PER CAPITA INCOME**

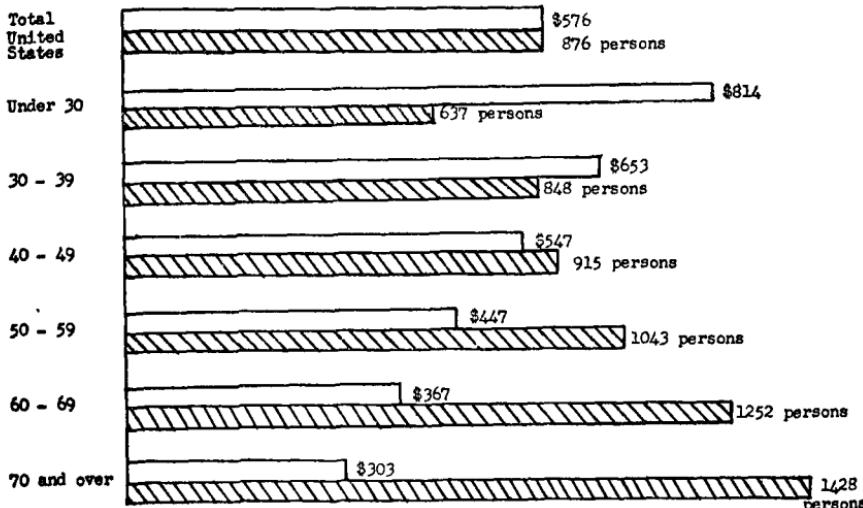


U.S. DEPARTMENT OF AGRICULTURE

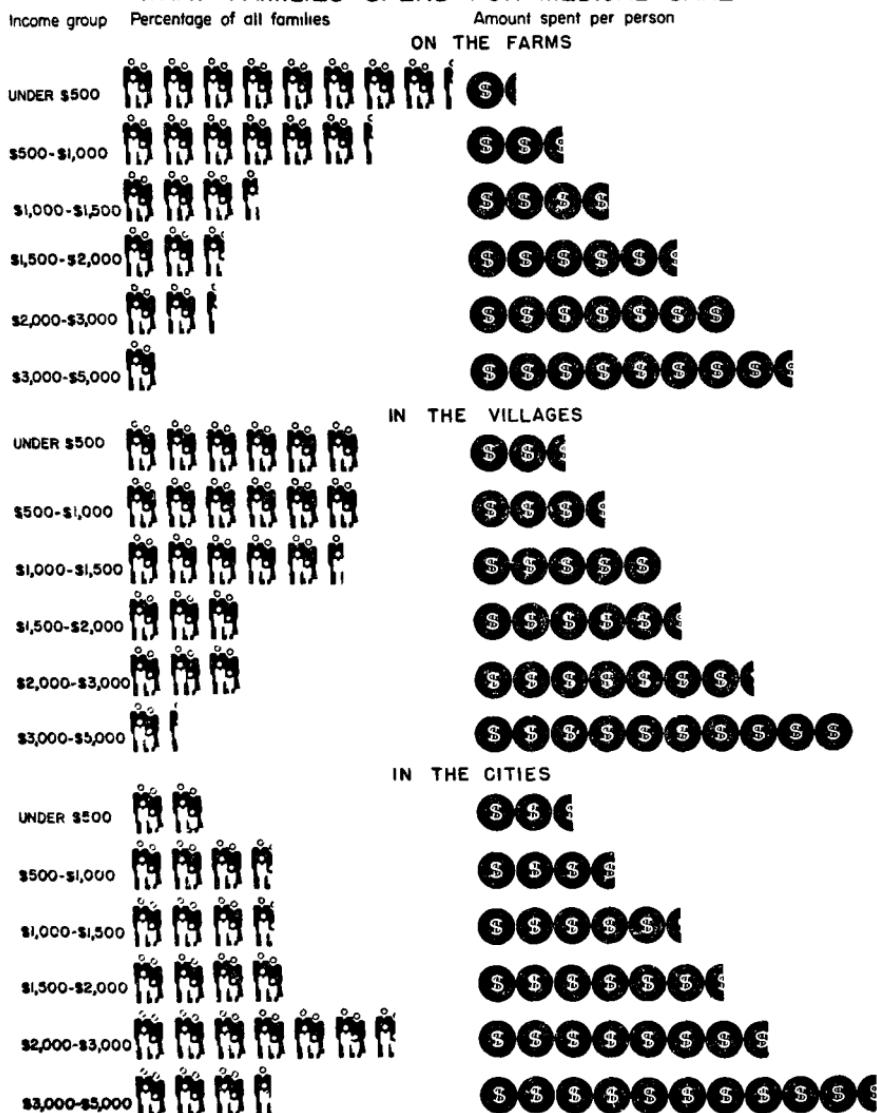
NEG 45139 BUREAU OF AGRICULTURAL ECONOMICS

Physicians and State Wealth: Number of persons per effective physician in states grouped by rurality and relationship to per capita income, 1940.

Percent rural
(State populations)



WHAT FAMILIES SPEND FOR MEDICAL CARE



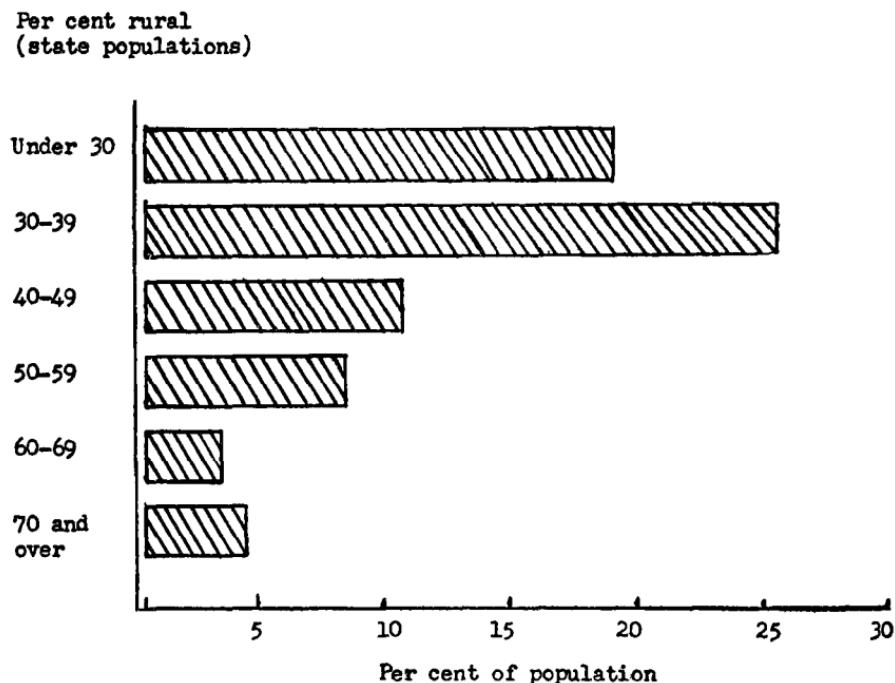
Each symbol represents 4 percent of the families

U.S. DEPARTMENT OF AGRICULTURE

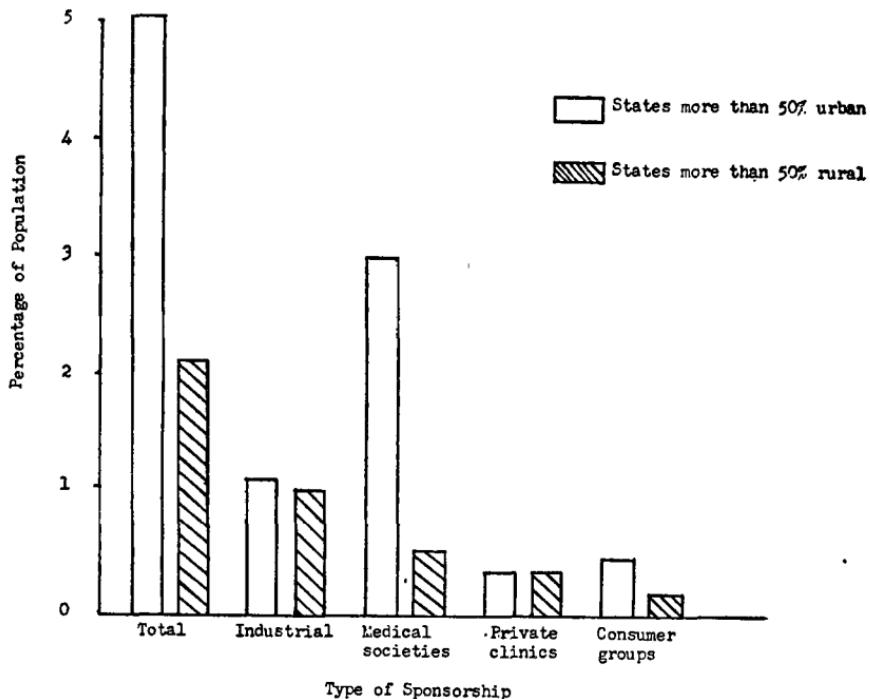
Each symbol represents 4¢

APRIL 1944

Blue Cross Plan Membership: Proportion of populations of states grouped by rurality enrolled in Blue Cross group hospitalization plans, July 1, 1945.



Voluntary Medical Care Insurance Plans; Proportion of populations, of urban and rural states with membership in voluntary prepayment plans, by type of sponsorship, excepting Government-sponsored plans, 1945.



Mr. BRANNAN. May I say that in the event there are questions of a technical nature, or of other character about this program, and the Department's experience with them, I have asked Dr. Frederick Mott—Col. Fred Mott—to sit at the witness table with me, and I should like to have the privilege of referring such questions to him from time to time.

The CHAIRMAN. Mr. Brannan, at the bottom of page 18, where you are talking about migrant farm workers, you say—

actually we have hardly scratched the surface as far as the medical care needs of all domestic migrants are concerned. We welcome this bill, therefore, as a means of protecting the migrant and his family, who we assume will ordinarily be found among the insured group.

Do you mean that the migrant farmers are ordinarily found among the insured group?

Mr. BRANNAN. I intended to indicate by that, Mr. Chairman, that they will be wage earners, and that they will earn a wage in excess of \$150 per year, we hope, and the experience has taught us that most of them will. Therefore they will not be in the indigent class, but will be in the insured class.

The CHAIRMAN. They will come within the provisions of this bill?

Mr. BRANNAN. Of title II.

The CHAIRMAN. If it is enacted, and put into force.

Mr. BRANNAN. Indeed they will, sir.

The CHAIRMAN. But at the present time they are not in any manner protected by any system which would enable them to prepay for medical care?

Mr. BRANNAN. They are not. They are only protected by the limited facilities which the Farm Security Administration and later the Labor Division of the Production and Marketing Administration has been able to afford to them along with the assistance we have given the foreign workers that have been imported during the war.

The CHAIRMAN. In your Department you have had considerable experience with voluntary systems of insurance. Have you found that they supplied the needs in the rural communities?

Mr. BRANNAN. Senator Murray, Dr. Mott, sitting here to my left, is the person who has been very much in charge of those programs over the past years, and I would like to have him answer that, if I may.

The CHAIRMAN. Very well.

Will you first give your name and your position or connection with the Department of Agriculture?

STATEMENT OF DR. FREDERICK D. MOTT, CHIEF MEDICAL OFFICER, FARM SECURITY ADMINISTRATION, DEPARTMENT OF AGRICULTURE

Dr. MOTT. My name is Dr. Frederick D. Mott, Chief Medical Officer, Farm Security Administration of the Department of Agriculture.

FARM SECURITY ADMINISTRATION EXPERIENCE WITH VOLUNTARY INSURANCE

Senator Murray, our experience with voluntary health insurance for farm people was, of course, touched on in the statement, but I am delighted to enlarge on that.

There is a positive side, of course; our experience has not been entirely negative, by any means. The Farm Security borrower families, who are typically in a quite low income group, have been helped to receive needed care through these programs. They have had through the programs, I think, a degree of security which is hard to over-emphasize, even though the services have had to be limited. Of course from a hard-boiled point of view, this program has helped to secure Government loans, something we sometimes forget. There have been other good sides of it. A great deal of health experience with health insurance has been gained by farm people, some farm leaders, and by local professional medical people in over a third of the counties in the United States.

On the other side, though, I think our outstanding experience has been that not enough families join these plans, even when they have been organized and are right there ready to be joined. In fact, even though there are certain supervisory controls or influences in the Farm Security program—that is, we have county supervisors and a program of education in farm and home management—and in spite of educational efforts of the county staff and the assistance of loans and so on, not nearly enough farmers tend to join the plans.

I think I can illustrate that by pointing this out—that in 1941, just 60 percent of the Farm Security borrowers joined the plans in the counties in which they were already organized and right there, to join. That dropped by 1942 to 55 percent of those eligible; in 1943 to 49 percent; and in 1944, to 41 percent; and in 1945, June 30, 30.8 percent.

In other words, less than one-third of the borrowers eligible for the plans joined.

There are other disturbing features. I will be brief. One is the tremendous turnover. A study made by people at Ohio State University of several plans in Ohio, over a period of a little over 3 years, showed that of the families who started in the program, only 24 percent were still members at the end of a 3-year period.

In fact, of all of the families who were members at one time or another during the 3 years, only 8 percent had been members throughout the whole period from beginning to the end.

That type of turnover, of course, tends to leave poor risks in the plan and that same study revealed something very interesting. It showed that the families who stayed in, in continuous membership, required much more service than the other families. The families who stayed in throughout the 3 years received over 3,000 office and home calls per year per 1,000 people. The figure for those who were in for 1-year periods was about 2,000. This shows the effect of leaving poor risks in a voluntary plan, thus keeping costs high and services low.

There have been other points, such as that when people pay just from their own resources on the basis of ability to pay, benefits have to be quite rigidly limited, and it has not been possible to have comprehensive plans. The effect of the plans, too, has not been to do anything fundamental about improving local resources. They simply do not mobilize the purchasing power that would bring physicians into an area, or enable a hospital to be maintained better.

Those, I think, are some of the major points in our experience. The plans have done some good, but these inherent weaknesses have certainly been perplexing, and we see no other answer except a more or less universal program for the whole population, both rural and urban.

The CHAIRMAN. Only a universal system of this kind would enable the farmers to get the low-cost medical care they need?

Dr. MOTT. I believe that is right. The economic status of farm people in general is such that if they are to have adequate care it will require pooling the financial resources of the whole Nation to bring up the level and to make it possible to provide adequate care.

FREE CHOICE OF DOCTOR

The CHAIRMAN. Some complaints have been made against the system proposed under this legislation as limiting the free choice of doctors. Have you any comment on that, Dr. Mott?

Dr. MOTT. I would be very glad to, sir.

Of course, one point that I might bring out right at the start is that there is extremely little choice and very often no choice at all for rural people in many areas.

First, there is the economic side. When you cannot afford medical care, it happens in the case of many of these farmers that they simply do not get the care, and that could hardly be called a choice of physicians.

The CHAIRMAN. The doctors often live considerable distances from the homes of these rural people.

Dr. MOTT. The distance factor raises the cost. We still tend to keep to the horse and buggy institution of \$1 a mile, thus making costs prohibitive.

The CHAIRMAN. Sometimes a single call will cost \$25 in some rural areas where you have to use an automobile and go a considerable distance.

Dr. MOTT. I heard Ransom Aldrich of the Farm Bureau Federation testify to that effect just the other day about his home county in Mississippi.

There is another point on this question of choice, if I may say so, and that is we have of course many counties in which there is not even a single physician. Toward the end of the war there were some 81 counties with no physicians at all. There were another 20 counties with only 1 doctor, which had populations of over 10,000 people. There is hardly much choice there. There were another 50 counties with only 1 doctor, with populations of from 5,000 to 10,000 people. There were another 51 with only 1 doctor with populations of from 3,000 to 5,000 people.

Of course, I believe that under this bill freedom of choice will be increased and enhanced. The economic barriers are removed, and you can go to your chosen physician.

The CHAIRMAN. That is, so far as the rural areas are concerned.

Dr. MOTT. That is right. And the bill, of course, we feel will bring more physicians to rural areas which will again increase the possibilities of choice.

The CHAIRMAN. Are you familiar with the northern section of Montana, up around Scoby and that section?

Dr. MOTT. Not too familiar, sir. I have been in some other areas of northern Montana.

The CHAIRMAN. I do not know whether other sections of the country may be found that are similar to that section, but I recall that some years back I visited there, and the local physician discussed the situation with me. This was long before these health bills had been introduced, and he was telling me that he would have to leave although an epidemic was threatening at that time. He pointed out that it was impossible for him to make a living there and sustain his family, and that he would be required to leave, and was planning on leaving the following week. The local people there asked me to make an application to the Red Cross to see if it was not possible for them to get some section help. They were unable to pay the expense of bringing doctors into that section.

Do you know of that situation in any other sections of the country?

Dr. MOTT. There are many, many sections, sir. I think the most extreme case, and I hope it has been corrected to some extent, was Breathitt County, Ky., with a population of about 22,000 people, and 1 doctor. That was the most extreme case that I heard of.

The CHAIRMAN. That is in the eastern section of our country.

Dr. MOTT. Yes.

The CHAIRMAN. Where the population is not so thinly distributed, where you would expect better situations so far as available medical care is concerned.

Dr. MOTT. Yes.

The CHAIRMAN. Some people have complained that this bill will be very expensive to administer. Would you like to make a comment on that argument?

Dr. MOTT. Senator, I do not see why the bill should be expensive to administer. In the first place the prospects are that the total medical bill of the American Nation under this legislation will not be increased. It will simply call for the organization of expenditures, which will mean savings in some respects. In fact, the whole program may cost the American people less than today's total bill because of the present lack of organization.

I think the record of Government in administering a system of this sort is good. I think we may take the Social Security Board experience as an analogy. I understand they have extremely low overhead costs for old-age and survivors insurance administration.

I think the avoidance of duplication, of overlapping and numerous smaller systems, will mean in effect that there will be an over-all saving.

PREVENTION OF DISEASE UNDER S. 1606

The CHAIRMAN. Do you think that the operation of such a health program as this over a period of years would tend to produce a better situation in the country with reference to serious illness? Would it not tend to prevent the occurrence of catastrophic illness in the Nation to a large degree?

Dr. MOTT. I think there is no question, sir, but that legislation of this kind, and within a very relatively short period of time, would make possible to almost every section a kind of medical care that very few of our population have had. I think the fact of accessibility without a financial barrier to medical care early in illness is an extremely important factor. A point which doubtless has been brought to the attention of this committee before, and yet I think is worth repeating, is this, that something like only 1 out of every 22 deaths today is from a condition that ordinary public health can prevent through our known methods of prevention, whereas 21 out of 22 deaths today are due to other conditions that public health as we know it cannot control.

In the face of that situation, it is perfectly clear that the prevention of the future is simply early and adequate medical care. I do not think there can be any question about that. I think a system which makes medical care accessible and which sets under way forces that will lead to the better distribution of facilities and personnel, will represent the best kind of prevention that we ever have had a chance to know.

The CHAIRMAN. In addition to that method of prevention, the bill, of course, contains other provisions in regard to preventive medicine. You are familiar with those provisions, too, are you?

Dr. MOTT. There are certain points under title I, of course, relating to organized community-wide services, and there are more points under title II.

The CHAIRMAN. All scattered through the bill we find references to preventive medicine. That is one of the strong features of this legislation, the idea of preventing illness, rather than curing illness.

Dr. MOTT. That is right, sir, and I think the references to preventive functions under title II are far less important than the fact that the system in itself will spell prevention.

EXPERIENCE WITH STATE MEDICAL SOCIETIES

The CHAIRMAN. Your department has had much experience in medical-care plans sponsored by State medical societies. Will you give us your experience with those kinds of plans?

Dr. MOTT. We have had some experience, sir, along those lines. Of course in certain States it has been most expedient for us to work out contractual arrangements with medical society plans. In some States it has been the only way in which we could bring any protection to our borrowers, because of State enabling—or we sometimes think of them as disabling acts—making it possible for a medical-care system at this time to exist only as one dominated by the organized profession.

We have had arrangements with medical society plans in several States, in New Jersey, western New York, in North Carolina, in Oregon, and in California. I may have missed perhaps one, but those are the ones that I think of at the moment.

Two or three points about our experience, I think might be worth bringing out. To me one of the discouraging things about the development of plans sponsored by the organized profession is that the very group which should believe most in a high quality of service, and should put every ounce of effort behind the development of programs that would produce services of high quality, are doing the least. They are doing the least in this way, that the plans being sponsored are restricted in the main to care received in hospitals. Usually it is the end result of illness or disability of some kind or another that puts you in the hospital. Not always, by any means, but when one thinks of what medical service of real quality would be, preventive services, early care, diagnostic services of various kinds, laboratory services, X-rays, consultations—all of the patients usually go through before being in the hospital—it is clear that these plans are woefully weak in that respect.

That brings me more closely to our own experience. Virtually the only medical society plans in the United States today offering any kind of general medical service, including home and office care, are the special arrangements which we have induced the medical society plans to put into effect, often for our borrowers or for a low-income group of farmers. It has taken constant struggle and effort year after year and often every quarter of the year for us to keep these plans going. The whole tendency of the organizations is to drop plans of that type.

I might cite the California Physicians' Service, for example. I believe there has been some testimony with respect to that organization here.

We have had a plan, or an agreement with the California Physicians Service for a period of something like 4 years. There is a special contract for all farm families who wish to join, or join in

groups, who have annual net incomes of under \$2,000. The plan has been confined almost entirely to our borrowers, however.

The rates were forced up at one stage during the last 3 or 4 years, to the point where the families are now paying around \$60 a year for a family of three or more, for a somewhat limited service, but one that does include home and office care, some hospitalization and surgical care, except for chronic conditions. That is the only plan administered by the California Physicians Service for families which provides a general medical service, including home and office care.

They now are threatening, and this has gone on for some months, to close out each of our local farmers' health associations at the end of the fiscal year, offering in return higher rates for less service in a contract that is almost precisely like their so-called commercial contract. It is not a happy prospect for our families. They will have to pay more for less service, dropping home and office care. And I suppose the more or less monopoly situation is such that no other plan will be open to them if they are dropped from that program.

The CHAIRMAN. Is that confined to families with incomes of \$2,000 or less?

Dr. MOTT. \$2,000 net or less, farm families; yes.

The CHAIRMAN. So that farm families that have more than that income are not eligible for membership at all?

Dr. MOTT. That is correct, sir.

The CHAIRMAN. And you say that they are proposing now to close out the existing agreements with the health groups that you have built up and threatening to offer a new style of contract with a greatly increased cost?

Dr. MOTT. The cost is not greatly increased so much, but the services are reduced. It is a combination of the two. I might say they have been working recently with the State Grange, I understand; I do not know the latest details. They have been trying to persuade the Grange to have its members in groups join what is in effect their regular, commercial, limited contract.

The CHAIRMAN. How long has this California Physicians Service been in operation?

Dr. MOTT. Sir, I could only guess at that. I would say since approximately 1940, but that is frankly an estimate.

The CHAIRMAN. An estimate?

Dr. MOTT. Yes. I do not recall that it was in operation a couple of years before that. I do not believe so; 1939, possibly.

The CHAIRMAN. How is it controlled or managed? Do the consumers, the patients, have any position on the board of directors or the governing body of that organization?

Dr. MOTT. I am not certain about that, sir. I am under the impression that the great majority of the members of the board are physicians. I remember some discussion that I read on it somewhere within a year, as to whether they should take in one or more union representatives. I am not clear as to whether they have on it public representatives.

The CHAIRMAN. What about this charge that is sometimes made against this proposed compulsory insurance system that it would result in a dictatorship by the Surgeon General? Have you looked into that feature of this plan?

Dr. MOTT. Senator Murray, those of us who have worked in agriculture with its programs that extend right to the farmer, I believe, would be as concerned as any other one group as to whether this legislation made full enough allowance for local and decentralized administration. I am quite satisfied in my own mind that the legislation if administered intelligently, as I believe it would be, does allow for a considerable degree of local participation.

I cannot believe, certainly from our experience, that any medical program could be or that anyone would ever try to, administer it from Washington. It is clearly impracticable, and would never be considered. I think the cry of dictatorship is amply answered by the establishment of the Advisory Council at the Federal level, with its powers, and by the fact that the Surgeon General must report to the Congress regularly as to the action taken by the Council, and as to when he differs from the Council. I think that, taken together with the decentralization, the directive that State and local agencies must be used whenever feasible in administration, the requirement that such agencies have advisory committees representing the producer and the consumer at the State and local levels, and the further requirement that if no such arrangements are made in the State, and other arrangements are followed, that local area advisory committees be appointed—it seems to me that taking all of those things together, we need not fear any dictatorship administration.

SELECTIVE SERVICE REJECTIONS

The CHAIRMAN. You are familiar with the reports issued by the Selective Service Administration during the war, and you have noticed, I suppose, the large number of rejections that have come from the farm areas. How do you account for that?

Dr. MOTT. I think without question, Senator, that simply represents in the main the end results of inadequate health protection and medical care. I do not believe there is much question about that at all.

There are conditions, of course, which are not preventable. Some people are born with certain conditions.

The results of a certain serious accident are such that nothing can be done about them.

But in the main, and I think that it has been so reported in a Public Health Service report, the conditions for which men are rejected are conditions which might be considered preventable or at least remediable through normal medical measures.

Of course, there are examples of this: deafness from a long unattended ear infection, orthopedic deformities of many kinds, simply through improper care or lack of care with an ensuing infection, cases of mental disorder, which through proper mental-hygiene services, might have meant a well-adjusted individual.

I think it is pretty clear that in the main these defects simply represent the end result of inadequate care.

The CHAIRMAN. In connection with your purpose of securing proper hospital and clinical centers in the rural areas, is legislation, such as this proposed, essential in order to make it possible to support hospitals that may be erected in those areas?

Dr. MOTT. I believe so, sir. I had the privilege of testifying to that

effect before this committee on the Hill-Burton bill. I think it is unquestionable that if hospitals could be maintained adequately in rural sections today, the hospitals would be there now.

In fact, there is under-occupancy even in the hospitals that are there. That is a very telling point as to the economic cause of this lack of maintenance.

The CHAIRMAN. Indicating that the people there are unable to pay the cost of proper hospitalization?

Dr. MOTT. That is correct, sir. And because there is an almost mathematical relationship between the availability of hospital beds in a State and the per capita income of that State.

The CHAIRMAN. Thank you, Dr. Mott.

Do you have some questions, Senator?

Senator DONNELL. Yes; I do, Mr. Chairman.

I would like to examine each of these gentlemen, Mr. Chairman, with some questions.

Mr. Brannan, I understood you to say that your statement which you have delivered this morning was prepared under your direction?

Mr. BRANNAN. It was, sir.

Senator DONNELL. Did you prepare any of it yourself?

Mr. BRANNAN. I wrote and rewrote some sections of it.

Senator DONNELL. It is approximately 20 pages in length?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Approximately what portion of that statement was personally prepared by you?

Mr. BRANNAN. Well, sir; I think that I passed judgment upon every paragraph that went into the statement.

I dictated some sentences in some paragraphs, but for the most part, of course, the thing was prepared by the people who are at this time closest to the work of the department connected with rural health problems.

I do not intend to represent to you, sir, that I sat down and dictated every statement that I make for and on behalf of the Department, nor would the Secretary, if he were sitting here, make that representation.

Senator DONNELL. Mr. Brannan, my question was not intended to be critical, but simply to ascertain your own personal knowledge and what part of this statement was personally the result of your own knowledge and opinion.

Mr. BRANNAN. May I answer that directly?

Senator DONNELL. You may.

Mr. BRANNAN. I was regional director of the Farm Security Administration.

Senator DONNELL. Yes.

Mr. BRANNAN. The agency of the Department which handles the initial efforts of the Department in the rural health field is the Farm Security Administration for which I was regional director.

My territory was Colorado, Wyoming, and Montana, the State of the Chairman.

Senator DONNELL. Yes, sir.

Mr. BRANNAN. And in those three States we had an active medical program, or active program of rural health and rural health associations.

Senator DONNELL. Yes, sir.

Mr. BRANNAN. So it is based upon my own personal experience of a few years back, I also had experience with the initiation of the migratory labor program, and also with the initiation of the health program to take care of the foreign workers which were brought in at the early part of the war.

Senator DONNELL. Mr. Brannan, returning again to the statement, did you write any of this statement initially or was it all prepared by some one else and submitted to you for you consideration and approval and suggestions?

Mr. BRANNAN. Senator, the outline of it was discussed originally with a group of us and then some of the folks went back to their offices and put our thoughts down on paper, brought it back, and we went over it together on several occasions until we got this document.

Senator DONNELL. That is not just the answer to my question, Mr. Brannan. I asked you whether or not you prepared in the first instance any of this statement.

Mr. BRANNAN. Well, Senator, if I may differ with you, it is an answer. Certainly, if you mean did I sit down and write out or dictate that to my secretary, no.

Senator DONNELL. That is what I was asking.

Mr. BRANNAN. But if you mean to say, did I participate in the gathering together of the thoughts and ideas that went into the statement, the answer is yes.

Senator DONNELL. I understand the distinction, but what I was trying to get at in the first instance of it, and what I again ask you is: Did you personally compose any of this statement as it was originally drafted?

Mr. BRANNAN. As it is in your hands today, I contributed for a percentage, maybe 5 to 10 percent of the phraseology of the language.

Senator DONNELL. But the original phraseology and language of it—

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Was prepared after the conference you speak of?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. And after the statement of these ideas, that was prepared by some one else entirely, 100 percent; that is correct, is it not?

Mr. BRANNAN. That is right; yes. The ideas were put on paper by other people, but they were my ideas just as well as theirs.

Senator DONNELL. I have no quarrel with you, Mr. Brannan. I simply want to get the facts as to what you did.

As I understand it, you had a conference with various other persons and yourself, in which various plans and thoughts were outlined, and thereafter they took it away and somebody else prepared the statement. Is that right?

Mr. BRANNAN. That is right. I did what any executive of a department the size of the Department of Agriculture would do in the preparation of all the reports and statements we make to the various committees of Congress.

Senator DONNELL. Yes. But I am still trying to get an answer concretely without any addition to it for the moment as to whether you prepared personally any of the statement as it was originally written down. Did you dictate any sentence? Did you write any sentence in

this 20-page report as the original draft of it was laid on your desk for your inspection?

You can answer that, Mr. Brannan "yes" or "no" and then explain it, can you not?

Mr. BRANNAN. Not of the original draft, but of the draft you have in your hand, sir.

Senator DONNELL. Yes, sir; I understand.

Mr. BRANNAN. I have dictated, for an offhand figure, approximately 10 percent.

Senator DONNELL. Approximately 10. You said a moment ago 5 to 10. You now revise that to 10?

Mr. BRANNAN. Any point in that area you would like.

Senator DONNELL. It is not a question of what I would like, it is a question of what the fact is.

Anyway, I think we understand each other.

You had a conference with other persons. How many persons participated?

Mr. BRANNAN. Dr. Mott participated.

Senator DONNELL. The gentleman who just testified?

Mr. BRANNAN. Yes, sir. And the people in his section, from Farm Security Administration, from the Office of Labor, and other parts—I will stop there. Those. Those two groups generally.

Senator DONNELL. About how many persons participated in that conference?

Mr. BRANNAN. Four, in addition to myself.

Senator DONNELL. Four in addition to yourself. Dr. Mott and three other persons and yourself. Who were the three other persons?

Mr. BRANNAN. Mr. Pohlmann, Dr. Weinerman, and Dr. Axelrod.

Senator DONNELL. And they are all in the Department of Agriculture?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Mr. Brannan, going back for a moment to your own personal experience, you are a native of what State?

Mr. BRANNAN. The State of Colorado.

Senator DONNELL. The State of Colorado. And what was your educational background?

Mr. BRANNAN. I am a graduate of the University of Denver Law School.

Senator DONNELL. The University of Denver Law School.

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Did you study agriculture in the University of Denver or in any other university of Colorado?

Mr. BRANNAN. No, sir.

Senator DONNELL. And then after your graduation from the Denver University Law School, which was in what year—?

Mr. BRANNAN. 1929.

Senator DONNELL. 1929; what did you do then? What did you do immediately after you left law school?

Mr. BRANNAN. Engaged in the practice of law.

Senator DONNELL. For how many years?

Mr. BRANNAN. Until 1935.

Senator DONNELL. Until 1935.

Mr. BRANNAN. In the private practice of law.

Senator DONNELL. Where did you practice?

Mr. BRANNAN. In the city and county of Denver.

Senator DONNELL. Did you know Mr. James Grafton Rogers there?

Mr. BRANNAN. I certainly did. He was dean of the school part of the time I was there.

Senator DONNELL. Which you attended?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Were you associated with him in any way in the practice of law?

Mr. BRANNAN. I was not.

Senator DONNELL. But you practiced until 1935?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. What did you then do?

Mr. BRANNAN. I became a member of the staff of the solicitor of the Department of Agriculture for the area—may I change that, sir?

Senator DONNELL. Yes.

Mr. BRANNAN. I became a member of the staff of the general counsel for the Resettlement Administration, which later became a part of the Department of Agriculture.

Senator DONNELL. That was legal work, also, was it not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. How long were you associated with the office of the general counsel?

Mr. BRANNAN. Until, I think, the Farm Security became a part—Resettlement Administration became a part of the Department of Agriculture in 1937, if I remember correctly.

Those are facts of common knowledge. I do not carry them around.

Senator DONNELL. And your work during those 2 years, or thereabouts, was in the office of the general counsel, as you have indicated, is that right?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. From 1937 on, what did you then do?

Mr. BRANNAN. I worked as an attorney for the Department of Agriculture as assistant regional attorney and then regional attorney, and somewhat later became regional director for the Farm Security Administration, left the Solicitor's Office and became regional director for the Farm Security Administration in 1941.

Senator DONNELL. So, from 1937 or thereabouts, until 1941 you were in the office of the attorney for the Department of Agriculture; is that right?

Mr. BRANNAN. Right, sir.

Senator DONNELL. Yes. You were doing work in that office?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. And in conjunction with those duties; is that right?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Now, what part of 1941, by the way, did you leave that work?

Mr. BRANNAN. I think in November, if I remember correctly.

Senator DONNELL. November of 1941. And then what did you do after that?

Mr. BRANNAN. I became regional director for Farm Security Administration at Denver.

Senator DONNELL. At Denver. And how long were you there in that capacity?

Mr. BRANNAN. Until 1944.

Senator DONNELL. What part of the year?

Mr. BRANNAN. I think, again, it was around April.

Senator DONNELL. And then from then on what have you done?

Mr. BRANNAN. I became Assistant Administrator of Farm Security Administration, with my headquarters in Washington.

Senator DONNELL. And you have served in that capacity for how long?

Mr. BRANNAN. For about 2 or 3 months when I was appointed Assistant Secretary of the Department of Agriculture.

Senator DONNELL. So that you have served as Assistant Secretary for the Department of Agriculture since about June of 1944 up until the present time. Is that right?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Yes, sir.

Now, Mr. Brannan, you have never studied medicine, have you?

Mr. BRANNAN. No, sir.

Senator DONNELL. No, sir. The statement that Mr. Anderson prepared, which was filed this morning by the chairman of our committee, dated April 18, 1946; do you know who actually prepared that statement?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Who did?

Mr. BRANNAN. The same group of folks, including myself, who prepared my statement this morning.

Senator DONNELL. Did Mr. Anderson himself prepare any part of this statement which has been filed in his behalf this morning?

Mr. BRANNAN. He examined that statement in its initial forms. He went over it and made some suggestions and the suggestions were incorporated in the final document.

Senator DONNELL. Would you say, perhaps, that his contribution in the language, I should say, of the statement, was about what yours was on your statement; say, 10 percent.

Mr. BRANNAN. That or less.

Senator DONNELL. That or less. All right.

Mr. BRANNAN. Probably much less.

Senator DONNELL. Excuse me. Did the four persons who participated in this conference with you then prepare his statement initially as was the case with your own statement? That is right, is it not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Mr. Brannan, I note in the early portion of your testimony, and I have forgotten the exact language, but the gist of it was that the Secretary of Agriculture's statement was either not inconsistent, or was along the same line of your own. It, of course, is not by any means as extensive, is it?

Mr. BRANNAN. That is right.

Senator DONNELL. That is right.

I want to come to one or two phases of your statement there for a few minutes.

Now, Mr. Brannan, you referred both in your original statement and in your examination by our chairman to the selective service physical examination.

You are familiar with the fact, are you not, that included in the figures of the rejections were those which related to physical disability; a man who had a deformed arm, or a deformed leg, and mental incapacity, and even his inability to pass certain mental examinations; you realize all that was included in the Selective Service figures of rejections, do you not?

Mr. BRANNAN. May I correct you on the latter part of that statement?

Senator DONNELL. Yes, sir.

Mr. BRANNAN. The figures quoted at the top of page 3 of my statement—

Senator DONNELL. Yes.

Mr. BRANNAN. If you will observe from the last phrase, or the end of that paragraph which starts at the top of page 3, it is indicated that they are based on physical defects alone. They are not based on mental aptitude.

Senator DONNELL. Very well. That last sentence relates to the farm youths in the significant 18-19-year-old group who were turned down at a rate of 40 percent higher than for all others.

The figures are based on physical defect alone. That is the sentence you refer to?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Those physical defects also include defects of the kind I mentioned, a man who had a deformed hand, or a broken down instep, those were all included?

Mr. BRANNAN. I understand they were, sir.

Senator DONNELL. Yes, sir. All right.

Mr. Brannan, I notice that in your testimony you mention in various places, or make reference in various places to State administration and to decentralization of administration, et cetera.

Turn, for instance, to page 17 of your statement, where you say:

We need a national program to equalize health opportunities for the entire population, but day-to-day administration under this bill will be decentralized and essentially local.

That is your statement, is it not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Have you examined this bill to find out whether there is anything mandatory on the Surgeon General requiring decentralization?

Mr. BRANNAN. Senator, if you care to have me take the time I will try to put my finger on it. I am confident it is in there.

Senator DONNELL. I wish you would, Mr. Brannan. I might assist you by referring you to pages 38 and 39, if you do not have these pages at hand. Those might be the pages you refer to. The area committees, et cetera.

Mr. BRANNAN. Well, Senator, you have put your finger on the place that I would refer to you, too.

Senator DONNELL. Very well. Now, the first one, on page 39, starts out as follows, does it not:

Except with the respect to States or local areas for which other arrangements have been made, under the provisions of this section, the Surgeon General shall appoint local area committees to aid in the administration of this title.

That is the language, is it not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. What is that exception? "Except with respect to states or local areas for which other arrangements have been made"?

Mr. BRANNAN. Sir, I understand it to refer back to the language which begins on line 24 on page 37, which is as follows:

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

Senator DONNELL. I call your attention to the fact there, Mr. Brannan, as you undoubtedly have observed, that in that language which you have read, it states that "the Surgeon General shall, insofar as practicable."

Mr. BRANNAN. Yes.

Senator DONNELL (reading) : "give this priority and preference." Who determines the practicability of that under the act?

Mr. BRANNAN. I would assume that the Surgeon General did.

Senator DONNELL. Yes. I call your attention also, Mr. Brannan, to the next section, (f), on page 38, which says:

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

There is nothing obligatory to that delegation section that he should delegate those functions, mentioned in subdivision (f) to State authorities, is there?

Mr. BRANNAN. No, sir.

Senator DONNELL. Indeed, it expressly says, "to any officer or employee of the Public Health Service" which is a Federal authority, is it not?

Mr. BRANNAN. Yes.

Senator DONNELL. Or "any Federal." That is certainly a Federal authority, is it not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. And so forth, "State or local cooperating department or agency."

Mr. BRANNAN. Yes, sir.

Senator DONNELL. So that there is left an option on the part of the Surgeon General, first, to determine the practicability of these priorities and preferences, and in the second place, to determine to what officer, State or Federal, there shall be the delegation to which you refer. That is correct, is it not?

Mr. BRANNAN. Yes, sir. The language in (f) is the language which I suspect you will find in one form or another in almost every piece of legislation which the Congress puts in force and effect, and is designed to make it possible to use existing facilities and not to have to duplicate facilities, wherever you want to put the program into force and effect.

I read nothing sinister and of devious design through investing the Surgeon General with extraordinary powers in that language. I think it is facilitating.

Senator DONNELL. I did not indicate or say I saw anything devious or sinister in it.

My point is this: You emphasize in your statement, as indeed does Mr. Anderson in the statement which was prepared and on his behalf has been filed here, you emphasize the matter of the alleged decentralization, which exists under S. 1606; and I call your attention in that connection to the fact that this statement, prepared as you have indicated, which is largely Secretary Anderson's subscribed by him after examination, contains this sentence:

The provisions of S. 1606 calling for decentralized administration appear to be sound.

And then he proceeds in that same paragraph to say:

I am particularly glad to note the provision for local area committees to serve in an advisory capacity to local administrative officials.

There is nothing mandatory, Mr. Brannan, is there, that the Surgeon General must follow the advice of the local area committees, is there, in this statute, or this bill?

Mr. BRANNAN. No, sir.

Senator DONNELL. In other words, as indicated by Mr. Anderson, those committees serve in an advisory capacity only, and the ultimate authority is vested back in a Federal office in Washington to make the decisions, is it not?

Mr. BRANNAN. I think that is right, for uniformity's sake.

The CHAIRMAN. Right there, is it not true that the Surgeon General has to make a periodical report to the Congress?

Mr. BRANNAN. To the Congress.

The CHAIRMAN. About his consultations. The assumption would be, if he failed or neglected to take the advice of these advisory boards, that he would be subjected to some study here on the part of Congress; is that not true?

Mr. BRANNAN. That is certainly true, Senator.

Senator DONNELL. I appreciate the correctness of the reference to which the chairman addresses himself in this section, although I am not at all clear as to the validity of the conclusion which he draws in its ultimate extent.

In order that the record may be clear, I quote from page 41:

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

I take it, Mr. Brannan, that a man of the ability of the Surgeon General, believing as he does in the correctness of his views, if he thinks his views are right as against what the Advisory Council thinks, the comments which he places before Congress might be exceedingly persuasive in determining Congress, as to whether it would support the views of the Surgeon General or the views of the Advisory Council.

Mr. BRANNAN. Yes; but I would expect they would be subjected to the searching kind of examination which you are capable of giving, sir.

Senator DONNELL. I thank you for the compliment, Mr. Brannan, coming from a brother lawyer.

The CHAIRMAN. Mr. Brannan, you have noticed section 203 (a) at the bottom of page 35, which provides:

The Surgeon General of the Public Health Service shall perform the duties imposed upon him by this Act, under the supervision and direction of the Federal

Security Administrator, and after consultations with the Advisory Council (hereinafter established) as to questions of general policy and administration, and in consultation with the Board, shall also have the duty of studying and making recommendations as to the most effective methods of providing personal health service benefits, and as to legislation and matters of administrative policy concerning health and related subjects.

Senator DONNELL. I may say, Mr. Brannan, in that connection, that that is exactly the section I intended to come to next in my questions to you.

And I want to call attention to the fact that I have left out one element in this section which the chairman just read which I regard as of extremely great importance and which I think should be specifically emphasized.

That is, although these various duties are cast upon the Surgeon General and the decisions are to be made by him, as was read by the chairman :

The Surgeon General of the Public Health Service shall perform the duties imposed upon him by this Act, under the supervision and direction of the Federal Security Administrator, and after consultations with the Advisory Council (hereinafter established) as to questions of general policy and administration—

and so on—

and in consultation with the Board.

Mr. Brannan, are you familiar with the law as to whether there is any requirement that the Federal Security Administrator shall be a physician? Is there any such requirement as that in the law?

Mr. BRANNAN. I am not aware that there is.

Senator DONNELL. You are acquainted with Mr. Miller, who possibly is here this morning; you know Mr. Miller is the Federal Security Administrator at this time?

Mr. BRANNAN. That is right.

Senator DONNELL. It is your best information, is it not, Mr. Brannan, that Mr. Miller is not a physician?

Mr. BRANNAN. That is right.

Senator DONNELL. And your best judgment is that there is no requirement of the law requiring that the Federal Security Administrator be a physician or surgeon; that is correct, is it not?

Mr. BRANNAN. That is right.

Senator DONNELL. And yet, as I have indicated, although these various decisions are left to the ultimate determination of the Surgeon General between him and these various area committees and the General Advisory Council, yet the performance of the duties of the Surgeon General, as indicated in section 203 (a), is itself "under the supervision and direction of the Federal Security Administrator."

Now, where is the Federal Security Administrator's office? Is it in Washington?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Well, then, you would not say that the Federal Security Administrator is very much decentralized, would you? In exercising his supervision and direction, he is right here in Washington, is he not?

Mr. BRANNAN. That is correct.

Senator DONNELL. Now, Mr. Brannan, I assume that you agree with me and other persons as to the great importance of State administration of as many functions as are practicable, do you not?

Mr. BRANNAN. I do, sir.

Senator DONNELL. That is your general view, as a lawyer, is it not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. And you learned that, generally speaking, in your professional practice, and believe in it personally, do you not?

Mr. BRANNAN. Yes, sir, I do.

Senator DONNELL. You do, of course.

We will turn, with that in mind, to page 6 of this bill. I take it that recognizes the validity of the legal conclusion and the matter of policy which I take it you likewise agree with, as to the advisability of giving to the State as much to do with the administration of affairs as practicable?

Mr. BRANNAN. Within the Federal system. They cannot be autonomous on this or any other thing.

Senator DONNELL. You are exactly right.

I call your attention to title I, which consists not of compulsory health insurance but grants-in-aid.

At page 6, it is provided and appropriate that a State plan, in order to be approved under that subsection, must

Provide for the administration of the plan by the State health agency or supervision by the State health agency of the administration of any part of the plan administered by another State agency or by a political subdivision of the State.

That is a recognition, is it not, in your judgment, on this particular bill, of the importance of the State administration, as far as practicable, of the functions relating to health?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. I refer you also to page 14 of the bill, in section 122 (a), where, referring to the State plan for maternal and child-health services, the act says:

A State plan for maternal and child-health services to be approved under this section must—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.

That is based on the same proposition, is it not?

Mr. BRANNAN. Yes, Senator, but you have in mind, of course, that they operate with a delegated authority.

Senator DONNELL. That the States operate with a delegated authority?

Mr. BRANNAN. In those committees.

Senator DONNELL. I certainly do not.

Mr. BRANNAN. Under title II.

Senator DONNELL. I certainly do not agree with that. I undertake to say that the theory of these portions of the bill, is that the States operate themselves but are assisted by the Federal Government and with the right of the Federal Government to withhold the grants unless the plan, as defined by the States, shall fit into the plan as approved by the Federal Government.

Mr. BRANNAN. That is correct.

Senator DONNELL. And there is no delegative power, according to my conception.

Mr. BRANNAN. I agree with you.

Senator DONNELL. I thought you would, Mr. Brannan.

As a matter of fact, is it not true, Mr. Brannan, that with the possible exception of the Government dealing with external affairs, with foreign nations, that the general rule is that the National Government possesses only such powers either expressly or by necessary implication, conferred upon it by the Constitution?

Mr. BRANNAN. That is right.

Senator DONNELL. And all powers not delegated to the National Government are retained respectively by the States and the people. That is correct, is it not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. I refer you also to page 27 of the bill, which is the next part of the first title, namely, grants to States for medical care of needy persons, and again I call your attention to the fact that the language says:

A State plan for medical care must provide for the establishment or designation of a single State public assistance agency to administer or to supervise the administration of the plan for medical care.

That, likewise, is in recognition of that same principle of the importance of the local State administration under the local authority, is it not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Your answer was in the affirmative, was it not?

Mr. BRANNAN. It was, sir.

Senator DONNELL. Yes, sir.

Mr. Brannan, when we get over to title II, that is to say this matter of a prepaid personal health-service benefit, or what we call compulsory health insurance, we do not find there grants-in-aid to the States, do we, in that title? There are no grants-in-aid by the Federal Government to the States under title II?

Mr. BRANNAN. That is right.

Senator DONNELL. I am correct in that?

Mr. BRANNAN. That is right; yes, sir.

Senator DONNELL. Title II proceeds on the theory of the operation of a compulsory health-insurance plan not by the State but by the Federal Government. That is correct, is it not?

Mr. BRANNAN. With the aid of local committees.

Senator DONNELL. Yes.

Mr. BRANNAN. Institutions and wherever they exist, local agencies.

Senator DONNELL. Yes. I understand that is correct, and I agree to that, but the act operates on a plan of Federal operation under the supervision of the Surgeon General, aided as he is by the Advisory Council and the local area committees, by himself, subject to the supervision and direction, as I quote, "of the Federal Security Administrator." That is correct, is it not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Under title II of this S. 1606?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. I can well understand, Mr. Brannan, both your emphasis upon the importance of decentralization and the emphasis given by the Secretary of Agriculture to the same point as exemplified by these earlier provisions of this act.

Let me ask you this: Have you undertaken to compute, Mr. Bran-

nan, approximately the number of Federal employees that will be required to operate this system of compulsory health insurance?

Mr. BRANNAN. No, sir; we have not.

Senator DONNELL. You have not undertaken to do that?

The CHAIRMAN. I might say, that a study of that is being made now, and will be presented here before these hearings are concluded.

Senator DONNELL. Yes, sir.

Now, Mr. Brannan, at pages 7 and 8 of your statement—I beg your pardon—page 10 of your statement, you refer, and I quote, as follows:

The lowest figures suggested for the average cost of good family medical care, about \$100 a year, are beyond the reach of some 80 percent of all farm families.

I close the quotation. Are you able to tell us, Mr. Brannan, approximately how many families there are in the United States?

Mr. BRANNAN. Senator, may I refer that question to Dr. Mott?

Senator DONNELL. Yes, sir.

Mr. BRANNAN. Who has some of these statistics at his fingertips.

Senator DONNELL. Yes, sir.

Doctor, can you answer that question as to approximately how many families there are in the United States?

Dr. MOTT. Not rural families, you mean all families?

Senator DONNELL. Yes, sir.

Dr. MOTT. I suppose the figure is approximately somewhere between 35,000,000 and 38,000,000. I do not know.

Senator DONNELL. 35,000,000 and 38,000,000?

Dr. MOTT. I am just giving an estimate, sir, on the basis that the average size of the family is under four at the present time.

Senator DONNELL. I see; 35,000,000 to 38,000,000. We will take that. I appreciate this is only an estimate. But I want to get some idea of the cost of this thing from Mr. Brannan's figures here.

As I understand it, and as I recall from the testimony, the total number of persons who will come under this act will be about 105,000,000 to 112,000,000.

Do you know whether that is correct, Dr. Mott?

Dr. MOTT. I believe it has been so estimated, sir.

Senator DONNELL. For ready figuring, could we say 110,000,000? That is, in round figures. It may be a few million off one way or the other, but approximately. The total population is, today, how much?

Dr. MOTT. In 1940 it was 131,000,000 plus. It is probably closer to 140,000,000.

Senator DONNELL. About 140,000,000, so that about eleven-fourteenths of the population, as our estimate, 110,000,000, is to come under this act, eleven-fourteenths of the entire population would be under S. 1606. That is right?

Dr. MOTT. Probably at least that.

Senator DONNELL. We will make it twelve-fourteenths or six-sevenths of the population. Do you think that is a fair estimate of about the proportion?

Dr. MOTT. I would think so, sir.

Senator DONNELL. If we take the lower number of the figures of the families you gave, 35 to 38, for the purpose of getting the cost, let us

take the lower figure, and make it six-sevenths of 35,000,000 families, which would be 30,000,000 families, would it not?

Dr. MOTT. Yes, sir.

Senator DONNELL. 30,000,000 families. Mr. Brannan's estimate says, "The lowest figures suggested for the average cost of good family medical care, about \$100 a year."

Applying \$100 to those 30,000,000 families who, roughly speaking, would seem reasonable to think would come under this bill, that would produce 30,000,000 times 100, or \$3,000,000,000.

Dr. MOTT. That is right, yes, sir.

Senator DONNELL. That is for the medical care. I take it that that does not include administration of some system. That is just the cost, as I understand your statement, Mr. Brannan, of this medical care?

Mr. BRANNAN. I think so.

Dr. MOTT. The medical services in that estimate include hospital care, prescribed drugs, and at least some dental care.

Senator DONNELL. I see. It would be about \$3,000,000,000. As I understood the testimony of one of you gentlemen, you think probably the aggregate cost under S. 1606 will not exceed the aggregate cost today, but it is merely a matter of distributing it throughout the population rather than the present plan where a large portion is paid by one segment of the population and the other segment does not spend enough to take care of itself.

Dr. MOTT. That is right.

Senator DONNELL. In addition to the \$3,000,000,000 cost of good family medical care, including hospitalization, as you mentioned, and dental care, and was there one other item?

Dr. MOTT. Among the medical services, sir?

Senator DONNELL. Yes.

Dr. MOTT. Physician's service, hospital service, dental care.

Senator DONNELL. Nursing benefits?

Dr. MOTT. Perhaps nursing benefit, and prescribed drugs.

Senator DONNELL. Let me ask Mr. Brannan this question:

Did you include under the language "good family medical care," nursing services also?

Mr. BRANNAN. It is my recollection it was included in our discussion; yes, sir.

Senator DONNELL. You think it was?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. In addition to those items, Dr. Mott, have you made any investigation, or has Mr. Brannan, as to what it would cost to administer this thing against the administrative cost of having a representative of the Surgeon General in the various towns and cities of the country, and maintaining an office and a clerical force and the postage and the telephone and the telegraph? Have you made any estimate along those lines?

Dr. MOTT. No study has been made, sir.

I would like to make two or three remarks.

Senator DONNELL. I would be glad to have you do so.

Dr. MOTT. Of course, the types of programs which we have administered, some directly and some indirectly, in the Department of Agriculture, are not really analogous.

Our simple Farm Security plans are administered for approximately 5 percent or less. The arrangements are very informal usually.

In these so-called experimental plans, which have been subsidized and which are open to all farmers, where we have full-time managerial personnel in the counties, overhead expenses have been less than 10 percent.

Senator DONNELL. 10 percent of what?

Dr. MOTT. 10 percent of the total funds, the total family and government contributions.

Senator DONNELL. Yes.

Dr. MOTT. I understand, sir, that in the administration of the Old Age and Survivors Insurance program of the Social Security Board, that the administrative cost is less than 2 percent of the family and other contributions—less than 2 percent of the contributions and approximately 14 percent—and it is certainly not higher, and I may be wrong, it may be 12 to 14 percent—of outpayments to beneficiaries.

Senator DONNELL. I see.

Dr. MOTT. There is apparently an example there of very efficient administration once a very difficult system is established.

I believe the Blue Cross experience is that administration averages something like 12 percent.

I believe the experience of foreign governments in national health programs varies from 10 to 11, 12, 13, or 14 percent, right in that general range.

I believe overhead expenses, at least from our experience and discussion, would not exceed 10 percent or 12 percent, which is a perfectly fair expenditure for administration, which is very intimately connected with the quality of the services.

Senator DONNELL. Very well, Doctor, that is helpful. We will take the lower figure, say 10 percent of the \$300,000,000 would be about \$30,000,000; that is right, is it not?

Dr. MOTT. Yes, sir.

Senator DONNELL. That would make the total expenditure \$3,300,000,000 a year.

Dr. MOTT. Yes, sir.

Senator DONNELL. Doctor, I am not sure whether you answered this or not. I know Mr. Brannan did.

Have you investigated as to know how many persons will be actually required in the operation of this compulsory insurance plan all over the United States?

Dr. MOTT. No, sir; I have not.

Senator DONNELL. You have not.

Dr. MOTT. I have heard some discussion, sir, on the basis of some of the testimony before this committee.

Senator DONNELL. Yes, sir. There was one gentleman who testified, as I recall it, that would take, in his judgment, around a million and a half persons to do it.

Do you have any basis on which to judge whether he is correct or incorrect on that factor?

Dr. MOTT. A million and a half persons, sir, would be 1 employee for every—well, not 100. What would it be?

Senator DONNELL. One employee for every 140 if we have 140,000,000 people.

Dr. MOTT. I would be extremely interested to know the basis for any such suggestion.

Senator DONNELL. You think it is too high?

Dr. MOTT. It seems to me completely out of line. I happen to have heard some discussion on this point. I was not in the hearings when that was discussed, but the simplest explanation I heard was that a decimal point had been missed by the witness.

Senator DONNELL. You have not investigated the experience along that line and whether this figure would be too high or not?

Dr. MOTT. I am not prepared to make a statement on that, no.

Senator DONNELL. Doctor, there would be the necessity of having under the jurisdiction of the Surgeon General, and finally back under the direction and supervision of the Federal Security Administrator, such employees in every city of any size in the country, would there not? That is, in the administration of this?

Dr. MOTT. Any city of any size, I would think you are right.

Senator DONNELL. Would it not be necessary almost to have somebody in every town in the country as a representative to make quick decisions as to matters arising under the compulsory insurance act?

Dr. MOTT. I would not think so, sir. Knowing rural counties fairly well, and I have not given a great deal of thought to this, but I might say, sir, that I would think that an employee in a single county would often be excessive.

If we get into the kind of a district organization of health services which most of us hope for, with coordination of public health and medical-care services in districts, the rural district will often comprise, let us say, three counties.

I am not sure how much detail would be involved in this bill. I would think in terms of a full-time employee at such a level, that would be more logical perhaps once the system was under way.

Senator DONNELL. Mr. Chairman, I am not unmindful of the passage of time. I realize, however, that these two gentlemen, I think, testified jointly from about 5 minutes or 10 minutes after 10 until around 11:20, so that when two as important witnesses as these come up, I realize it requires some time to make the examination. I shall endeavor to make it as fast as I can.

The CHAIRMAN. I have never criticized you about that, Senator.

Senator DONNELL. You have been very kind and courteous. I appreciate it very much.

May I return to Mr. Brannan, please.

On page 14 of your statement, you say:

In a voluntary program there is little incentive for preventive medical practice and little inducement to improve the quality of medical care.

Do you not think that, as a matter of fact, under the voluntary program that we have had of the administration of medicine in this country, for the entire history of the country, that there has been some incentive for doctors to advance and to progress and that there has been advancement in the country?

Mr. BRANNAN. Senator, I am a profound admirer of the medical profession, and I do think they have done wonderful things with limited facilities, but I think it is time this Nation ceases to impose upon them. We should make adequate facilities to do the type of job they are doing, and not ask them to take on unlimited numbers of

charity patients, or patients from whom they can reasonably not expect to get adequate remuneration.

Senator DONNELL. Mr. Brannan, in your testimony, at page 16, you say this, which I was impressed with as probably being a little stronger than you intended:

One feature of the national health bill that is impressing farm people and country doctors is the fact that health insurance is a change only in the method of payment for medical care.

I think there are plenty of illustrations in this bill, are there not, to show that there are other changes?

For instance, let me give you one and ask if you concur: There is under this bill the right of the Surgeon General to prescribe the maximum number of patients that a doctor may take in those communities in which the majority of the doctors decide on the per capita basis of payment; is there not?

Mr. BRANNAN. I do not think that is specifically set forth anywhere in this bill.

Senator DONNELL. Yes, it is, at page 50, section 205 (j):

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

That is in there, is it not, Mr. Brannan?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. That differs from our present system, does it not, under which you or I may go to a doctor and if he thinks he can take us he takes us as a patient, so there is that difference?

Mr. BRANNAN. Yes. But this applies to doctors that come within the plan.

Senator DONNELL. Yes. I understand. Certainly it applies to those doctors.

Mr. BRANNAN. Yes.

Senator DONNELL. But the point I make is that there is some change made by this bill in addition to the method of payment; that is to say, the illustration I mentioned.

I think I could give others, but I will not take the time.

The illustration I gave certainly indicates a difference between the present situation in which any of us here today may go to a doctor, and he has the right to take us if he thinks he can do so.

Mr. BRANNAN. Yes, sir.

Senator DONNELL. And under this bill, the section I read, if the Surgeon General has prescribed the maximum limits, the doctor operating under S. 1606 cannot take that patient. That is correct, is it not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Mr. Brannan, I want to call your attention also to the fact that, if I read this correctly, and I think I do, that this provision about the Surgeon General prescribing maximum limits to the number of potential beneficiaries is likewise modified by the provision of section 203 (a), which says that the Surgeon General shall perform the duties imposed upon him by the act, "under the supervision and direction of the Federal Security Administrator."

Mr. BRANNAN. Yes.

Senator DONNELL. So the ultimate power of determining how many patients Dr. John Smith in Sedalia, Mo., may take, if that system is in effect, resides back in the Federal Security Administrator in Washington, D. C.?

Mr. BRANNAN. Subject to the supervision of the Congress.

Senator DONNELL. All right. Subject to the supervision of Congress.

Mr. BRANNAN. Yes.

Senator DONNELL. So it all rests back here in Washington under this bill, the ultimate decision of how many patients Dr. John Smith of Sedalia, Mo., may take, if Sedalia has adopted this per capita payment plan?

Dr. MOTT. Senator—

Mr. BRANNAN. Well—

Senator DONNELL. Pardon me just a minute. If you do not mind, Mr. Brannan—

Mr. BRANNAN. May I ask Dr. Mott to answer that?

Senator DONNELL. Inasmuch as Mr. Brannan presented this statement, and I have quoted from it, I would really like to have your own answer to that.

Mr. BRANNAN. All right, sir. I just asked to have Dr. Mott answer it directly to you. He was the source, among other sources, of much of the material.

If you will permit me, I will go directly to my source and have the answer in a moment. It would expedite it if you took it directly from him.

Senator DONNELL. I would like to have you answer it, Mr. Brannan.

The CHAIRMAN. You want Mr. Brannan to answer it?

Senator DONNELL. Yes.

Mr. BRANNAN. Would you give me just a moment.

Senator DONNELL. But he wants to consult with Dr. Mott, which is all right.

The CHAIRMAN. Yes.

Senator DONNELL. What is your answer, Mr. Brannan?

Mr. BRANNAN. May I impose on the clerk to read the last part of the question?

(Record read.)

Mr. BRANNAN. The answer is "yes."

Senator DONNELL. Yes, sir.

The CHAIRMAN. Right there, let me ask you: You assume that because this language is in here, "under the supervision and direction of the Federal Security Administrator," that he will make the ultimate decision in the field as to the number of patients that a doctor is allowed to have.

Does not that language "supervision and direction of the Federal Security Administrator" have reference to the general operation of the act being under his supervision?

He does not supervise the conduct of the Surgeon General, but sees that the whole thing is carried on under the law as it is written in the statute.

Mr. BRANNAN. That is right, Senator Murray.

The CHAIRMAN. But it does not give the Federal Security Ad-

ministrator the power to come in and say that the action of the Surgeon General is wrong and that he raises the number that the doctor is permitted to have, or lowers it, is that right?

Mr. BRANNAN. That is right. And the advisory councils are ever present there to guide both of them or whoever needs it in those kinds of circumstances.

Senator DONNELL. I am particularly glad you are a lawyer and have practiced so many years.

I want you to take that act and look at pages 35 and 36, and give me your judgment as a lawer of what this language means:

"The Surgeon General of the Public Health Service shall perform the duties imposed upon him by this act, under the supervision and direction of the Federal Security Administrator," and then it proceeds, of course, "after consultations with the advisory council."

But I want your judgment as to the meaning of the clause "under the supervision and direction of the Federal Security Administrator." What does that mean? Does the Federal Security Administrator have the right to direct or not under that provision?

Mr. BRANNAN. Certainly it means that.

Senator DONNELL. Why, certainly.

Mr. BRANNAN. It means, of course, that in Government operation, the ultimate responsibility must rest somewhere.

I suppose we could both read into this, Senator, that under the direction of the President, who, after all, directs the Federal Security Administrator, and who can remove him at will, and replace him at will, that even he, not being a medical man, might not fit the criteria or specifications.

Senator DONNELL. May I beg to differ with you?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. I am not familiar with the Federal Security Administration statute, but I shall be extremely surprised to find anything there that says that the power rests in the President of the United States.

Mr. BRANNAN. The power rests in the President of the United States to remove and replace him at any time he wants, and that is equivalent to telling him what he wants done any time.

Senator DONNELL. I do not think it is, by any manner of means. I think that when the Federal Security Administrator is placed in charge of his office, so long as he is there, he is the Administrator.

Mr. BRANNAN. Yes, sir.

Senator DONNELL. It is true that the President may remove him, but the power of acting while he is in office, I shall be greatly surprised to find that there resides anywhere other than the Federal Security Administrator any power at all. I am correct in that, am I not?

Mr. BRANNAN. You certainly are; but I am also correct in saying that, practically, the President could do anything he wants to do by merely having control of the occupant of the position which does the particular function we have under consideration.

Senator DONNELL. I do not know what the system is.

Mr. BRANNAN. In other words, if, let us say, the Surgeon General recommended to Watson Miller a specific general policy, Watson Miller did not approve it, and the President agreed with the Surgeon Gen-

eral, agreed so vociferously that he cared to remove Watson Miller to enforce his point of view he could do it, and by that practical route, the will of the people, or the will of the President, or the will of the people expressed through the President would be carried down to that county level.

Senator DONNELL. Very well. Assuming the correctness of the statement, the point remains even more so that instead of a decentralization existing, as you and Mr. Anderson have the view, it demonstrates that the ultimate decision lies down here in Washington in the President of the United States. That is where the President is.

Mr. BRANNAN. And in the Congress of the United States.

Senator DONNELL. And in the Congress.

Mr. BRANNAN. But, Senator, somewhere the ultimate authority must rest.

Senator DONNELL. Certainly.

Mr. BRANNAN. The people of the United States have put it in the Congress and in the President and in turn the administrative officials. It is not conceivable, so far as I can see, that the operations of this big Government, that decisions of advisory committees at county levels, based on the sound judgment of the people of the community, is going to be overruled arbitrarily and facetiously, or without regard unwarrantedly by the Surgeon General in the first instance, and by the Commissioner of the Federal Security Administration, or by even the Congress, as a matter of fact.

Senator DONNELL. I get your point, Mr. Brannan. I do not want to argue the legal point with you, but the fact still remains, as indicated a little while ago, and we agreed on this, that the Federal Government is not a government of unlimited power, nor is the President an officer of unlimited power. He has only such authority as is conferred upon him by the Constitution of the United States and the Congress has only such power as is conferred upon it by the Constitution of the United States.

Mr. BRANNAN. Yes.

The CHAIRMAN. Gentlemen, I think we have pursued this far enough. I think this is nothing but an argument. It is not testimony. It is not going to help us at all, because all of this argument will be completely ignored when the committee comes to discuss the bill.

Senator DONNELL. I hope not, Mr. Chairman.

The CHAIRMAN. This particular argument, I mean. You will present the argument, of course.

Senator DONNELL. Yes.

The CHAIRMAN. At that time.

Senator DONNELL. Yes.

The CHAIRMAN. But I do not think we are going to rely upon the argument being made here at this moment. Do you think so, Senator? If you do, I will be glad to let you continue.

Senator DONNELL. I think the chairman is quite right. It is a legal argument. I agree upon the fundamental views indicated this morning, and I shall not pursue that further, but I think it is of great importance to have the conception of the relative functions of the Federal and State governments, and I think we all agree to that.

The CHAIRMAN. My impression would be that the Surgeon General of the Public Health Service shall perform the duties imposed upon

him under this act, and that the Federal Security Administrator will examine his conduct and he will determine whether or not he is acting within the act. It does not mean that he is going to step into the local communities and supervise and direct the Surgeon General.

Senator DONNELL. Of course, I appreciate and agree thoroughly with the chairman that the ultimate power conferred by the act is of the Government's.

Mr. BRANNAN. That is right.

Senator DONNELL. And there can be no doubt about that.

Mr. BRANNAN. And I do, too, sir.

Senator DONNELL. The point I make is not that the Federal Security Administrator is personally going to travel all over the United States to every community, but the point I do make, as stated on pages 35 and 36:

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.

I shall not pursue that further.

The CHAIRMAN. Do you desire to make a comment on that, Dr. Mott?

Dr. MOTT. Just a brief moment, if I may.

On this question of limitation of the number of patients: Of course the provision is there with the objective of insuring high quality of service. That is an objective no one could quarrel with. The policy, of course, will be determined in consultation with these various councils with their professional representatives.

The CHAIRMAN. That kind of a system is followed in the big hospitals of the country under the present-day system of medical care.

Dr. MOTT. There are many forces today which have the same net effect in practical experience.

I would simply like to make this point: I wonder if enough emphasis has been put on that language of that section, section (j), page 50, where it indicates that the Surgeon General "may"—it is not mandatory—"may prescribe maximum limits to the number of potential beneficiaries" and such limitation "may be nationally uniform" or "may be adapted to take account of relevant factors." You will notice there is specific provision for flexibility in the act, to cover special situations, such as one would find in rural areas with very few physicians, until the full weight of the act were felt in the economic force it would release, which would tend to attract more physicians into these areas.

Senator DONNELL. Doctor, who determines what are the relevant factors, as you read that section?

Dr. MOTT. I would imagine, sir, that the whole question would be a matter for administrative officials at all levels and for the advisory groups at levels to consider. Out of which would come a flexible policy. In fact, it might not be imposed at all.

Senator DONNELL. The point I was getting at, is who are authorized to make the decisions ultimately of what are "relevant factors"?

The CHAIRMAN. The Surgeon General.

Dr. MOTT. The Surgeon General, sir, leaving out the Federal Security Administrator.

Senator DONNELL. He makes it, but it is subject to the direction and supervision.

Dr. MOTT. That is correct.

The CHAIRMAN. He makes it after advising with the advisory board.

Dr. MOTT. That is right.

The CHAIRMAN. And if, for instance, a physician is limited to 250 patients, and another patient comes along and needs attention from that physician, there is nothing in this law that would prevent the surgeon General from permitting him to take that extra patient?

Dr. MOTT. That is correct, sir.

The CHAIRMAN. In other words, it is a flexible provision.

Dr. MOTT. It is flexible, sir, and if I may make the comment, it seems to me we should be a little more concerned about the 1,000 or 1,500 patients who, under such a provision, will get a higher quality of service, and under such an act will have access to medical care, than to worry about the half dozen or so, who, for a temporary period, might undergo some hardship.

Senator DONNELL. Mr. Brannan, I shall endeavor to make my further examination very brief; and I want to ask a very few questions of Dr. Mott.

In your statement, the concluding statement is:

It—

referring to S. 7606—

has the full support of the Department of Agriculture and I am confident that it has the backing of the farmers of America.

There has been no poll taken of the farmers of America?

Mr. BRANNAN. I did quote the three major farm organizations' points of view.

Senator DONNELL. I was coming to that.

Mr. BRANNAN. And may I also state that the report submitted here by the Secretary was referred to every interested agency in the Department of Agriculture for consideration.

Senator DONNELL. Yes.

Mr. BRANNAN. And, for example, the Extension Service, which has a person in every county, or has contact with a person in every rural county in the United States, examined the statement carefully, and it bore the approval of that service when we took it into the Secretary the first time, and several other agencies likewise.

Senator DONNELL. Thank you, Mr. Brannan. I observed as carefully as I could as you were giving it, your mention of the action taken by certain of the leading farm organizations, and though I may have overlooked it, though I do not recall, I fail to find anything in this statement of the American Farm Bureau Federation, appearing on page 19 of your testimony, adopted at the 1945 national convention, that has anything to say about compulsory health insurance.

The language there is:

One of rural America's most urgent problems is to provide a program to bring about better facilities in rural areas for hospitals, medical care, and improved health.

There is no statement there in favor of compulsory medical insurance in that sentence, is there?

Mr. BRANNAN. No, sir.

Senator DONNELL. And that is the resolution which you recited in your statement?

Mr. BRANNAN. Yes.

Senator DONNELL. Now, I also wish to call your attention to another section.

Mr. BRANNAN. But it does reflect that the people of that organization are aware of the need for a more comprehensive and full coverage medical program in rural areas.

Senator DONNELL. I think you are quite right, and I have no disagreement. The point I am making is that there is no expression in that sentence which you quote in favor of compulsory health insurance. I am right in that, am I not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. The National Grange, you quote as having resolved at its last convention—

that because of the uneven and unpredictable cost of illness, it is of prime importance that rural people should spread the risks and share the costs of sickness by developing a comprehensive form or prepayment plan for hospital bills and health insurance.

That question of "uneven and unpredictable cost of illness, it is of prime importance that rural people should spread the risks and share the costs of sickness by developing a comprehensive form of prepayment plan for hospital bills and health insurance" and that "rural people should spread the risks"—

Mr. BRANNAN. Yes.

Senator DONNELL. In that sentence there is nothing said in favor of compulsory health insurance operated by the United States Government, is there?

Mr. BRANNAN. Only by implication, Senator, that if you are going to spread the risks, it does not seem feasible to me that you are going to spread it on a voluntary basis.

The people who live in the urban communities are not going to make voluntary contributions for helping people in rural areas, so it does by implications suggest that the plan have a compulsory character.

Senator DONNELL. I understand your view, and I respect it. I reiterate, however, there is nothing expressly stated by that resolution of the National Grange to the effect that the National Grange favors compulsory health insurance operated by the Federal Government.

Mr. BRANNAN. The word "compulsory" is not in the statement. But the implication is there strongly.

Senator DONNELL. That is your opinion, and I respect that. I am not sure it is right, but it may be.

The next refers to public or private funds combined with insurance funds to equalize the ability of these families.

That is likewise consistent with the idea of grants-in-aid back to the States that occur under all features of this bill preceding the compulsory health insurance provision. I am correct in that, am I not?

Mr. BRANNAN. Yes, sir.

Senator DONNELL. Now, you referred also here to the National Opinion Research Center "reported in 1944 that 68 percent of those polled indicated a desire to have social security cover doctor and hospital bills."

Did you have a copy of the language that was presented to the voters at that poll, and also, do you know whether those were farmers that voted on that?

Mr. BRANNAN. We can furnish that for the record.

Senator DONNELL. Would you mind doing that?

Dr. MOTT. That was a national poll.

Senator DONNELL. Of farmers alone?

Dr. MOTT. No, sir. I think it is rather interesting that that 68 percent figure held up to 58 percent when the question was asked: "Would you have your social security contribution amount to 2½ percent to make that possible instead of the present 1 percent?" The favorable vote was still at 58 percent.

The CHAIRMAN. Will you furnish that for the record, please?

(The information referred to is as follows:)

The question was worded as follows:

"Do you think it would be a good idea or bad idea if the social-security law also provided paying for the doctor and hospital care that people might need in the future?"—(From the National Opinion Research Center, September 1944.)

Senator DONNELL. That is all I desire to ask Mr. Brannan.

I would like to ask Dr. Mott one or two questions.

One is, I understood you to say that the voluntary program that has been used in the past has, by no means, been entirely negative in its result?

Dr. MOTT. That is correct, sir.

Senator DONNELL. That is correct. And I note in the language of Mr. Brannan's statement, at page 12, where he is referring to "voluntary prepayment medical care plans" sponsored by the Farm Security Administration, he says this:

These plans included, at their peak, over 600,000 persons in 43 States—

That is a fact, is it not, Doctor?

Dr. MOTT. That is correct, sir.

Senator DONNELL. Doctor, may I ask you, how long have you been in the Government work here in the capacity you are in now?

Dr. MOTT. In my present capacity as Chief Medical Officer of the Farm Security Administration, since February 1942, but in Government since January 1937.

Senator DONNELL. Have you been associated in any of your work with Mr. Falk, Mr. Isadore S. Falk?

Dr. MOTT. From time to time, I have had the opportunity to take part in some meeting or something of that sort with him.

Senator DONNELL. May I ask if he cooperated in the work of the preparation of the statement or suggestions for the statement made by Mr. Brannan and that submitted by Mr. Anderson?

Dr. MOTT. No, sir.

Senator DONNELL. He had nothing to do with that?

Dr. MOTT. No.

Senator DONNELL. But you have conferred with him from time to time. Have you conferred with him on that subject of compulsory health insurance?

Dr. MOTT. In a very informal way. In the past, there may have been informal discussion, but I have not seen him for over a period of weeks.

Senator DONNELL. You mentioned also that there is today in prac-

tice very little choice in rural areas for people to choose their own physician, because, as I understand it, the physicians are not there.

Dr. MOTT. In many instances they are too few, and the economic barrier negates free choice to an extent.

Senator DONNELL. You mentioned Breathitt County, Ky.

I believe you said 22,000 people were there and there were no doctors.

Dr. MOTT. I believe you will find in the record that I qualified my statement. I think it was Breathitt County. I believe it was Breathitt County which toward the end of the war had a population of 22,000, and I believe one practicing physician. I cited that as the most extreme case I know.

Senator DONNELL. Certainly there would be an opportunity for a doctor to make a reasonable income in a community of 22,000 under the present system? Take any county in Kentucky with 22,000 population, there is surely enough there to pay a man to practice there?

Dr. MOTT. The chances are a man would be extremely busy, extremely useful, and would have quite a modest income. The chances are he would lack the facilities that most physicians have, colleagues to consult with, and so on.

The CHAIRMAN. There are some communities where they have no physicians at all.

Dr. MOTT. Oh, yes.

Senator DONNELL. You mentioned, also, and I am not a shorthand reporter and I may not have this exactly accurate, but as I recall it, you said that some of the bodies that could be expected to be doing the most along the planning for this solution of the health problem, are doing the least.

Do you include in that such an organization as the American Medical Association?

Dr. MOTT. Sir, I do not believe I expressed myself as their doing the least planning. I believe the point I was making was that it was disturbing to me, as a physician and as a member of the organized medical profession, that in this planning there is not a concentration of imagination and energy and effort on building a program that will give care of high quality, preventive services, diagnostic service, comprehensive service. Not simply the service to the hospitalized patient.

I believe that was the point I was making.

Senator DONNELL. At any rate, Doctor, is it a fact, Doctor, of your own knowledge that the American Medical Association is devoting a great deal of time and thought to the question of the solution of the health situation in this country? You know that to be a fact?

Dr. MOTT. There has been a stepping up of attention to this problem and of course this bill may have had something to do with that.

The CHAIRMAN. Prior to the introduction of this problem in the Congress, they were not doing so much?

Dr. MOTT. There has been a slow and steady movement toward the development of medical society plans in the past few years.

The CHAIRMAN. Did not the medical profession criticize with great apprehension the development of these voluntary systems at first?

Dr. MOTT. There was a stage when that was true, as exemplified by the minority report of the Committee on the Costs of Medical Care,

where several eminent physicians took the stand that if we must have something we should not repeat the mistakes of all the other nations in going through this stage of voluntary health insurance.

Senator DONNELL. Now, Doctor, just these two points. In the first place, with respect to the State grange out in California. Do you know the status of that situation there? Do you know whether or not the State grange has entered into an agreement with the California physician service involving treatment for about 100,000 people? Do you know whether that is a fact?

Dr. MOTT. I am sorry, sir. I do not. And I think I so stated. I do not know the present status of those negotiations.

Senator DONNELL. And, as I understood it, your point in response to the question of our esteemed chairman, Senator Murray, on the dictatorship matter, first you took the view under the bill there is a decentralized administration; second, that there is a further answer to that in the existence of the advisory council with its power; and, third, that there is a requirement in the bill for the use of State and local agencies when feasible. Those were the points, were they not?

Dr. MOTT. I believe they were, sir, the principal points.

Senator DONNELL. We discussed decentralization of administration. We are not going further into that.

The advisory council power is purely advisory. That is correct, is it not? Plus the fact that a report is to be made to Congress as to what that advice has been?

Dr. MOTT. I believe that is correct.

Senator DONNELL. The advisory council does not have any power of putting into effect any of its recommendations?

Dr. MOTT. I believe that is correct.

Senator DONNELL. And that is likewise true of the area group mentioned in the bill?

Dr. MOTT. I believe that would be true.

Senator DONNELL. And, finally, you referred to the use of State and local agencies when feasible. I take it, the section you had reference to is subdivision (f) on page 38.

Dr. MOTT. I was not reading the bill at the time. I may have used slightly different language.

Senator DONNELL. I assumed that you meant that. It does not say that they shall use those agencies when feasible in the section I have reference to, and I assume you have this in mind, subdivision (f) of section 203, appearing at page 38.

I beg your pardon.

Dr. MOTT. I believe I used the term "directive." I felt that the act had a directive that the Surgeon General should give preference to using State and local agencies.

Senator DONNELL. I think probably the one I thought you had reference to was subdivision (f). Possibly it is subdivision (e), which was previously read:

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

That is what you had reference to?

Dr. MOTT. Yes.

Senator DONNELL. We have already discussed that. I will not burden the record further along that line. Thank you very much.

The CHAIRMAN. I might ask one more question.

Since the filing of this bill in Congress, great interest has been developed in the rural sections of the country, and voluntary meetings have been held in the agricultural sections, where this bill is being discussed by the farmers. Is that not true?

Dr. MOTT. There is tremendous evidence of interest, sir. I have heard recently of district meetings being held all over the States of Washington and Idaho, for example, with Extension Service people taking the lead.

The CHAIRMAN. There would be an indication that there is a need for some way of meeting the problem of bringing adequate medical care and hospitalization to the farming sections of the country?

Dr. MOTT. Yes, sir.

The CHAIRMAN. In the past, nothing has been done to remedy that situation, and now they see an opportunity for some relief, and they are very anxious to see something done about it.

Dr. MOTT. That is correct, sir.

The CHAIRMAN. Thank you, Doctor.

We appreciate your appearance here this morning.

We think you have made a considerable contribution to the committee.

We will recess now until 2 o'clock.

(Whereupon, at 12:35 p. m., a recess was taken until 2 p. m., this same day.)

AFTER RECESS

(Pursuant to taking of the noon recess, the hearing was resumed at 2 p. m.)

The CHAIRMAN. The committee will resume the hearing. The witness this afternoon is Mr. James G. Patton, president of the National Farmers Union.

Mr. Patton, you may state your full name, and the organization with which you are connected.

STATEMENT OF JAMES G. PATTON, PRESIDENT, NATIONAL FARMERS UNION

Mr. PATTON. My name is James G. Patton; I am president of the Farmers Educational and Cooperative Union of America, commonly known as the National Farmers Union.

Mrs. Evanson, who is a farm woman and member of our organization, is sitting beside me. She is, I understand, on your schedule following me.

The CHAIRMAN. Yes.

ENDORSEMENT OF S. 1606

Mr. PATTON. For many years the National Farmers Union and I personally have contended for the use of the full power of the national Government to bring to rural America the facilities and lacks that are so deplorable as to shame the great Nation of which we are

a part. I appreciate doubly, therefore, the opportunity to appear before the committee today to give unqualifiedly the endorsement of my organization and myself to the national health bill, S. 1606.

This interest in health goes back to the very inception of the Farmers Union. At the thirteenth annual convention of the Farmers Union in 1917, for example, it was recommended that steps be taken to improve the health of rural youth. It had been found by Selective Service rejections that 38 percent of farm boys were physically unfit for military duty. Twenty-eight years have elapsed since that recommendation was made and the evidence, both on and off the record, is that despite the scientific and technical improvements made in medicine, and its availability since, the farm population is still far behind the rest of the country.

Consistently, the Farmers Union has supported every progressive effort during the 7 years since the National Health Conference in 1938 to implement the recommendation of that conference. We have supported the health activities of the United States Public Health Service and the Children's Bureau, particularly where it was evident that these activities were directed toward the general improvement of maternal and child health and preventive medicine among rural people. We have also supported in congressional hearings the various hospital bills that would have aided many rural areas, including S. 191, although we have urged amendment of that bill to provide additional facilities for farm people.

And only last month, at our annual national convention, the delegates adopted a program that contained a comprehensive statement of our views on health needs and legislation, particularly with reference to bills now pending before Congress. That statement was as follows:

We highly commend President Truman for his courage and vision in calling for a universal, prepayment medical-care program for all Americans, and call upon Congress to enact legislation putting that program into effect at the earliest possible date.

We also urge that such a legislative program include adequate provision for maternal and child welfare services and expanded facilities to aid the mentally ill and the establishment of a Federal commission for the physically handicapped.

In addition, we call upon Congress, in any legislation authorizing a program for Federal Aid for hospital construction, to make it possible for rural areas to participate in such a program by providing adequate grants for construction and equipment, including facilities especially adapted to rural areas such as clinics and mobile health units. Areas not now being adequately served should have first call on medical supplies and hospital equipment as they are declared surplus. In addition, if health needs of rural people are to be adequately met, Federal financial assistance must be provided for maintenance for various types of institutions in areas unable to support them without such assistance.

THE RURAL HEALTH PROBLEM

As a matter of fact, the bill now before the committee represents the first real attack ever made on the health problems of rural people. At the bottom of all of these problems in farm and rural areas are the same causes, low incomes, scattered populations, and inadequate facilities. None of these causes can be grappled with except on a national basis. Only through a universal prepayment plan such as is provided in S. 1606, for example, can the costs be spread sufficiently to enable mass participation of rural people.

The need is very great. It is indeed an ominous fact that, in 1900, American farmers enjoyed a death rate 50 percent below that of urban citizens, and that now farmers' death rate is only 10 percent better than that of people in cities, and the death rate among infants and small children is greater on farms than in cities, about one-fourth higher. Maternal mortality too, is almost a third higher in rural areas than it is in cities.

It is significant, too, that the death rate from preventable diseases is highest in rural areas, for it is in defeating these diseases that modern medicine is most proficient. Typhoid, diphtheria, malaria, pellagra, and pneumonia, for example, rarely claim lives in cities any longer, whereas they take a heavy toll in the countryside. It has been estimated that in one State alone, North Carolina, 16,000 lives could be saved annually if the rural areas of the State had equal health protection with the cities.

Moreover, such common ailments as colds, intestinal disturbances, joint pains, and so forth, are of common occurrence in farm families and are rarely attended to. Indeed, many of the statistics as to the health of farm people, I am convinced, tend to show a better situation than really exists. Their illnesses often do not get reported. Often there is no way to get to a doctor or a hospital, and the illness may never be known to any authorities. Lack of doctors and facilities, too, makes rural people easy prey to patent medicine vendors and to fake cures of all kinds, as witness the advertising columns of almost any papers that circulate among low-income groups in agriculture.

Studies of the Farm Security Administration bear out the view that rural health is far worse than the figures usually disclose. Covering thousands of low-income farmers in 17 States, the Farm Security studies showed between 3 and 4 significant physical defects per person. Fourteen percent had varicose veins. Of every 12 farm operators, 1 had a hernia. Among the women, 42 percent had internal tears arising from childbirth. Defective vision and teeth, undernourished children—there was a long and pitiful catalog of physical handicaps, the great majority of them the aftermath of illness or accident that had not been properly treated.

Perhaps the most startling spotlight on this situation was cast by the Selective Service System when the United States entered World War II. An interbureau report of the Department of Agriculture has said that—

farm people should be more distressed than others because farm youth showed considerably higher rejection rates than the average—

and goes on—

among 9,000,000 draftees examined, 43 out of every 100 were rejected, but among those coming from farms, 53 out of every 100 were turned down. This is the opposite of the situation in the last war, so the health of rural youth is relatively going downhill.

This condition cannot be permitted to continue because it undermines the substance of the Nation. In demanding that they be counted in on a share of the tremendous material and cultural resources and production of the Nation, farmers are not being selfish, nor should Senators feel that when they legislate to the benefit of rural areas that they are acting solely for the benefit of rural groups. The fact of the matter is that farm and small towns in rural areas are the seedbed

of our national population, the reservoir of our greatness as a people.

Every year scores of thousands of young people from the farms and villages go to the cities to replenish the population there. It has been estimated that 50 percent of the children of America come from these farms and villages. The Nation no longer can afford to permit its future as represented in these children and young people to be mortgaged by disease and premature death.

These vast needs are not being met now. In the 1,000 most rural and isolated counties before the war there was only one doctor to 1,750 persons, whereas in cities there was a doctor for each 650 persons. During the war, the situation has become even more alarming. In hundreds of rural counties the war has caused the ratios to rise to one physician to 3,000 to 5,000 or even in extreme cases to 10,000 persons. The same thing is true of dentists and of nurses. Before the war there was one dentist for 1,400 persons in the cities and but one to 4,200 in the country. As to nurses, the rural State of Mississippi in 1940 had but 62 active nurses per 100,000 persons, whereas Massachusetts, largely industrialized, had 403.

Rural areas are at the same disadvantage, so far as hospitals are concerned. More than 1,250 of the 3,070 counties in the United States are without a satisfactory general hospital, and more than 700 of those counties contain 10,000 or more persons.

The key to this situation lies in the universal compulsory prepayment plan embodied in this bill. Only on such a base will it be possible to erect the structure that is needed in rural areas. The most altruistic of doctors, must, after all, earn a living, and a hospital cannot operate without an economic base. That base does not exist in rural areas and will not exist unless a prepayment plan of the kind proposed here is adopted. As Dr. Henry B. Richardson, chairman of the Physicians' Committee on Research, an eminent physician himself, has said:

You can hardly expect a doctor to settle in a small community if it is contrary to his professional growth, or if it is contrary to the interests of his family and the education of his children.

VOLUNTARY PLANS CANNOT DO THE JOB

Voluntary plans will not do the job. This is not to condemn their efforts. Indeed, the National Farmers Union not long ago inaugurated its own voluntary prepayment plan, the Triangle Health Insurance Plan, and naturally I would not have urged the adoption of that plan if I held any bias against voluntary programs. But at their best, such plans cannot give complete coverage. Those most in need of insurance against disease are the very people who fail to benefit from voluntary programs. Both membership and services of such plans are restricted, in most instances necessarily, in order to protect the structure of the program itself.

Then, too, the costs of such plans are always much higher than a universal compulsory prepayment plan, if for no other reason because they cannot achieve the coverage that a national program can achieve. Moreover, many of those who are attracted to voluntary programs are those who expect to require medical treatment or hospital care, hence costs are inevitably increased for all participants.

There is no graduation of costs in voluntary plans on the basis of the ability of those taking part to pay, whereas under the proposed national program, charges are based on ability to pay. Finally, many of the existing voluntary programs fail to give any representation in management to the participants, those who after all are the ones whose needs are supposed to be met.

On the other hand, I do not believe that the adoption of the bill would mean that existing voluntary programs would be damaged, since S. 1606 provides for the utilization wherever possible of existing programs.

Moreover, a universal prepayment program will provide a base not only for doctors in rural areas, but also for hospitals. This is a matter that also is very close to the hearts of the members of the National Farmers Union, for it was a group of our members who many years ago sponsored the first cooperative rural hospital in the United States, that at Elk City, Okla.

Others of our State Farmers Unions now are engaged in promoting the construction of additional cooperative hospitals, and I believe firmly that this bill will contribute greatly to the spread of such institutions, as well as to the building of more hospitals of all types. With the insurance of payment for hospital care for the whole population, hospitals can safely be constructed in areas where otherwise the risk would be prohibitive, and the insurance of a steady, year-round, year-in-and-out income will eliminate a great deal of the risk of future operations. It will be possible to plan ahead upon the basis of a stable income. The result should be not only more hospitals but better ones, attractive to better personnel and instrumental in training more personnel. Finally, the provision of hospital facilities will do much to attract doctors to rural areas now lacking practitioners.

This is not to say that rural areas' problems all will be solved by a universal prepayment plan. It is my own conviction that the National Government should provide whatever maintenance sums are necessary to provide adequate hospital care for every person in the United States. I do not necessarily urge that such provisions be written into this particular bill. But certainly, in the appropriate legislation, such maintenance should be provided, along with specific authorization of facilities adapted to rural needs, such as additional clinics, traveling healthmobiles, and similar facilities.

For conditions in rural areas are far different from those in cities, and the method adopted to deal with those conditions should be varied, to meet the problem. It would be a great mistake for this committee or for Congress to seek to set up a rigid program for hospital construction and medical care generally in rural areas without taking into account possible future changes in crop production, mechanization, and population. A more flexible, easily adapted system is more desirable. Such provisions are embodied in title I of this bill and in the pending hospital construction bills, in that State plans are to be submitted for approval and it is to be assumed that the States will be guided by trends within their borders. On the other hand, State governments are just as liable to mistakes as the National Government, and it seems to me proper here to insert a warning note against ignoring the special character of agriculture in this and related legislation.

ARTICLE BY DR. HORACE HAMILTON

Dr. C. Horace Hamilton, director of sociological research of the commission on hospital care, has stressed this matter in an article in "Hospitals" for November 1945, which I should like to offer here for the record.

The CHAIRMAN. It may be inserted in the record. Is it a long article?

Mr. PATTON. No.

(The article is as follows:)

POPULATION DENSITY AND THE SIZE OF HOSPITAL COMMUNITIES

(C. Horace Hamilton, Ph. D., director of sociological research, Commission on Hospital Care)

In rural areas, the determination of the size of hospital communities is an important problem in hospital planning. The problem is a serious one in the sparsely settled rural areas. Hospital communities should be large enough to justify the building of a complete hospital and medical-care unit and yet small enough to reach all the people at the most distant points in the community.

Proper standards on the one hand and accessibility to patients on the other are, therefore, the two opposing interests to be considered in determining the size of hospital communities. The cost of hospitalization is also a factor. Small hospitals, if they are adequately equipped and staffed, may be very expensive to operate. On the other hand, hospital communities may be so large that the inconvenience and cost of travel will discourage hospitalization.

Obviously, in sparsely settled areas, there must be a compromise between the size of the hospital and the radius of the community. In rural areas, as compared with urban, hospitals must be smaller and the area of hospital communities must be larger. In other words, those constructing hospitals must give consideration to the size of the hospital community, which is determined largely by population density and to a smaller degree by the demand for hospitalization.

NOTE.—In this analysis a hospital community is defined as the area immediately surrounding any city or center having one or more general or special hospitals serving the general population. Hospitals excluded from this analysis are: Nervous and mental, tuberculosis, Army and Navy, veterans' hospital departments of institutions, convalescent homes. Federal hospitals operated for merchant seamen and for American Indians were included on the grounds that they served a large segment of the civilian population. For the same reason industrial and isolation hospitals were also included.

Since we are thinking of hospital centers and not hospitals, the ex- or in-clusion of certain specialized types of hospitals has very little effect on the problem. Most special hospitals are located in cities having general hospitals also. The average size of a hospital community in a State is simply the total land area in square miles divided by the total number of cities or other centers having one or more hospitals.

As a first step in understanding and solving this problem the relationship of population density to the size of hospital communities must be measured. It is not enough to know the general nature of the relationship—this relationship must be measured. It can be measured most effectively by relating the average size of hospital communities to population density and to hospital beds per 1,000 people. In order to do this, a statistical measure of the average size of hospital communities must be selected.

In this study, the average size of hospital communities in each of the 48 States was determined by dividing the square miles of land area by the number of centers having one or more hospitals in 1944.¹ We need not be concerned too much about the fact that hospital communities do not have definite shapes and boundaries. The essential statistical fact is that the distance between hospital centers can be measured and that such a measure is correlated perfectly with our measure of the average size of hospital communities. That is to say, the size of a hospital community may be expressed in square miles, or by the radius of a circle having an equivalent number of square miles. For instance, a circular hospital community of 10,000 square miles will have a radius of 56.4 miles

¹ The population of each State on July 1, 1944, is shown in a special population report of the Bureau of the Census, dated March 10, 1945, series P-45, No. 2. The land area of each State may be found in the Sixteenth Census of the United States, 1940, Population, United States Summary, First Series. Communities with one or more hospitals are shown in the hospital number, Journal of the American Medical Association, March 31, 1945.

and the average distance between hospital centers in such cases will be twice the radius, or 112.8 miles.

The general relation between population density and size of hospital communities may be seen best in figure I, the data for which are shown in table 2.² As population thins out, the hospital areas get larger and population per community gets smaller. In other words, there is a compromise between the size of the community area and the number of people to be served. Although the communities in sparsely settled States are very large, they are not large enough to include as many people per community as the more densely settled States. A State with 50 people per square mile and 4 beds per 1,000 people has on the average 730 square miles and 36,500 people per hospital community. But a State with only 10 persons per square mile and 4 beds per 1,000 people has 2,097 square miles but only 20,970 people per hospital community.

Insofar as the relation of population density to community size is concerned, the degree of concentration of population in and around large cities seems to make little difference. The relationship within States is much the same as the relationship between States. The elimination of metropolitan areas would reduce the average population density of a State but at the same time the average size of hospital communities would be correspondingly increased.³ Metropolitan areas have not only dense populations but also many suburban communities with hospitals. Thus there is little to be gained by eliminating densely populated metropolitan areas from these calculations.

In order to test the relation of the influence of metropolitan centers further a special analysis was made of four major areas within the State of Michigan. It was found that the relationship of population density to hospital community size within Michigan was very similar to the relationship in the United States as a whole. For instance, northern Michigan has about 16 people per square mile and the average hospital community has about 971 square miles. On the other hand, southwestern Michigan has 89 people per square mile and 317 square miles per hospital community.

An increase or decrease in hospital use has the same general effect on community size as does an increase or decrease in population density. As table 2 and figure I show, States from 4 to 6 beds per 1,100 people have much smaller communities, in both area and population, than do those States having from 2 to 4 beds per 1,000 people at all levels of population density. For instance, consider States with 50 people per square mile: Those with 2 beds per 1,000 people have 1,042 square miles and 52,100 people per hospital community, as compared with only 730 square miles and 36,500 people in States which have 4 beds per 1,000 people. Yet the 2-bed-per-1,000 States have only 104 beds per community as compared with 146 beds in the 4-bed-per-1,000 States.

The practical significance of this point is that hospital communities will likely be much smaller if ways and means are found to extend hospitalization to all people in proportion to need rather than to effective demand or ability to pay.

Another significant point is: A State may be under-hospitalized in proportion to population density as well as in proportion to need or demand. Some States have plenty of hospitals but they need more hospital beds, and possibly a better distribution of hospitals. Other States may have nearly enough hospital beds but need more hospitals and hospital communities. Perhaps most States in some degree need both new hospitals and hospital beds.

² The data of table 2 and figure I are based upon a correlation analysis involving three variables: (1) people per square mile; (2) square miles per hospital community; and (3) hospital beds per 1,000 people. Each variable is a series of averages for the 48 States. The estimating or regression formula, derived from these variables, is:

Log X = 4.2868 - .6559 Log Y - .0773Z, where

Log X = square miles per hospital community.

Log Y = people per square mile.

Log Z = hospital beds per 1,000 people.

Ninety-two percent of the variation in community size is associated with variation in population density and hospital beds.

When variables X and Y are reduced to logarithms, the relationship appears to be a straight line. This means that a percentage change in population density is associated with a constant percentage change in community size regardless of the level of population density being considered. An increase in population density from 10 to 20 people per square mile results in the same percentage decrease in community size, as does an increase from 20 to 40, or from 100 to 200 per square mile.

³ Partial regression or correlation analysis shows that the regression of community size on population density remains the same regardless of the percentage of urban population in the States.

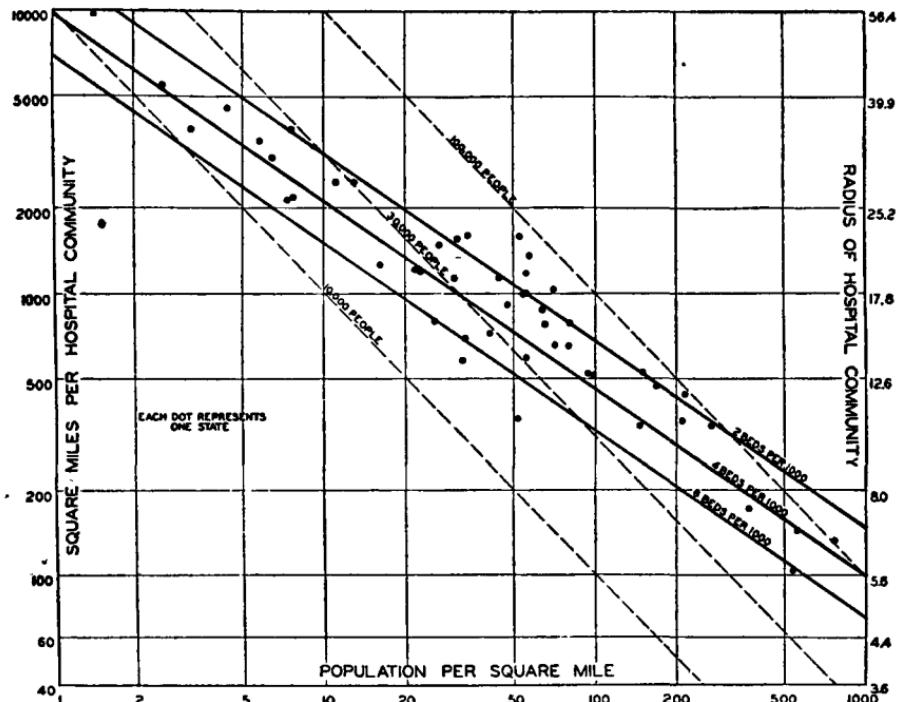


FIGURE 1.—Size of hospital communities by population density and bed ratio. (See note below.)

The dots represent population per square mile and square miles per hospital community for each of the 48 States in 1944. The three diagonal solid lines show the relation of community size to population density at three levels of hospitalization: 2, 4, and 6 beds per 1,000 people. The three diagonal broken lines are points on the chart representing populations of 10, 30, and 100 thousand people. The horizontal and vertical scales are logarithmic simply because the relationship between the two factors is relative. That is, a percentage variation in community size is associated with a constant percentage variation in population density regardless of the level of population density under consideration. For instance, an increase in community size of 58 percent is associated with a decrease in population density of 50 percent. If logarithmic scales were not used, the lines of relationship would be very curvilinear and difficult to interpret.

(See text for further explanation of the nature and significance of the relationships shown by the chart.)

Areas with one or less persons per square mile can afford and usually have only one hospital per community. At 40 people per square mile, there is an average of 1.5 hospitals per community; and at 1,000 people per square mile there are 2 hospitals for each community. A great urban center like Detroit with 12,000 people per square mile has 50 or more hospitals.

A practical hypothesis of planning, based on this analysis, is: More than one hospital per community is impractical in sparsely settled areas, but does become possible and practicable at population densities above 40 people per square mile.

CONCLUSION

This study has shown the folly of trying to set up one ideal size for the hospital community. Some have said that we should have one hospital every 30 miles, or possibly for every 30,000 people. Such standards are artificial and unrealistic. Even in a planned economy, the influence of hospital density on community size must be given due consideration. There must inevitably be a compromise between the size of the hospital service area and the size of the hospital. In sparsely settled areas hospital communities must continue to be large and the number of people somewhat smaller than in the more densely settled areas. Just how large any particular hospital community should be is a matter for careful study by people well acquainted with all the facts.

TABLE 1.—*Average size of hospital communities, 1944, by States*

States	Population per square mile	Square miles per hospital community	Population per hospital community	Hospitals per community	Beds per community	Beds per 1,000 population
Alabama	55.2	1,110	61,300	1.54	118	1.93
Arizona	5.6	3,684	20,600	1.23	68	3.29
Arkansas	33.7	1,505	50,800	1.51	88	1.73
California	55.8	1,128	62,900	1.76	212	3.38
Colorado	11.0	2,363	26,100	1.45	93	3.56
Connecticut	362.7	189	61,300	1.41	243	3.96
Delaware	143.5	330	47,300	1.83	214	4.53
District of Columbia	869.0	296	257,200	4.00	613	2.38
Florida	43.6	1,107	48,300	1.61	120	2.49
Georgia	55.1	975	53,700	1.63	108	2.00
Idaho	6.4	2,855	18,300	1.24	56	3.07
Illinois	138.2	500	69,000	1.94	263	3.82
Indiana	94.5	496	46,800	1.38	127	2.71
Iowa	40.5	718	29,100	1.35	93	3.20
Kansas	21.6	1,157	25,000	1.38	84	3.35
Kentucky	65.6	757	49,600	1.40	105	2.11
Louisiana	56.1	1,329	74,600	1.74	225	3.01
Maine	25.6	776	19,800	1.30	74	3.75
Maryland	215.2	420	92,500	2.04	339	3.67
Massachusetts	526.5	99	52,000	1.84	277	5.33
Michigan	95.2	492	46,800	1.61	144	3.07
Minnesota	31.4	678	21,300	1.42	95	4.46
Mississippi	45.9	878	40,300	1.50	69	1.72
Missouri	51.8	1,539	79,800	2.29	273	3.42
Montana	3.2	3,658	11,600	1.25	73	6.25
Nebraska	15.8	1,217	19,300	1.36	74	3.84
Nevada	1.4	9,982	14,200	1.09	66	4.62
New Hampshire	50.7	347	17,600	1.19	83	4.73
New Jersey	554.1	134	74,400	1.75	274	3.69
New Mexico	4.4	4,340	19,000	1.21	50	2.64
New York	263.6	320	84,200	2.37	405	4.81
North Carolina	71.9	630	45,300	1.64	121	2.67
North Dakota	7.5	2,123	16,000	1.30	79	4.94
Ohio	166.3	457	76,000	1.80	256	3.37
Oklahoma	29.8	1,100	32,800	1.54	84	2.57
Oregon	12.6	2,471	31,100	1.54	112	3.59
Pennsylvania	205.3	344	70,600	1.91	280	3.97
Rhode Island	736.3	132	97,400	1.50	351	3.60
South Carolina	62.9	874	55,000	1.51	122	2.22
South Dakota	7.3	2,069	15,100	1.22	53	3.83
Tennessee	68.4	976	66,700	1.95	141	2.11
Texas	26.1	1,425	37,200	1.62	85	2.30
Utah	7.4	3,743	27,600	1.27	90	3.25
Vermont	33.5	515	17,300	1.11	71	4.26
Virginia	80.2	753	60,400	1.60	151	2.50
Washington	30.7	1,522	46,700	1.82	177	3.80
West Virginia	71.2	651	46,400	1.70	160	3.46
Wisconsin	54.4	570	31,000	1.45	123	3.97
Wyoming	2.6	5,132	13,500	1.11	44	3.29
United States	44.5	1,074	47,800	1.63	162	3.39

¹ Including Arlington and Fairfax Counties in Virginia and Montgomery and Prince Georges Counties in Maryland.

The formula describing the relationship between community size and population density should not be interpreted as a rigid guide for setting up new hospital communities. It describes only an existing situation which may or may not be the most desirable one. However, if planning is to be realistic we must first know what the existing situation is. If plans for new hospital communities involve something quite different from the existing situation then the proposed changes must be justified by good and logical reasons.

In other words, it might be said that the formula which describes the existing situation in the United States is only a general law of averages from which some deviations are to be expected; or that it represents a norm of social behavior from which deviations should be made only after careful investigation.

Because hospital use is increasing one might assume that hospital Communities in sparsely settled areas could be made smaller in the interest of convenience. On the other hand, improved roads and transportation facilities operate in the opposite direction. Yet, even with good transportation, distances greater than 25 miles constitute a serious barrier to more frequent use of hospitals.

To be sure, persons seriously ill will go great distances for high-quality hospitalization. On the other hand, it must be remembered that an increasingly large

number of hospital beds are being used for obstetrics and minor illnesses. After careful study of population distribution, hospital planners in most States will find that few people need travel more than 25 miles to a good hospital. It is only in large areas having fewer than 10 people per square mile that distance will become a serious inconvenience.

TABLE 2.—*Average size of hospital communities by population density and beds per 1,000 people, United States, 1944*

Population per square mile	Average size of hospital communities			Hospital beds per community
	Square miles	Radius in miles	Population	
At 2 beds per 1,000 people				
1	13,558	65.7	13,558	27
2	8,605	52.3	17,210	34
5	4,718	38.8	23,590	47
10	2,994	30.9	29,940	60
20	1,900	24.6	38,000	76
50	1,042	18.2	52,100	104
100	661	14.6	66,100	132
200	420	11.6	84,000	168
500	230	8.6	115,000	230
At 4 beds per 1,000 people				
1	9,497	55.0	9,497	38
2	6,028	43.8	12,056	48
5	3,305	32.4	16,525	66
10	2,097	25.8	20,970	84
20	1,331	20.6	26,620	106
50	730	15.2	36,500	146
100	463	12.1	46,300	185
200	294	9.7	58,800	235
500	161	7.2	80,500	322
At 6 beds per 1,000 people				
1	6,653	46.0	6,653	40
2	4,222	36.7	8,444	61
5	2,315	27.1	11,575	69
10	1,469	21.6	14,690	88
20	933	17.2	18,660	112
50	511	12.8	25,550	153
100	324	10.2	32,400	194
200	206	8.1	41,200	247
500	113	6.0	56,500	339

Source: See footnotes 2 and 3, p. 1216.

As an answer to the problem of the sparsely settled community with not enough people to support a hospital, the small health center has been proposed. Such centers, it has been suggested, should have a few hospital beds for emergencies and the more simple cases of sickness needing hospitalization. Elementary diagnostic and laboratory facilities would also be provided.

It is not to be assumed that the health center could take the place of the larger hospital, 25 or more miles away. The small health center, if closely affiliated with the hospital, would relieve the hospital of many simple cases and in return send the more complicated cases to the hospital.

Mr. PATTON. Dr. Hamilton says that his study—

has shown the folly of trying to set up one ideal size for the community hospital. He concludes:

Because hospital use is increasing, one might assume that hospital communities in sparsely settled areas could be made smaller in the interest of convenience. On the other hand, improved roads and transportation facilities operate in the opposite direction. Yet, even with good transportation distances greater than

25 miles constitute a serious barrier to more frequent use of hospitals. * * * As an answer to the problem of the sparsely settled community with not enough people to support a hospital, the small health center has been proposed. Such center * * * should have a few hospital beds for emergencies and the more simple cases of sickness needing hospitalization. Elementary diagnostic and laboratory facilities also would be provided. * * * The small health center, if closely affiliated with the hospital, would relieve the hospital of many simple cases and in return send the more complicated cases to the hospital.

I cite these conclusions because they are illustrative of the approach that should be used in rural areas, a much more flexible approach than in urban centers, and because they apply in general to the provisions of title I of this bill, which call for the allocation of Federal funds to expand maternal and child care, for the conduct of a more effective war on tuberculosis, for expansion of public-health work, and for aid to the needy who are not otherwise aided. We endorse all of these provisions as being greatly needed and as contributing to the solution of the health problems of rural people.

The desirability of the formulas for the allocation used in this bill also should be emphasized, since they stress the allocation of funds to those States most in need. In nearly all cases these are predominantly rural States, and for that reason we strongly urge the retention of these formulas or formulas even more carefully designed to channel funds where they are needed.

APPEAL FOR PROMPT ACTION

In conclusion I wish to appeal to the committee to proceed as rapidly as possible to the approval of the bill and to Congress to enact it speedily. It has been said that the bill is "State socialism," which of course is nonsense. Every advance in the use of governmental power for the people has been greeted with the same phrase. Democracy does not mean impotence or lethargy. To me, it means the right of the people to use their government to their own ends. "Government of the people, by the people, and for the people" would be a futile array of words if "for the people" were omitted. I think that this bill is an illustration of government not only "by the people" but "for the people" and as such illustrates the workings of democracy at its best.

It has been said that the bill may restrict the freedom of choice of patients in choosing their doctors, or of doctors in choosing whether to stay in or out of the program. These objections seem to me to be quibbling. The bill has been carefully drawn to protect these rights within any reasonable interpretation. Moreover, I ask, what choice does a farmer have now in the hundreds of counties where there is no doctor at all? His only choice is made for him. He must die or get well without benefit of choice.

I urge Senators not to stand on such technicalities. While we discuss the precise wording of this bill, people right now are dying for the lack of it. It is a frightful responsibility that is upon us. We have in S. 1606 the means to save literally thousands of people in the next few years who otherwise will die. In face of such responsibility, let us have done with legal quibbling and pass the bill.

The CHAIRMAN. Your organization has been interested in this problem for many years, you say?

Mr. PATTON. That is correct.

The CHAIRMAN. Has your organization had before it this particular bill that is now the subject of this hearing?

Mr. PATTON. Yes. We started out studying a couple of years ago in our locals, through our educational department and by having discussions, and carrying on a great deal of discussion, having local meetings, county meetings, and at State meetings, and regional workshops, discussion of this whole thing, and of course the President's health program and this bill, during the time particularly since it has been introduced, have been a matter of discussion among our people.

Then of course, as I stated in my prepared statement, the national convention specifically endorsed the President's health program which was covered by this bill. We assume it is covered by this bill.

The CHAIRMAN. In these discussions that have been held, has there been an effort to determine the precise language of a bill to bring about this improved medical care or medical care for the people, or have you just discussed the general need for such a program?

Mr. PATTON. Well, normally we do not discuss the precise language of a bill, because we feel, first, that our people are not familiar with legislative procedure. We discuss principles and it is very seldom that our organization at any level endorses a bill, for the simple reason that by the time their endorsement may be felt in Congress, some Congressman or Senator may have gotten an amendment which completely changes that bill.

So we seldom go on a certain numbered bill until its character is pretty final, pretty well determined, because it takes all the way from 6 months to 2 years for things like this to work up, through our organization, particularly to have the amount of participation and the amount of interest that this particular bill or this particular proposal has among our people.

The CHAIRMAN. But you have in your discussions gone into the subject of the need of some form of legislation that would overcome these difficulties?

Mr. PATTON. Oh, yes; decidedly. About a year ago at the request of a number of State conventions and State leaders, I appointed a special committee made up of farm women, feeling that farm women were the ones who would be closest to this whole matter of health and medical care, and they have met regularly and have discussed not only as a committee composed of people from several States, but have in turn taken it back to their respective States and discussed it with people and provisions of this bill, and particularly the principle involved in the provisions, the specific provisions which you have written into this bill have been thoroughly discussed, I would say at all levels.

The CHAIRMAN. And your organization has had the advantage of advice from members of your organization from all parts of the country with reference to the conditions that prevail?

Mr. PATTON. That is right.

The CHAIRMAN. In rural sections?

Mr. PATTON. That is right. As a matter of fact, we have at various stages of development, to show you some indication of the amount of interest, various types of cooperative hospitalization and medical care programs, going all the way from the one which is quite established at Elk City up to much more recent ones in other communities,

in I do not know how many States, but there are several States where that is going on.

The CHAIRMAN. You found that it was necessary for your organization and other farm groups of the country to take an interest in this problem?

Mr. PATTON. Very decidedly.

The CHAIRMAN. No other organizations were advancing any solutions for the problem in the farm areas?

Mr. PATTON. Well, we do not think so. When we started developing the Farmers Union Cooperative Hospital, known then as the Community Hospital in Oklahoma, in Elk City, all we got was resistance from the professional people, and we finally had to take that whole business to the State legislature and fight them from the line clear through. They did everything possible to throw stones in our way and in the way of the people whom we did engage.

The CHAIRMAN. The medical profession itself in the rural areas undertook no program or proposed no program which would make it possible for modern medical care to be made more accessible to the farmers?

Mr. PATTON. Not that I know of and I did not speak of any proposals publicly until there were a lot of other things being moved by the people themselves, and then I hear a lot of talk about voluntary organizations, and so on, but even then I see very little action in the rural areas.

The CHAIRMAN. Is the medical profession at the present time proposing any program whereby the farmers could be better served with modern medical care at reasonable costs?

Mr. PATTON. Not that I am familiar with. Of course, Blue Cross, which was more of the hospitals, it is the organization of hospitals, is moving in in some rural areas through some organizations.

The CHAIRMAN. Of course.

Mr. PATTON. That is not as I understand it—not connected directly with the medical society nor with the American Hospital Association.

The CHAIRMAN. And it does not purport to give office medical care or home medical care.

Mr. PATTON. Not unless recently. The last time I looked at it, which was 2 or 3 months ago, that is the material we had, it did not indicate anything like that, Senator.

The CHAIRMAN. Of course, many rural areas have not sufficient doctors to take care of the people in the rural areas if they were able to pay for it.

Mr. PATTON. Many of them do not have doctors. In many areas where there is a doctor, he is badly overworked, and usually is some man who has in many instances a feeling of responsibility to the community and has retired and come back in; that is particularly true since the war.

The CHAIRMAN. And usually where they do have doctors, they do not have the facilities to work with.

Mr. PATTON. That is right.

The CHAIRMAN. Are you acquainted with that section of Montana in the northeastern end of the State?

Mr. PATTON. I certainly am. You mean up around Dagmar and Sidney and Scoby.

The CHAIRMAN. And Scoby. I remember being in there 5 or 6 years ago when there was only one physician in that neighborhood.

Mr. PATTON. That is right.

The CHAIRMAN. He told me he was preparing to leave there because he could not support his family.

Mr. PATTON. That is right.

The CHAIRMAN. And I was asked to send a message to the Red Cross to have them send help to the community because they were suffering and there was an epidemic of flu at the time, and this doctor was leaving. At that time he regretted it very much, he told me, because he like the people, but unfortunately he had to raise his family and had to provide for his own family, and therefore could not remain under the conditions.

Mr. PATTON. That is right.

The CHAIRMAN. Have you found situations of that kind in other sections?

Mr. PATTON. Yes. In several sections of my home State of Colorado. I think Mrs. Evanson will testify regarding similar situations in North Dakota and South Dakota.

As a matter of fact, we found very much, not exactly the same situation, but it was very much that same general situation, plus poverty that really started Elk City Cooperative Hospital, and incidentally, speaking of your own State, Senator, I think you will find that the desire and the promotion which is now going on among the people themselves out in that area that you are talking about for a cooperative medical care plan arises very much out of the situation you described.

The CHAIRMAN. Under the cooperative plan, what is the arrangement; do they hire the doctors, or do they pay them on a fee basis?

Mr. PATTON. It varies. At the Elk City hospital, and I think in most of the ones which our members are interested in and have developed, they pay an annual fee into a common pool and they employ the doctors on a salary basis, and then the members come, as out-patients or as patients of the hospital, and the fee includes both hospital and medical care.

There are certain charges sometimes for special medicines or items which normally do not come in the usual range of care.

The CHAIRMAN. Did you find any difficulty inducing doctors to work under that plan?

Mr. PATTON. The situation as it has been described to me in relation particularly to the Oklahoma development was that the medical society took great offense at the development, and doctors who normally would want to come and be in the service were either afraid to come or in some instances felt that they could not be licensed, and in other instances the doctors who were there were excommunicated from the professional society. That was the story that was related to me by the director of the hospital.

The CHAIRMAN. You have no knowledge concerning that matter yourself; have you?

Mr. PATTON. No; other than from printed statements. I have been to Elk City any number of times and have been through the hospital and talked to them, but I have not—

The CHAIRMAN. But you do know that your efforts to organize cooperative plans of that character have developed considerable opposition.

Mr. PATTON. In many instances; yes.

The CHAIRMAN. And no substitute plans were offered by the medical profession to take their place?

Mr. PATTON. Not in those instances about which I know.

The CHAIRMAN. There is considerable criticism of this bill, Mr. Patton, on the ground that it limits the right of the patient to free choice of physicians. Is that a matter that concerns the farmers a great deal, the question of the right to select the physician?

Mr. PATTON. Well, in the first place, in a great many rural communities he has not any choice, except the one doctor there in the community, and sometimes he does not have that much choice, and in the second place, when he goes in many areas to a clinic he neither knows the doctors—well, you have clinics in Montana, Senator; you know how some of them operate. He does not know the doctors there, and they send him to specialists.

The CHAIRMAN. For instance, if a farmer from an adjoining county has to go in the city of Billings for medical care in the hospital, it would not be likely that he would know any doctor.

Mr. PATTON. That is right.

The CHAIRMAN. Or specialist who might be employed in that clinic.

Mr. PATTON. That is right.

The CHAIRMAN. So that the problem of choice of physicians is a problem that does not seem to interest the farmers very greatly.

Mr. PATTON. He cannot be interested in a great many instances, because there is one doctor there and he goes to him regardless, or if he goes to another, I think the same is true in North Dakota and in Montana, if he goes to a clinic, he does not know anyone there, and he is sent to a specialist, which I think is all right. He should go to a specialist.

The CHAIRMAN. I notice in your statement here you say that the studies of the Farm Security Administration bear out the view that rural health is far worse than figures usually disclose, and you say that the Farm Security study covering thousands of low-income farmers in 17 States showed between 3 and 4 significant physical defects per person, 14 percent have varicose veins. Is that a condition that affects farmers greatly, varicose veins?

Mr. PATTON. Yes.

The CHAIRMAN. Because they are on their feet so much?

Mr. PATTON. There is a lot of it and they do hard work and straining work.

The CHAIRMAN. They work long hours and are on their feet a great deal?

Mr. PATTON. That is right.

The CHAIRMAN. Of every 12 farm operators, 1 had a hernia. That seems to be another disease that attacks farmers.

Mr. PATTON. Heavy work.

The CHAIRMAN. Among the women, 42 percent had internal tears, arising from childbirth, defective vision and teeth, undernourished children, physical handicaps, the great majority of them as a result of illness or accident that had not been properly treated.

Most of these conditions of ill-health in the country you believe could be removed if the farm population had easier access to modern medical care and treatment?

Mr. PATTON. I do. There is another important factor which I did not mention here which is important in terms of availability of doctors. The accident rate on farms and among farm people is a great deal higher than it is in the cities, you have a horse kick you or get your arm tangled up in the tractor or something else happens, and by the time you can get to a doctor, sometimes 50 or 100 miles away, you have lost so much blood that you, I think, are handicapped. I have known of some instances specifically myself where if there had been a greater availability of medical care, that would not have happened.

Further than that, the unavailability of X-rays. Quite often there is a disablement because of the fact that the broken bones are not properly set.

The CHAIRMAN. In some of these rural areas in the Western States a railroad station is sometimes 40 or 50 miles away from a rural community.

Mr. PATTON. That is right.

The CHAIRMAN. In fact, I have been on some of the rural sections in Montana where they were 75 miles away from a railroad station.

Mr. PATTON. The community in which I grew up, 50 miles to the closest railroad and that was a narrow gage.

The CHAIRMAN. You have appeared so many times before committees down here, urging this problem, that I cannot count them.

Mr. PATTON. That is right.

The CHAIRMAN. I remember that you were here when we had the first hospital bill, and also the original Wagner and national health bill.

Mr. PATTON. That is right.

The CHAIRMAN. And so you have been interested in this subject for many, many years.

Mr. PATTON. Many years.

The CHAIRMAN. You believe that it is something that should be taken care of if the health of the Nation is of concern to the Congress?

Mr. PATTON. Yes; I personally started out in 1928, I think it was, when I believe it was President Hoover appointed a Cost of Medical Care group. I took the trouble to buy that set of studies. As I remember I got hold of them about in 1931 or 1932, somewhere along in there, and I waded through that whole business. I tried to become informed. I do not pretend to be an expert, but I have my people, the people whom I represent who have been deeply and very much interested over a long period, and many of them have an interest which goes beyond the medical care itself.

We found ourselves engaged in terrific struggles, some of them political, because there were those who offered no substitute for what we were doing and who wanted to prevent our experiments which we felt were anything but socialistic, but were democratic in character, and represented the wishes of the people. In two or three of them there was no governmental subsidy of any kind involved, and still we found ourselves heckled and fought from pillar to post by the people who should have had a very real interest in the health conditions of the people in those communities.

Senator DONNELL. Mr. Patton, reference has been made to the fact that testimony has been given on behalf of your organization.

Mr. PATTON. That is right.

Senator DONNELL. With respect to the hospital bill, S. 191.

Mr. PATTON. That is right.

Senator DONNELL. Do you recall whether or not that testimony referred to the importance of maintaining a State administration of hospitals?

Mr. PATTON. I do not recall offhand whether it did or not, Senator.

Senator DONNELL. I am not saying that it did. I want to ask you whether it did.

Mr. PATTON. I do not recall.

Senator DONNELL. You do not recall?

Mr. PATTON. No.

Senator DONNELL. Have you expressed yourself at any time before this or any other committee on that general subject, Mr. Patton, as to whether you favor generally speaking a policy of grants-in-aid to the State accompanied by State administration rather than a federally operated system of health facilities?

Mr. PATTON. The feeling of our people as expressed on various policy matters, Senator, including things like this, is that Government wherever the Government touches the people should be as close to the people and as responsive to the people as possible.

Senator DONNELL. Yes.

Mr. PATTON. Let me express first a personal opinion and then give a background of the organization's attitude.

I am not so concerned about the struggle between State and Federal government as I am concerned to see that whichever it is that it is directly responsible to the people. There are some instances in which I feel that State government is less responsible to the people than the Federal, and vice versa. But somehow we have to get enough of the responsibility back close to the people so that there is a real attachment of responsibility to those charged with administering the program.

WORK OF THE FARM SECURITY ADMINISTRATION

The CHAIRMAN. Might I ask a question there? Have you found that the Farm Security Administration has operated close to the people and has been satisfactory to the farmers?

Mr. PATTON. Yes. Well, we have supported the Farm Security Administration, and through their county committees, through their county supervisors, through their State offices, and particularly through their regional offices, we have found a great deal of responsiveness. Very frankly, what we did on a situation like that, whenever we did not like what they were doing, you know, we came to you, and we began to put the bee on them to higher up, so as to see that there was responsiveness. But along with that, and more important than that, was that these community and county committees of which our members and other farmers were participants, there was not very much that the supervisor got away with very long if he were doing anything wrong. There was not a community responsibility attached to him. I think the real essence of this whole thing, and I have a real concern about bureaucracy whether it is municipal, State or Federal, the real essence of this thing is giving the people themselves an opportunity to participate in the things which are being done for them.

The committees are very important in AAA and Farm Security. You asked about that, and also in Soil Conservation.

Senator DONNELL. Mr. Patton, has your organization also testified before this committee through its representative with respect to grants to States in aid of educational projects?

Mr. PATTON. Yes; they have.

ADMINISTRATION OF HEALTH INSURANCE

Senator DONNELL. Do you recall whether or not your general suggestion has or has not been to the effect that State administration as distinguished from Federal administration is preferable in matters relating to education?

Mr. PATTON. Our feeling in general and I do not recall the specific terminology of that testimony—although I read it, as given by our representative—but our feeling is that curriculum, determination of curriculum content and educational policy of that character should not even be determined by the State, but should be determined by the local community. In several of the States we have been participants in seeing that either legislation or in the constitution a provision was there for curriculum determination, and course of study, at the community level by the local boards, and certainly my own position to the extent that they have expressed themselves, that is various organizations composing the national, have felt that educational policy should not have a strike on it by grants of funds.

Senator DONNELL. In other words, your thought has been, as I understand it, that the people in the given community are best qualified to know the needs of that community?

Mr. PATTON. That is right.

Senator DONNELL. And that it is advisable insofar as possible and practicable to vest in the people locally the administration of the affairs related to their own community; that is your thought in the matter?

Mr. PATTON. We feel that way; on the other hand, we also want a basis of upward appeal. We do not want to be stopped at the state level, or the Federal level. We want a device whereby we can go to whatever distance we have to go to see that what we feel is necessary and needed in the local community will have some response along the line.

Senator DONNELL. The point I am addressing myself to, Mr. Patton, is the one that as I understand you have recognized namely, that the local communities at least in some matters are better qualified to pass upon what is to be done there than somebody down in Washington.

Mr. PATTON. Yes.

Senator DONNELL. A thousand or two or three thousand miles away.

Mr. PATTON. Our proposal, which illustrates your point, I do not want to belabor it.

Senator DONNELL. That is all right.

Mr. PATTON. We propose in the new agricultural legislation which we are proposing, that the policy matters in relation to the county agricultural program, be in the hands of an elected committee of farmers in that county, and that they be a board of appeal. I am not

suggesting that same exact mechanism or anything like it in relation to this. I am just illustrating what you are trying to get our point of view on, that they in a sense be a board of appeals so that the farmer, that is, the administration of the program would be in an appointed agricultural agent or whatever you want to call him, but that in relation to farm plans, acceptance of farm plans, and so on, that elected committee of farmers would say that it is either accepted or send the farmer and the employed administrator back to work out one which did fit satisfactorily.

I feel that to the extent that is both administratively feasible and workable, the participation of the people in any program, and their voice to the extent that it is possible should be the guiding principle.

Senator DONNELL. And in part that thought, I take it, is based on the fact that conditions differ in various parts of the country.

Mr. PATTON. Yes.

Senator DONNELL. And you indicated in your statement, and I quote from it—

Mr. PATTON. They will vary in counties.

Senator DONNELL. From county to county.

Mr. PATTON. Yes.

Senator DONNELL. Take in my home State, for instance; are you familiar with Missouri?

Mr. PATTON. Very little.

Senator DONNELL. Take the southern part of the State, we have mountains or semimountains there, the Ozarks section, and up in the northern part of the state we have rolling country, better suited to certain types of agriculture than the south. Your thought is that conditions may differ even from community to community within a State, and so far as practicable there should be local government with respect to local affairs; that is your thought?

Mr. PATTON. I agree with that. On the other hand, we do not want to see a condition frozen by fencing communities and states off, so that the responsibility can not run further. That is our same basic attitude in Federal aid to education.

Senator DONNELL. I notice in your statement here, and I am going to quote just a little portion of the testimony which I think indicates the general trend of your thought along that line, you say, and this is page 3, I believe, Mr. Patton:

For conditions in rural areas are far different than those in cities and the method adopted to deal with those conditions should be varied to meet the problem. It would be a great mistake for this committee or for Congress to seek to set up a rigid program for hospital construction and medical care generally in rural areas without taking into account possible future changes in production, mechanization, etc.

Then you say:

Such provisions are embodied in title I of this bill, and in the pending hospital construction bills, in that State plans are to be submitted for approval, and it is to be assumed that the States will be guided by trends within their borders.

That is 191, the Hill-Burton hospital bill that provides for Federal grants to the States for the construction of hospitals. That is correct; is it not?

Mr. PATTON. Yes; and also for survey, I think.

Senator DONNELL. Yes; I should have put that first, the survey and subsequent construction. But it does not apply to the operation of the hospitals.

Mr. PATTON. No.

Senator DONNELL. That is correct, is it not?

Mr. PATTON. Yes.

Senator DONNELL. In S. 1606 if we go up to page 35, all of the parts that precede that—namely, the parts that relate to the administration of public health, maternal and child health, and care of needy persons—those all proceed upon the theory of grants by the Federal Government to the local State governments in aid of the programs of the State governments; that is right, is it not?

Mr. PATTON. That is my understanding.

Senator DONNELL. That is my understanding of it, too.

Title II from there on in the bill which relates to the compulsory health insurance follows a different pattern, does it not, namely, a federally operated pattern of health insurance and distinguished from merely aiding the States to operate their own plans? I am correct in the differentiation, I think, am I not there, Mr. Patton?

Mr. PATTON. I believe that is correct.

COST OF HEALTH INSURANCE

Senator DONNELL. Mr. Patton, I am wondering if you have gone into the question of the cost of this compulsory health-insurance plan; have you gone into that to any considerable extent?

Mr. PATTON. As to the over-all cost, no, except the figure which has been estimated by Social Security between 3 and 4 percent.

Senator DONNELL. There have been figures; I do not know whether you have been present on any other days or not.

Mr. PATTON. No, I have not; today is my first day.

Senator DONNELL. This 1606 is taken in largest part out of the preceding S. 1050. Is that correct?

Mr. PATTON. The Wagner—

Senator DONNELL. The Wagner-Murray-Dingell bill.

Mr. PATTON. Yes.

Senator DONNELL. I have before me here figures which have been mentioned earlier in the testimony which give several estimates as to the total cost of the over-all plan in the entire Wagner-Murray-Dingell plan as envisaged in S. 1050. First, based on Senator Wagner's figures and remarks, \$11,625,000,000 per year. Second, based on Tax Foundation studies, \$11,787,000,000. And third, based on the estimate of Earl E. Muntz of New York University, \$13,405,000,000. And fourth, based on Gerhard Hirschfeld's study, \$14,625,000,000.

Mr. PATTON. May I ask a question?

Senator DONNELL. You certainly may.

Mr. PATTON. Did they deduct from that what the Nation is spending presently for health?

Senator DONNELL. No.

Mr. PATTON. Is that a net figure?

Senator DONNELL. These are the figures, as I understand it. I may be incorrect, but as I understand it, that means if you take S. 1050 and lay it on the table and put on another sheet of paper the expenses

of operating it, those would be the figures. I appreciate the fact that under existing conditions many of those functions in some way or another are being carried out and they cost money; I do not mean these are additional over and above the current expenses.

The CHAIRMAN. If the record could show what institution or people made this estimate, I would like to ask for that.

Senator DONNELL. This is the American Enterprise Association, Inc., volume known as No. 418, entitled "Proposals for Health, Old Age, and Unemployment Insurance, a Comparison of the 1943 and 1945 Wagner-Murray Bills by Earle E. Muntz," who is described on the flyleaf as being of New York University.

The CHAIRMAN. Could the record show who organized this institution; who it represents? It is not governmental.

Senator DONNELL. No, sir; it is not.

The CHAIRMAN. It is an estimate made by some private group?

Senator DONNELL. The estimate as I indicated here is based on various figures and studies as indicated in what I dictated. I will be glad to read this part, if you so desire.

The CHAIRMAN. Just to say the name of the organization and where its head offices are located.

Senator DONNELL. American Enterprise Association, Inc., 4 East Forty-first Street, New York 17, N. Y., and 710 Eighth Street, Washington, D. C.

It might be well to tell who is on the advisory board.

"A nonprofit organization devoted to the study of current economic problems," and the advisory board is as follows:

Charles C. Abbott, chairman, associate professor of business economics, Harvard University Graduate School of Business Administration.

Henry Hazlitt, editorial staff, the New York Times.

R. A. Hohaus, actuary, Metropolitan Life Insurance Co.

James E. McCarthy, dean, school of commerce, Notre Dame University.

William I. Myers, dean, New York State College of Agriculture, Cornell University.

Roscoe Pound, university professor, Harvard University.

Edgar W. Smith, General Motors overseas operations.

John V. Van Sickle, professor of economics, Vanderbilt University.

Leo Wolman, professor of economics, Columbia University.

The CHAIRMAN. Leo Wolman, that is the columnist.

Senator DONNELL. I do not know about that, Senator.

The CHAIRMAN. Could you show who finances this organization?

Senator DONNELL. I have no idea. I do not know anything about it.

The CHAIRMAN. Again, what is the title?

Senator DONNELL. Proposals for health.

The CHAIRMAN. Of the organization.

Senator DONNELL. American Enterprise Association.

The CHAIRMAN. The title of it seems kind of strange to me, the Enterprise Organization. If it is an institution for economic studies, I should think it would have a more appropriate name than that.

Senator DONNELL. I cannot answer the question as to why it was called that. It states the purpose is to inquire into and appraise current economic and social questions as they bear on public policy and

to disseminate its findings so as to further public understanding of such matters. As an educational and nonpartisan body, the association endeavors to be completely impartial and objective in its work. The association takes no stand either in favor of or against any proposed legislative matters.

There is quite an additional frontpiece in the book.

Mr. PATTON. S. 1050, was that not the number of the Wagner bill?

The CHAIRMAN. Yes.

Senator DONNELL. There was one before that, S. 1161.

Mr. PATTON. It seemed to me that one of those, and it seems to me it was S. 1050, included in it the old-age pensions and the unemployment features.

Senator DONNELL. That is included in this one.

Mr. PATTON. I would like to ask Mrs. Evanson when she comes on what the statement of the American Medical Association was at Chicago as to the cost of this.

Senator DONNELL. I would be glad to do that. That includes the entire program under S. 1050.

I observe in this book that I have read from this language:

The social security program as set up in this bill (that is, I understand, S. 1050), would require a Federal subsidy based on the most conservative estimate in excess of 50 percent of the total expenditures.

I am wondering, Mr. Patton, if you have gone into that question as to whether or not the entire program set out in S. 1050 would necessitate a Federal subsidy in addition to pay roll tax. Have you gone into that?

Mr. PATTON. I have not analyzed that report. This is my general feeling. I have read recently a statement by one of the social science foundations, and you can get various figures, but we send every year in average times about two and a half billion dollars worth of young people to the city. We pay the bill now. We feed them. We clothe them. We educate them. We do the whole business. So far there has not been anything coming back from the cities, and from the urban centers to compensate on that.

If we can improve the efficiency, just looking at it not from the human side but the hardboiled side of the young people whom we sent to the cities, by 25 percent, it was a staggering amount. It will amount to half a billion dollars a year, to say nothing of the efficiency increases in agriculture.

The American people are paying a very big bill for the poor health in terms of higher food costs, by just putting it on the toughest, hardest, hardboiled basis you want to put it on, and not on the human basis.

THE NATIONAL FARMERS UNION

Senator DONNELL. Mr. Patton, you stated, as I understand it, in your direct testimony that your organization does not as a general rule pass upon specific bills.

Mr. PATTON. That is right.

Senator DONNELL. That is right, is it not?

Mr. PATTON. Very unusual, as a matter of fact, for them to go as far as they did in endorsing President Truman's health program.

Senator DONNELL. The point I was addressing myself to was this: you held a national convention just last month.

Mr. PATTON. Yes.

Senator DONNELL. Was that held here in Washington?

Mr. PATTON. At Topeka, Kans., March 21, 22, and 23.

Senator DONNELL. About how largely attended was that?

Mr. PATTON. It is a delegate convention. I have forgotten the exact number. I can have my secretary present that. There were about 300 in attendance.

Senator DONNELL. From all over the country?

Mr. PATTON. Yes. It is set up on this basis, Senator. First, the local, which is composed of five or more farm families, and sometimes runs up to as many as a hundred farm families, usually not that big. It is a community affair.

Then when there are three or four locals in a county, they can form a county organization, and when there are 5,000 or more farm families in the State, the National Farmers Union then grants them a charter. Those locals elect one delegate. It depends on each State, which adopts its own regulations regarding internal affairs within the State, but usually the locals elect 1 delegate for each 10 or 20 families, or sometimes they make 1 delegate to the State convention for each 25. It varies by States. They determine their own rules.

Then the counties in most States, the county organizations, are all allowed to send one delegate, regardless of the number of members, to the State and those delegates meeting at State conventions elect delegates to the national convention, who transact and who constitute the National Farmers Union.

Each State is permitted to have one delegate regardless of the number of members, so long as they have a charter and they cannot maintain a charter under the old rules, they could not, with fewer than a thousand families, and the new rules, I think the new constitution which is now out for referendum says 2,500.

Anyway, they are allowed one delegate for each 5,000 heads of families or families, or major fraction thereof. In other words, if they had 7,501 members, they would have two delegates, but each delegate votes the number of thousands of members he represents. If there is one delegate for 5,000 members, that delegate has five votes. If that particular unit has only 2,000 families, they would have only two votes. That is the way that the national convention goes. The only other people who are permitted to vote in that are the board of directors, which has one vote each, and the officers have one vote. There are no other people permitted to vote.

Senator DONNELL. That convention you say occurred what date?

Mr. PATTON. March 21, 22, and 23.

Senator DONNELL. A 3-day convention?

Mr. PATTON. Yes. It really was 4 days because they kept me up until 2 o'clock in the morning.

Senator DONNELL. And in that convention there was adopted this statement that you made here.

Mr. PATTON. Yes. I would like to present to you the program adopted. I will see that you get one, Senator Murray.

The CHAIRMAN. You have a subdivision in here—

Mr. PATTON. He may have one already.

The CHAIRMAN. You have a subdivision in here dealing with this particular subject?

Mr. PATTON. There is an index right in the front, Senator, dealing with that whole thing, on the flyleaf.

Senator DONNELL. Mr. Patton, of course at the time of your convention when they met, which was in March, S. 1606 had been pending already for several months.

Mr. PATTON. Yes.

Senator DONNELL. It was introduced on November 19, 1945.

Mr. PATTON. Yes.

Senator DONNELL. That particular bill, was it brought before your convention, do you recall?

Mr. PATTON. Well, usually, the way—

Senator DONNELL. I mean at the Topeka meeting on March 21.

Mr. PATTON. It undoubtedly was discussed by, this particular bill was undoubtedly discussed by the program committee, which is composed of delegates from a number of different States. I think there were seven different States represented on that. One State, I believe, had two.

Senator DONNELL. Were you present at the discussion?

Mr. PATTON. I intentionally do not go to those discussions because I am an officer.

Senator DONNELL. You do not know as a matter of fact whether that bill was discussed in that meeting or not?

Mr. PATTON. This specific bill, I do not. I know that the President's health program was discussed.

Senator DONNELL. I understand, but you do not know whether S. 1606 was discussed?

Mr. PATTON. I do not. That is, of first-hand knowledge I was told that it was.

Senator DONNELL. That is your supposition, however.

Mr. PATTON. I was told that it was, but I did not have first-hand knowledge. I was not in the room.

Senator DONNELL. At any rate, your convention did not adopt a resolution specifically favoring S. 1606.

Mr. PATTON. No; and I do not think we would on any bill for the simple reason that you might offer amendments which would, or some other Senator might, which we would not agree with at all.

Senator DONNELL. Then, Mr. Patton, if they did not pass on this particular bill, how are you authorized here to say, to quote your statement, "to give unqualifiedly the endorsement of my organization and myself to the national bill S. 1606"?

Mr. PATTON. Because I saw somewhere in the print first that the President said that S. 1606 embodied his health program and I am specifically authorized by the program adopted by the delegates to support unqualifiedly the President's health program.

Senator DONNELL. I do not recall having seen personally that statement by the President; he may have made it.

Mr. PATTON. I saw it.

Senator DONNELL. At any rate your organization never has passed a resolution endorsing S. 1606; that is correct, is it not?

Mr. PATTON. Yes; that is correct. And I doubt that we will, until it is, that is, until it becomes the law. We know what goes on up in

this place, and how many different times it can be twisted before it gets through, so we are not going to endorse something until we know what we are buying.

Senator DONNELL. I understand, however, if I read the language correctly, you do endorse it here today.

Mr. PATTON. As it is now constituted.

We will also refuse to endorse it the minute it gets some bad amendments in it which we do not agree with.

Senator DONNELL. I understand, but it is exactly the same today as it was when your convention met.

Mr. PATTON. That is right; I assume that it is.

Senator DONNELL. You have no hesitancy in endorsing it and you do endorse it; is that right?

Mr. PATTON. I said so, did I not, in my statement?

Senator DONNELL. You certainly have, and what I am getting at is, where you derived any authority from your organization to endorse this particular bill, when the resolution passed by your organization, although the bill was in existence for months before it, does not contain an endorsement of that bill.

Mr. PATTON. When I vote for my United States Senator, I do not authorize him to specifically vote for S. 1606 or S. 185 or anything else. I vote for that United States Senator, because on the basis of his statements, I think that he will adequately represent my general points of view. When the people of the Farmers Union elect me—and I stand for election every 3 years—they elect me because they have confidence in me. The first time that I was elected, I was elected by about 70 percent. I have been elected twice since by a unanimous vote.

These people vest in us a sense and a feeling and a confidence that we will, to the best of our ability, represent, based on the principles they set forth in their program, their point of view, just the same as I do when I vote for my United States Senator, and expect him to stand for the principles of the platform on which he ran.

Senator DONNELL. Be that as it may, Mr. Patton, the fact is that your statement adopted by your convention did not endorse S. 1606 specifically at any rate.

Mr. PATTON. That is right.

Senator DONNELL. And you have interpreted, however, as I understand, and you may be quite right, but it is your interpretation, in thinking that you are authorized to endorse here on behalf of your organization S. 1606.

Mr. PATTON. That is right.

Senator DONNELL. And that is the reason you are here today.

Mr. PATTON. Absolutely.

Senator DONNELL. Because you think that is a proper interpretation of what your organization did?

Mr. PATTON. That is right, and I think that is a proper interpretation in relation to the Truman health program. In other words, I think that S. 1606 embodies the principles as set forth by the Truman health program, which were undoubtedly studied by the program committee, and I know were endorsed by numerous State conventions. It would be interesting to you also to know how most of this program comes about.

The State conventions are held—well, this time all of them were held prior to the national convention. The State conventions are made up as I said before of delegates from the locals and the counties. They adopt programs; that is State programs. They refer in those State programs to both State and national affairs. Then those State programs are furnished to the program committee, and insofar as it is possible are reconciled and an attempt is made to express as near the grass roots as possible the various elements which have been brought in through the State programs.

The State programs arise primarily out of discussions, not in all instances, but in a great many instances, which have been going on at the locals. The local will resolve to ask the State convention to pass a resolution or adopt a plank in their program on this or that or the other, and the delegate from that local or that county is expected to carry it out.

I say that because in several, I do not remember how many, of the State programs there was also endorsement of the Truman program—

Senator DONNELL. Now, Mr. Patton—

Mr. PATTON. And in one or two the specific Murray-Wagner-Dingell bill that was referred to—

Senator DONNELL. Have you followed the experience of the Triangle health insurance plan which was inaugurated by your organization?

Mr. PATTON. Yes. It has not been in operation, I would say, long enough to give a broad experience. It came incidentally out of the demand upon our cooperative life insurance association to provide some kind of hospital insurance service for our members, and came up through that. It follows, in general, the same line of thinking. It is based on Farmer Union membership. It is the same line of thinking that the Blue Cross has.

Senator DONNELL. How long has the Triangle been in existence?

Mr. PATTON. Mrs. Evanson can answer that more accurately. As I recall it, we got it actually under way about 6 months ago, but she can correct that statement when she comes on, Senator.

Senator DONNELL. Very well, Mr. Patton. Have you personally examined with care the compulsory insurance plan set forth in 1606?

Mr. PATTON. I have read this bill.

Senator DONNELL. The bill?

Mr. PATTON. Yes; three times, as a minimum. I read it when it first came out, and when I was getting ready to testify. I read it three times.

Senator DONNELL. And you have studied the provisions then of the bill?

Mr. PATTON. Yes.

Senator DONNELL. What you think it contains?

Mr. PATTON. We had some of our people in our own organization who worked specifically and directly on this type of thing, analyzed it very carefully, I would say.

Senator DONNELL. That is all.

The CHAIRMAN. Your organization has approved President Truman's program?

Mr. PATTON. Yes.

The CHAIRMAN. And you understand that the President is supporting this legislation?

Mr. PATTON. That is my understanding. I read it somewhere; I cannot remember where, Senator.

The CHAIRMAN. And you feel that it is only through a universal prepayment plan of some kind that adequate health care can be brought to the people of the United States?

Mr. PATTON. I do.

The CHAIRMAN. You do not believe that it is possible to accomplish that by voluntary systems?

Mr. PATTON. You know, Senator, out in the West—you are from the West—we tried hail insurance. First the Farmers Union and some of the cooperatives tried hail insurance and as long as we had it so that to put it on their tax roll, you see the cost was away down, but when we got to it so that it was a voluntary business, the man who lived in the hail area always insured, but the fellow who did not, he would try and loop in and loop out, with the result that our cost began to go up very drastically, and the whole proposition of insurance is predicated upon getting a broad enough risk to get an actuarial or an adequate, at least, sampling.

The CHAIRMAN. The people who join the voluntary system are usually prompted by the fear that they are going to suffer ill health in their family.

Mr. PATTON. Yes.

The CHAIRMAN. If they feel that they are free from ill health, they take their time about joining such organizations, and the result is that you get a very small coverage.

Mr. PATTON. I would like to say just a word on that, and we have had quite a bit of experience in other fields on that, and we have had some experience in these voluntary things, that is, that your acquisition cost of the, insurance men ordinarily call it acquisition cost, is very high, or comparatively. You have to put in a whole lot of organization work to get an adequate participation on a voluntary basis. It is just like organizing members in the Farmers Union or any other farm organization. You have to go back every year and organize them over again, in some way, or somebody in the community does.

The CHAIRMAN. So to get an adequate program of national health care, you must have some kind of a compulsory system so that you have a continuing program.

Mr. PATTON. I think so; yes.

The CHAIRMAN. If you depend upon voluntary systems, they come in and drop out and in periods when they are unemployed, they cannot keep up the payments; therefore you must have some system that is sponsored by the Government and carried through.

Mr. PATTON. I agree with you. I feel that way very definitely.

The CHAIRMAN. I think you have covered everything I want to know.

Mr. PATTON. I want to thank you very much, gentlemen, for a very good hearing, and I would like to say that I asked Mrs. Evanson, whom you have on your list, to come in, because Mrs. Evanson is a rural woman, a mother, and has been all through this, and is very, very well informed, we feel, on how our people, our farm women, who belong to our organization, particularly in her own State, feel, and we

depend upon her and the women like her a great deal to give us the expression of how our farm women members feel. I want to thank you very much.

The CHAIRMAN. We are very glad to have you here, Mrs. Evanson. You are the Director of Education of the North Dakota Farmers Union?

Mrs. EVANSON. That is right.

The CHAIRMAN. Where do you reside?

Mrs. EVANSON. At Jamestown, N. Dak.

The CHAIRMAN. How long have you lived there in North Dakota?

Mrs. EVANSON. I was born and raised in North Dakota.

The CHAIRMAN. So you are very familiar with the problems on the farms of North Dakota.

Mrs. EVANSON. Yes, indeed.

The CHAIRMAN. You may proceed with your statement.

STATEMENT OF MRS. JEROME EVANSON, DIRECTOR OF EDUCATION, NORTH DAKOTA FARMERS UNION

Mrs. EVANSON. I am Mrs. Jerome Evanson of Jamestown, N. Dak., director of education of the North Dakota Farmers Union, and a member of the educational advisory council of the National Farmers Union. As a farm wife for 20 years and a mother of three boys who received their elementary education in a one-room country school, and as education director of our State organization, I speak for rural people of our State. As a member of the national council, I speak for rural people from all sections of the United States who are members of the farmers union.

RURAL PEOPLE HAVE THE RIGHT TO ADEQUATE MEDICAL CARE

Rural people can have adequate medical care and health services. World War II proved that hitherto debatable point. During World War II we saw modern health facilities and services—the best in the world—brought to our farthest desolate outposts on the Aleutian Islands in the North Pacific. Our Government provided medical care and services on the most inaccessible islands of the South Pacific, in the impenetrable jungles of Burma and India and over the “hump” to the natives in the interior of China. No spot in the world was too remote. It gladdened our hearts and made us proud but it also made us think.

No longer can these same services be denied to our own people here at home. No longer can anyone say it is not feasible to establish good medical care and services in our rural areas. The war provided these services wherever there was a need for them at the war front. The peace shall provide these services wherever there is need for them on the home front, and the greatest need on the home front today is in rural areas. What a pity that it had to take a world war to awaken us to the realization that “medical care for rural people can be complete and it can be good.”

You and I know that our best crop on the farm is not our grain or cotton or livestock. Our best crop is our children. In that light let us examine the situation in our rural areas. We find agricultural in-

stitutions in every State in the Union built, staffed, and maintained by Federal and State funds to train young men and women in the science of farming—to train veterinarians to give the best medical care to our livestock and poultry.

We find experimental stations in the varied sections of every State. In North Dakota we have nine experimental stations—built, staffed, and maintained by State and Federal Governments to carry on experiments with various types of grain and soil—to deal with diseases of grain and of soil, of poultry and livestock, and to develop hardy specimens to withstand drought and variable weather. But how about our best crop—our children? Do we have health centers built, staffed, and maintained by our Government to treat diseases of human beings who live on the land? Mercy, no! That would smack of Government control. Socialized medicine. Regimentation—and yet if we can build, staff, and maintain institutions for the welfare of our land resources, then it is time we do something about providing for our human resources and quit falling for the bunk that whatever the Government does is not good.

The CHAIRMAN. May I interrupt?

Mrs. EVANSON. Yes, please.

The CHAIRMAN. In American industry effort is made to provide even for the medical care of animals. We have in Montana mines, and in the mines they used to use donkeys in the lower levels of the mines to pull the cars, and when the mines would have to be shut down temporarily, they removed these animals to a farm, they would be under the supervision of the doctors that take care of animals, and they would be fed and cared for, and brought back in good condition to resume the operation of the property. That is something that ought to be interesting to people of this country, that we should be willing to do the same thing for people that we do for animals.

Mrs. EVANSON. That is right.

With every county in North Dakota listed as TB-free areas (that is for cattle) and 25 counties listed as areas free from Bangs disease, we are indeed proud of the record of our Government in disease control—for our cattle. The Public Health Service, now highly recommended by the American Medical Association, proves that the Government can do a good and efficient job of dispensing public-health services.

What do we want in rural America? Well, in substance we want disease-control areas for our people as well as disease-control areas for our cattle. Is that asking too much? It is good to have our cattle regularly tested for TB. It should also be good for our people. What has been done for the improvement of our poultry, our cattle, and our crops can be done for our people. How is it going to be done? Pretty much in the same way that areas have been freed from diseases in cattle. Proper food, good housing, periodical examinations, and corrections by doctors. For instance, mobile X-ray units can bring TB tests and immunization to the most isolated families of any given area.

I would emphasize corrections to follow examinations, for I am reminded of our district school on the farm where my three small boys were attending school. Each year the county nurse would go

through the routine of examining the children and making out slips of paper to take home to the parents listing needed corrections.

This was during the great drought when none of us had the cash necessary to get medical care, so corrections were put off in hopes that next year we would get a crop. The drought continued year after year, during which time the nurse made regular routine examinations. The parents finally asked the county superintendent of schools if he could arrange to use the money it took to send the nurse out for routine examinations to take care of two pupils who badly needed medical care. This request was granted and the one boy who because of bad teeth, adenoids, and poor eyesight had spent several years in one grade, moved ahead rapidly once corrections were made. We were indeed proud to read not long ago in the daily paper that this same boy had been given several citations for bravery in action in Europe. He repaid his Government for the care it had given him when he needed it. Without this care, he would have been numbered among the rejects. The other boy's parents disliked taking help (charity, to them) and so care was postponed until they could afford to take their son to a doctor. We found him listed among those rejected for Army service.

To shock people out of their complacency, I would like to suggest that for every area posted as disease-free for cattle we should have posted the list of needless cases of illness and deaths among the people in that area, who have not had the same consideration as our cattle. It may awaken some people to an awareness that even though our children haven't the cold dollars and cents value of cattle, they should and must warrant the same protection that is given our cattle. That protection has definitely not been given our people in rural areas to date. Shocking? Yes. So are the high rejections of rural boys for the services—the highest of any major occupational group. Shocking, too, are the figures for maternal and infant death rates and for death rates in all age groups in rural areas.

We have read with contrition that boys killed in action at the battle front in World War II number 205,000. In the same period of the war, we on the home front lost 430,000 babies, 225,955 more infant deaths than soldier deaths. No publicity in the papers, for it might raise a question in some people's minds as to just how good a job has been done with all our flaunted facilities and skilled personnel.

Yes; we are shocked when told that of 3,000,000 babies born in the United States in 1944, over 111,000 were dead before the age of 1, and 6,369 mothers died in childbirth—particularly shocking when we are told that 30 to 50 percent more mothers and 50 percent more infants die in the first month than would die if they got good medical care. Let us not forget that 52 percent of our children are born in rural areas and that infant and child death rates are highest there.

RURAL HEALTH NEEDS

Specifically, then what are our needs in rural areas? After an extensive study of the needs of their communities, Farmers Union members have listed the following definite needs.

First, a good public health program, available to families in the most remote rural areas, that includes:

1. An educational program to promote health and to bring people from the "knowing" stage to the "doing" stage. In a recent check of diets of grade schools children in North Dakota, only 5 percent had good diets, 13 percent had fair diets, 20 percent had poor diets, and 62 percent very poor diets. Do you doubt that we need an educational program in nutrition and health?

2. Sanitary and other health measures to prevent and control disease. Elin Anderson of the Farm Foundation tells us that of the \$30 per year spent on the average by each of us for medical services, \$29 goes for the treatment of disease and only \$1 for preventive measures made available through modern public health departments.

3. Maternal and child care.
4. Care and education for handicapped children.
5. Preschool clinics and clinics for all age groups.
6. Protection from environmental hazards such as water, milk, etc.
7. Safe, sanitary, healthful school environment for our children.
8. A recreation program for wholesome physical and mental development.

Second, we need hospitals, diagnostic facilities, and mobile units for sparsely settled areas.

A State-wide coordinated plan of hospital construction whereby health services and facilities would be integrated through a system of base, district, and rural hospitals and health centers. In other words, a State-wide plan that would provide for exchange between hospitals of information, training, and consultation services and personnel, making the best specialists available to patients who need special care from the most remote rural areas regardless of their income.

Third, we need doctors in rural areas. In sparsely settled areas, a general practitioner can be made available to several outlying trade areas where small health centers have been established with a registered nurse in charge and with ambulance service to bring patients into the centrally located hospital for special care. We are told that doctors will not come out to rural areas, yet an article in the Medical Journal states:

It is interesting to learn that a number (of doctors) prefer country to city locations.

Dr. F. W. Jackson, Deputy Minister of Health, Winnipeg, Manitoba, stated that on advertising for doctors for community hospital he received numerous applications for each position. We know there is a shortage of doctors, but make facilities available to them and they will come to the rural areas.

Fourth, we want a housing program, for well we know that poor housing, lack of electric power, unsanitary water supply, and improper sewage disposal are contributing factors to the shocking rural health situation. MVA and REA will do much to bring modern sanitary facilities and health standards to rural areas.

Fifth, we want easier ways of paying for needed health services. Rural people are carrying the greatest burden of any group—not that farmers are getting better health services but that they are paying out a greater percentage of their income for what they get, such as it is. Since incomes on the farms are inadequate, and hospitals and doctors are not as accessible as in the cities, farm people put off proper care

until the illness becomes serious and therefore more difficult to cure and much more expensive to the hard-pressed farmer and his family.

Sixth, we, the people want to participate in the formulation of a health program. We believe that those who receive services as well as those who give services should have the right of representation on councils determining quality, cost distribution of hospital care, and health services. Medical people seem to resent participation by lay people and seem to look upon it as interference. It would seem that to many people the sole responsibility of the consumer should be to furnish the patient and the fee. To justify their insistence upon control of programs, they speak of their past record and point to the high standard of services rendered. We can only think of how bad the services are for so many of our people. They talk of the high quality, and important as quality is, we think quantity and distribution are important, too, for what good is quality when it is out of reach of the people who are ill and need it? These problems will not be overcome until lay people actively participate in the formulation of health programs.

Hasn't the National Health Act been made necessary because the medical people have failed in the distribution of medical care? When we can bring adequate medical care to outposts of the world, what is that is denying this same medical care to our people at home? Is it not that we have left the entire matter with the medical people? Is it because the Government has not heretofore assumed the responsibility of making good medical care available? The medical people did not resent Government cooperation in making medical care available in all our far-flung outposts; why then is it "interference" when the Government wishes to cooperate in making medical care available to our people here at home?

ATTITUDE OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association's Committee on Rural Health (only very recently organized since national attention has been focused on the deplorable health situation in rural areas) states that low-income farmers have been given much thought and discussion by their committee. The low-income farmer is presented as above the indigent level that below the level of those able to join the prepayment group. Dr. Crocket, chairman of the committee, says, "He should be classed as medically indigent and cared for by taxation. Now, according to the American Medical Association, families with incomes under \$3,000 need help to meet their medical bills. In 1939, a fairly normal year, 90 percent of the population had incomes of \$3,000 or less; 15 percent of them were indigents, leaving 75 percent of the population in the bracket of which Dr. Crocket speaks. Isn't that quite a big order to hand to the Government, considering the opposition of the same group to Government participation in a health program? Do they presume that the Government would help pay the medical bills for 90 percent of the population without some "interference"? As subsidized by the Government, they still would not be assured medical care so long as it is voluntary as has been proven by FSA health programs.

Dr. Crocket goes to say:

He (the farmer) needs help, he wants help, but cannot pay for it. He refuses what he considers charity at the hands of the taxpayer, but complains of hardships and inequities when he fails to receive it.

Indeed, we, do not want medical care in the name of charity or relief. We want a plan that makes it possible for us to pay our way, and we want a plan that will be all-inclusive, and assure us adequate health care. Yes; and we will continue to complain of hardships and inequities, and I assure you it will not be a passive complaint, until inequities are removed and adequate health care is made available to all laboring people and their dependents—whether from the factories or the farms.

Of all the voluntary plans that now have the blessing of the American Medical Association, all of them together do not give complete coverage, and we will stop at nothing less than complete coverage. That seems to be beyond the comprehension of the medical people—so long have we been grateful for the crumbs that have been thrown at us. They believe that we should be delighted with the prepayment plans covering only a small part of the health problems we face. If they are sincere in their desire to serve us, why give it to us piecemeal, always denying us complete services under their plans. Is it an admission that they cannot meet the total problem with voluntary health insurance? Or is it merely a plan superimposed upon us to stall off a comprehensive Government sponsored program of health insurance? Isn't it time for the doctors to stop being negative, trying to stop the progress of people and to join with lay people in constructive planning for a complete medical-care program. I would remind them that people keep moving whether institutions do or not. We desire their cooperation, but we will keep moving with or without it.

Science says that most diseases are preventable. Then why are they not prevented? Is it because certain groups have a stake in our illness? Those who can pay well for their health services must know that no one is free from the scourge of disease until all are free. The only real insurance against disease is the elimination of that disease and that can only be done when complete medical care is made available and compulsory—and that can be undertaken only by the Government.

The American Medical Association is particularly opposed to the matter of compulsion—"it is so undemocratic." Would they take away compulsion in the matter of education and let every child volunteer to attend school? Would they take away compulsion in the matter of contagious diseases and leave it to the individual to voluntarily isolate himself? Would they take away the compulsion of sanitation laws, doctors' licenses, or intern training, or even the years one must study before one can practice medicine? Isn't compulsion a necessary safeguard where the welfare of all is at stake? The shocking revelation of health conditions in rural areas most certainly justifies compulsion in the matter of health care.

Norway and Sweden have practically eliminated venereal disease. Here it strikes 1 out of every 10 and spreads to a million new victims a year. They were not able to accomplish this until they made health insurance compulsory. Oh, yes, they experimented with voluntary insurance for some years, as did over 30 other countries, before they

finally turned to compulsory health insurance to solve their vexing health problems. None of these countries have gone communistic or have become less democratic because of it. Must we then blunder terrific toll in human lives, dissipating our human resources, because a small group would rather fight change than change their minds from the old rut of the status quo? To this group we would give this advice, be hospitable to a new idea, there might be something in it for you.

Now, for an example of voluntary versus compulsory insurance in North Dakota. Some years ago we passed a law making crop hail insurance compulsory. Because everyone carried it, the insurance premiums amounted to a mere 7 cents an acre. It was paid with the taxes each year and none begrudged the payment of this small fee. However, private hail-insurance companies and bankers who had enjoyed a nice income from private insurance went to the legislators and told them compulsion was a bad thing—it was a threat to our democratic way of life—an opening wedge for socialism or what was worse, communism, to come in and take over. They reasoned that our people recognized the worth of the insurance program so that they no longer needed compulsion and asked that they make only one change from "compulsory" to "voluntary"—and save our fair State from the real threat of communism. This was done. The insurance need no longer be paid with the taxes. Some forgot to meet the dead line for payment, some saw no necessity for worrying about dead lines since they did not live in the hail belt. The result of it all was that the insurance went up to 80 cents an acre and became prohibitive to those who really needed it and those whom we truly wanted to help lost their security. Those who say or imply that finding ways and means of making facilities available to all, instead of a few, of giving protection to the weak is un-American, are traitors to the very concept of democracy and the American way.

In North Dakota we have more than 50 requests for help in planning hospitals or health centers and we are told by the State secretary of the medical association that very few of these are justified. Yet we have many people who must go 225 miles to get hospital care. We have 21 counties without a hospital and five large counties with neither hospitals or doctors. We are told the minimum standard is one doctor for every 2,000, yet 49 out of 53 counties fall below that standard. There are 8 counties where 1 doctor serves over 5,000 people, 7 counties without a dentist. However, in contrast, four counties with 22 percent of the population have 40 percent of the doctors and almost half of all the hospital beds in the State. The cost of ambulance service in rural areas is prohibitive.

We are told that venereal disease and TB will be a rural problem if left unchecked in rural areas. Checking with our State health department we found cases of gonorrhea reported were almost doubled this past year—307 cases in 1944—602 cases reported in 1945. Isn't it the lack of compulsion that is making possible the terrific spread of this menace? Democracy is based on the general welfare and we must recognize what is the general welfare, and what part Government must play in guarding the general welfare of its people.

A State director of Blue Cross, speaking at a health conference of his experiences, stated that those that needed health insurance most,

because of their large families, were too often the ones that did not carry it—not because they could not afford it but because they were willing to gamble on their health and the health of their children, and the children became the innocent victims of the indifference of their parents. Does the Government have a responsibility to these children where the parents fail in their responsibility and in failing menace the general welfare? In one area, more than 40 percent of many hundreds of school children studied were found to be anemic—only 20 percent were normal and the remainder regarded as possibly bordering on anemia. Whose responsibility?

Our State director of welfare stated that he had seen too many good substantial homes broken and scattered because of illness and doctor bills that had wiped out family savings and had put such a heavy burden of debt on their shoulders that the breadwinner finding the burden insurmountable turned to drinking, and the family, destitute and ill, had no recourse but to swallow their pride and appeal to welfare for aid.

We know of too many cases of mortgage foreclosures on farms due to illness and accumulated doctor bills. We are told that 33 percent of the homes lost in Wisconsin were not due to unemployment but to illness. One of our members told us he had been paying on a doctor bill in Rochester, Minn., since 1914 and was still paying and finding it difficult to keep his head above water. He stated how grateful he would have been to have paid only 5 percent of his income for insurance against the burden he had carried these many years.

A few years ago in North Dakota we passed enabling legislation that made it possible for our counties to pool their funds to establish district health units. It was the medical people who fought to defeat this bill but it was made law in spite of their opposition. This past summer, 3 years later, the medical association officially approved the establishment of district health units which they had fought so bitterly. We are told they fought the voluntary insurance plan as vigorously with the same old cry of "un-American—regimentation, socialism—communism." Now, one would think voluntary health insurance was their baby. Scanning their record, why should we rely upon their judgment in the development of a program of Government health insurance, since their judgment in the aforementioned instances was 100 percent wrong? There is one redeeming feature about their past record. We have always been able to win their approval of our programs after we have fought our hearts out to get what we needed, and spent most of our energy fighting their opposition. The pattern of conduct in opposition to this bill is running true to form and we venture the prophecy of eventual approval by the American Medical Association—yes, of compulsory insurance—but not until we have been forced to sacrifice greatly of our human resources to win the good fight. The British Medical Society fought compulsory health insurance in Great Britain, but now endorse it. They do not claim that the panel system as it is called there is perfect but they are cooperating to perfect it as they gain experience.

Yes, the record of medical care and health services in World War II made us happy and proud, but it also made us think. We know that rural America can have medical care. We know it can be complete, and it can be good. We also know we shall have to fight for it.

The National Health Act, S. 1606, as it gives expression of our objectives, is the front on which we fight.

We wish to pay tribute to the President and to the members of Congress who are sponsoring S. 1606 and working—yes, fighting for it.

It takes courage to sponsor new ideas—to chart new courses.

They must have the full support of our people to make this—the Health Act the law of the land.

The CHAIRMAN. Mrs. Evanson, I do not think it is necessary for me to cross-examine you on this matter, after hearing your very able statement. I am convinced that you are in favor of compulsory health insurance.

Mrs. EVANSON. Yes.

The CHAIRMAN. And I think you have been brought to that conclusion by your own observations and your own studies and knowledge of the existing conditions in this country.

Mrs. EVANSON. That is right.

The CHAIRMAN. I think you have been brought to that conclusion by the same reasons that prompted me to join in sponsoring this legislation.

Mrs. EVANSON. Yes.

The CHAIRMAN. Of course, no bill is perfect when it is filed in Congress. I have never seen a bill come to Congress yet that was not amended and perhaps improved in some respects. Sometimes of course legislation is butchered in Congress. They hang onto it all kinds of emasculating amendments that would destroy it and prevent it from becoming effective. So it is up to the people of the country to support a program which will give the people of this country a fair and honest method of meeting this great problem.

I am sure that you have no desire to injure the medical profession, any more than I have.

Mrs. EVANSON. That is right.

The CHAIRMAN. But you believe that some means should be found to bring that modern medical care that has been developed in the world and especially in our own country to the people all over the United States.

Mrs. EVANSON. Yes.

The CHAIRMAN. I want to thank you for your very able statement here this afternoon.

Senator DONNELL. Mrs. Evanson, Mr. Patton, when I mentioned certain estimates in this pamphlet, this booklet by Erle E. Muntz, issued by the American Enterprise Association, Inc., had suggested that you had certain information and I stated that I would interrogate you about that. I do not recall exactly what it was that he said that you were able to give us the information on, except just generally.

Perhaps you know just what it is to which he referred.

Mrs. EVANSON. Well, Senator Donnell, I am a member of the National Committee on Health Services sponsored by the Farm Foundation. We meet with the American Medical Association in Chicago, and one of the members, I cannot say which of them, there were five doctors there, but one said, "Mrs. Evanson, do you realize that Senate bill 1606, the Compulsory Health Insurance Act, will cost the Nation between three and three and a half million dollars?"

Senator DONNELL. Million or billion?

Mrs. EVANSON. I beg your pardon, 3 or $3\frac{1}{2}$ billion dollars.

Yes; I said I was quite sure that it would cost that, but I felt that if we had the money and the resources to spend for the war to destroy people, certainly we could afford to spend $3\frac{1}{2}$ billion, we could afford to spend double that to build bodies instead of destroying them.

Senator DONNELL. Mrs. Evanson, you are the director of education for the North Dakota Farmers Union?

Mrs. EVANSON. That is right.

Senator DONNELL. You live in Jamestown, or do you live on the farm?

Mrs. EVANSON. I live in Jamestown at the present.

Senator DONNELL. You live in Jamestown?

Mrs. EVANSON. Yes.

Senator DONNELL. Have you been on a farm, living on a farm at times?

Mrs. EVANSON. I have lived on the farm practically all my life.

Senator DONNELL. Nearly all your life?

Mrs. EVANSON. And I spent 20 years on the farm previous to taking over this work.

Senator DONNELL. Are you an employee of the union, the North Dakota Farmers Union?

Mrs. EVANSON. Yes.

Senator DONNELL. You are on a salary?

Mrs. EVANSON. I am on a full-time basis now.

Senator DONNELL. And has that particular union, the North Dakota Farmers Union, an annual meeting like the national association does?

Mrs. EVANSON. Oh, yes; we have our State convention each year.

Senator DONNELL. Each year you have the State convention?

Mrs. EVANSON. Yes.

Senator DONNELL. Did you attend the meeting in—

Mrs. EVANSON. In Topeka?

Senator DONNELL. Yes.

Mrs. EVANSON. Yes.

Senator DONNELL. Were you on the committee, by the way, which drew up this statement of principles that Mr. Patton referred to?

Mrs. EVANSON. No; I was not a member of the resolutions committee. However, I was a participant in the discussions.

Senator DONNELL. I see.

Mrs. EVANSON. On medical bills.

Senator DONNELL. You were familiar with S. 1606 at the time?

Mrs. EVANSON. That is right.

Senator DONNELL. And that particular bill was not in express terms at any rate endorsed in those resolutions; was it?

Mrs. EVANSON. No.

Senator DONNELL. Simply there was a commendation of President Truman for his courage and vision in calling for a universal pre-payment of medical-care program, and so forth, and calling upon Congress to pass legislation to put that into effect?

Mrs. EVANSON. However, at this meeting, at this discussion, we stated that we would go out and work for any health compulsory health act, as it would give expression to our objectives, and we did state at that time, it was the Wagner-Murray-Dingell bill, and this

new bill, which we had not felt that we had given the study to that we should, but that we would endorse it as it gave expression to the objectives of our program.

Senator DONNELL. Who said that?

Mrs. EVANSON. I have that. It was at the committee meeting or at the discussion.

Senator DONNELL. You mean some individual said that?

Mrs. EVANSON. It was the consensus of opinion that the summary of our discussion was that we would go out and fight for any bill, as the Wagner-Murray-Dingell bill, and the new Senate bill 1606, as it gave expression to our objectives, and I have that here. That is really a direct quote from the summary of our discussion.

Senator DONNELL. From the summary of your discussions?

Mrs. EVANSON. That is right.

Senator DONNELL. There was no resolution adopted?

Mrs. EVANSON. No.

Senator DONNELL. Not to that effect.

Mrs. EVANSON. Not that I know of.

Senator DONNELL. And the national conference speaks, I mean the national conference of the National Farmers Union speaks through its resolutions, does it not?

Mrs. EVANSON. That is right.

Senator DONNELL. You refer in the conclusion of your remarks to new ideas. You say it takes courage to sponsor new ideas, to chart new courses. You do not undertake to say that this idea of compulsory health insurance is a new idea, do you?

Mrs. EVANSON. No; I do not, but it is a new idea to many, many people, and it seems to be a very new idea and a dangerous new idea, seemingly, to the medical association.

Senator DONNELL. I wanted to speak about the medical association in a moment, and ask you about that.

Generally, however, Germany adopted compulsory insurance back as early as 1883, did it not?

Mrs. EVANSON. I am not aware of that, but I know it has been a long time.

Senator DONNELL. It was approximately that. I think that is the date if my information is correct.

Mrs. EVANSON. Yes.

Senator DONNELL. So it is not this matter of compulsory health insurance, it is not a new idea, as a matter of fact, is it?

Mrs. EVANSON. You will admit that it is a new idea to many people and particularly in the United States.

Senator DONNELL. That may be true, but it is not a new idea as a world proposition, is it?

Mrs. EVANSON. No; indeed not.

Senator DONNELL. On the matter of this hail insurance that you speak of in Dakota, I presume we would agree that there are very many different problems applicable to hail insurance as distinguished from health insurance, would we not?

Mrs. EVANSON. I do not see why there should be too many.

Senator DONNELL. Just to illustrate, without going into detail, the matter of hail insurance involves first the payment of a premium,

and in the second place if there is a loss by hail, the ascertainment of the damage and then in the third place the collection of the damage; that boiled down is hail insurance, is it not?

Mrs. EVANSON. Yes.

Senator DONNELL. Whereas health insurance involves the matter of the selection of doctors, the question of the quality of doctors, whether or not initiative of the doctors is or is not encouraged, the question as to the best means of encouraging advancement in the medical profession, the question as to whether or not there is to be a national control of health insurance, and of the selection of doctors away down the line out in your State and mine, all of those things differ from hail insurance, do they not?

Mrs. EVANSON. That is right.

Senator DONNELL. However that may be, North Dakota tried the compulsory hail insurance, did it not?

Mrs. EVANSON. It did, that is right.

Senator DONNELL. And later on the legislature had the matter of repeal of that up before it, did it not?

Mrs. EVANSON. Yes, it did.

Senator DONNELL. Did it repeal it?

Mrs. EVANSON. It changed; it did not repeal the law. It changed it from compulsory to voluntary.

Senator DONNELL. All right.

Mrs. EVANSON. We still have it.

Senator DONNELL. So the question of whether or not you should retain compulsory hail insurance was in the first instance, presented to the legislature which passed a law providing for compulsory hail insurance, and in the second place, later on, the legislature had before it the question as to whether compulsory hail insurance should be abandoned and voluntary hail insurance be substituted, is that not correct?

Mrs. EVANSON. That is right.

Senator DONNELL. And the legislature, whether for good reason or for bad reasons, decided to abandon the compulsory hail insurance and substitute voluntary insurance, is that not right?

Mrs. EVANSON. That is right.

Senator DONNELL. How many years experience had North Dakota had with the compulsory hail insurance before it reverted to this, or before it adopted the voluntary plan that is now in existence?

Mrs. EVANSON. I am afraid I cannot give you the number of years offhand. I am sure it was let me see, well, I am afraid I cannot tell when we started it.

Senator DONNELL. Was it 5 or 10 years?

Mrs. EVANSON. Oh, yes; I think something like that.

Senator DONNELL. Something like that?

Mrs. EVANSON. Yes.

Senator DONNELL. Mrs. Evanson, just two other matters I wanted to ask you about. One is on page 4, where you make the statement that I am wondering just what you mean by it. You say;

Since most diseases are preventable, then why are they not prevented? Is it because certain groups have a stake in our illness?

Do you mean to imply by that that the doctors of our country are trying to hold back this country from solving the health problems be-

cause they are going to make more money out of it if we have sickness than if we do not have it? Is that what you mean?

Mrs. EVANSON. No; but I was reminded of the experience in Manitoba, where they are hiring doctors in municipalities, where he said that he had a stake in the health of the people so it was his job to keep them healthy, and he had gone into the preventive phase of health care, and developed much greater in that community, and he said it was because he had a stake in their health instead of their illness. It was his job to keep them well.

Senator DONNELL. I understand, but that does not quite answer the question I had in mind, and that I tried to state to you. You say:

Science says that most diseases are preventable. Then why are they not prevented? Is it because certain groups have a stake in our illness?

Let me say, who did you mean by "certain groups"?

Mrs. EVANSON. I would say the medical people.

Senator DONNELL. The medical profession?

Mrs. EVANSON. They are the ones that have the stake in our illness.

Senator DONNELL. So you are raising the question as to whether or not the stake that they have in our illness is causing them to act in a selfish manner against compulsory health insurance, is that the question you are raising?

Mrs. EVANSON. I would not like to say that.

Senator DONNELL. Is that what you mean?

Mrs. EVANSON. It means this, that if they had the desire to give us complete medical care, they would give us complete medical care program in their health insurance, and they do not give it to us. That raises the question in my mind, is it because they have a stake in our illness.

Senator DONNELL. Well, then, as I understand, and if I am wrong you stop me and correct me on it, but as I understand it, though, you mean that you at least have a question in your mind as to whether the doctors are opposing this compulsory health insurance because it is to their advantage to have more of us sick, than would be under compulsory health insurance. Is that your point?

Mrs. EVANSON. No; that is not it.

Senator DONNELL. What is your point?

Mrs. EVANSON. My point is, with their own voluntary health insurance programs, they refuse to give us a complete medical care program, and that raises in my mind the question. It is their program, not the compulsory program, that is raising in my mind why is it that they have a stake in that.

Senator DONNELL. We will just change the question a little. I understand then that you have in your mind the fact that the doctors have a voluntary health program which does not cover everything, every type of illness or every type of service, and that the question arises in your mind, is it because it is to the advantage of the medical profession to be able to collect more fees from us, that they are not putting us in on this voluntary complete health insurance. Is that your thought?

Mrs. EVANSON. No; I would like to make the statement—

Senator DONNELL. What is your thought?

Mrs. EVANSON. There are many, many doctors who are very desirous of giving us good medical care. I do believe that there is a clique of

doctors that are interested in the cold-blooded profit of our illness, and that is their stake.

Senator DONNELL. Well, that is what I thought you meant, namely, that you thought when you said this, that I read to you, is it because certain groups have a stake in our illness, that there is a certain clique of the medical profession that are more interested in the dollars and cents.

Mrs. EVANSON. That is right.

Senator DONNELL. Derived from their practice, than they are in the health of the country. That is your meaning?

Mrs. EVANSON. That is right.

Senator DONNELL. That is what you mean?

Mrs. EVANSON. That is right.

Senator DONNELL. Is that right?

Mrs. EVANSON. Yes.

Senator DONNELL. Let me ask you, now, you know a good many doctors, do you not?

Mrs. EVANSON. Yes, I do.

Senator DONNELL. Have you ever yet known a single solitary doctor that in your opinion was actuated by any such desire as that to get money at the expense of the health of his patients or the community? Have you ever known one?

Mrs. EVANSON. I have. I have seen doctors turn down people in our rural areas in my home town, and they have stayed out on the sidewalk, serious cases, and refused to accept them as their patients until they were guaranteed their payment, and the people were aroused almost to riot intensity, demanding that that doctor take care of his patients.

Senator DONNELL. You have seen that yourself?

Mrs. EVANSON. Yes; I have seen it.

Senator DONNELL. And you know who the particular doctors are that you refer to?

Mrs. EVANSON. Yes.

Senator DONNELL. Are they in Jamestown, N. Dak.?

Mrs. EVANSON. No.

Senator DONNELL. What town are they in?

Mrs. EVANSON. In my home town.

Senator DONNELL. What town is that?

Mrs. EVANSON. It is Northwood, N. Dak. But it is not the doctor that is there now.

Senator DONNELL. Is the doctor that you are referring to living or dead?

Mrs. EVANSON. No; I think he is dead now.

Senator DONNELL. You think he is dead?

Mrs. EVANSON. He moved away; he did lose prestige.

Senator DONNELL. Did you ever know of any other doctor besides that one?

Mrs. EVANSON. Yes.

Senator DONNELL. That was guilty of any such conduct as that?

Mrs. EVANSON. Yes; I heard of it but I did not see it. But I have heard of the very same situation right in the city of Jamestown, and I understand that groups of people got together and demanded that—they had to get a guaranty from the county to pay that bill before he would accept the patient.

Senator DONNELL. That is just one doctor in Jamestown; is that right?

Mrs. EVANSON. That is what I have understood.

Senator DONNELL. You do not personally know about it?

Mrs. EVANSON. No.

Senator DONNELL. That is just hearsay; is that right?

Mrs. EVANSON. It is not hearsay, because it was told to me by people who were interested in it and had to see that the county took care of it.

Senator DONNELL. But you yourself know only of it from what some of those people told you.

Mrs. EVANSON. Of that instance.

Senator DONNELL. You do not know the doctor's side of it?

Mrs. EVANSON. No.

Senator DONNELL. You never talked to him about it?

Mrs. EVANSON. No; I have not.

Senator DONNELL. Are those the only two doctors that you personally know of who have been guilty of this kind of unkind conduct?

Mrs. EVANSON. No; in our discussions of health out in the rural areas, I have heard enough stories to make me sick.

Senator DONNELL. You do not—

Mrs. EVANSON. Sick at heart and sick to my stomach for the things that have been done.

Senator DONNELL. You feel that the medical profession is in many instances guilty of very reprehensible conduct; is that your thought?

Mrs. EVANSON. Yes, indeed.

Senator DONNELL. As you have indicated, you think there is this clique that places dollars above health?

Mrs. EVANSON. I want to say this—

Senator DONNELL. Just a minute. Is that right?

Mrs. EVANSON. Yes.

Senator DONNELL. All right.

Mrs. EVANSON. I want to say this, that I will admit that many doctors have had to do a lot of charitable work and in North Dakota during the drought I think they came to the limit of their endurance, too, but nevertheless that was the case.

Senator DONNELL. Generally speaking, aside from the particular instances that you have referred to, and that you have heard of, generally speaking, did you not think, Mrs. Evanson, that the medical profession is composed of high-minded, generous, and honorable people? Is not that true?

Mrs. EVANSON. Yes, indeed; and I think they are too generous. They give too much for nothing.

Senator DONNELL. You think they give too much for nothing?

Mrs. EVANSON. And I do not think we should expect it, and we do not want charity. We want some way of paying for it.

Senator DONNELL. You know the American Medical Association contains about 125,000 doctors in our country, do you not?

Mrs. EVANSON. Yes.

Senator DONNELL. The other point I wanted to ask you about is just a few words about the Farmers Union, the National Farmers Union. I suspect I should have asked Mr. Patton about this, and if you do not know, do not hesitate to say so.

I am curious to know what is the difference, if any, between the

underlying principles of the National Farmers Union and the underlying principles of the Grange and of the Farm Bureau Federation. Do you know what the difference is, the underlying differences between them?

Mrs. EVANSON. I would say, and I do not think I am in a position to speak for Mr. Patton—

The CHAIRMAN. If you are not in a position to speak, this is an irrelevant point, it seems to me. We should not go into such details as that unless you are prepared to answer from your own knowledge.

Mrs. EVANSON. I would not want to speak for Mr. Patton.

Senator DONNELL. I agree with the chairman as to part of his statement, namely, if you do not know of your own knowledge, I do not think you should answer, and I tried to make that clear in my question. I do not agree with his observation as to the relevancy of this.

The CHAIRMAN. If you consider that relevant—

Senator DONNELL. She says she does not.

Mrs. EVANSON. I can speak as far as the health program is concerned, of course. The Farm Federation, the Farm Bureau, and you very likely know their stand, but they do not believe in compulsory health insurance.

Senator DONNELL. That was not just what I referred to. What I wanted to get at, I understand that you are not informed on this, and if you are not, I certainly do not want you to try to answer it. I wanted to know what the underlying differences are between the National Farmers Union, and the Grange, and the Farm Bureau.

Mrs. EVANSON. I can give you my observation.

Senator DONNELL. If you know, all well and good; if you do not, I do want to ask you. I think the chairman is quite right, if you do not know.

Mrs. EVANSON. We believe in the security—

Senator DONNELL. That is, the National Farmers Union.

Mrs. EVANSON. In the security of the family type farm and a more satisfactory way of life for the farm family on the land.

Senator DONNELL. Does the Grange believe in the same thing?

Mrs. EVANSON. I think the Grange is very much socialistic, that is, I mean it is more of a brotherhood fellowship society. I do not know too much of their stand. I think the Farm Bureau—and this is my observation—I think the Farm Bureau works among the people, the larger landowners, and are concerned about them. Of course, this is just my own personal observation as I have seen it. We are working for the small family type farmer, and the general welfare, always is considered in whatever program we take up.

Senator DONNELL. How long have you been employed by the Farmers Union?

Mrs. EVANSON. Since 1940.

Senator DONNELL. Since 1940?

Mrs. EVANSON. Yes.

Senator DONNELL. About in the neighborhood of 6 years; is that right?

Mrs. EVANSON. Yes.

Senator DONNELL. Full time all of that time?

Mrs. EVANSON. Yes.

The CHAIRMAN. You dwelt to some extent upon the difficulty of sick people sometimes in getting medical care.

Mrs. EVANSON. Yes.

The CHAIRMAN. Where they lacked the funds to pay for them.

Mrs. EVANSON. That is right.

The CHAIRMAN. That is not necessarily a reflection on the medical profession; they have to make a living.

Mrs. EVANSON. That is right.

The CHAIRMAN. Under our system, they have to raise their families and feed their children and clothe them and send them to college.

Mrs. EVANSON. That is right.

The CHAIRMAN. And they cannot afford to take medical cases unless they are going to be paid for them.

Mrs. EVANSON. That is true.

The CHAIRMAN. Of course, the experiences that you have related here could be found in every section of the United States. I do not believe there is anyone of any means in any community that has not at some time been compelled to guarantee the payment of medical care or hospitalization. I know I have had that experience, and I do not think it is any necessary reflection on the doctor. He has to get his money under that system, but we are trying to get away from that kind of system. You have been examined here very carefully today. In the questions there has been detailed to you the difference between compulsory health insurance and voluntary health insurance, and you believe that the compulsory system is the only system that will enable us to get the kind of medical care that we must have if we are going to take care of this problem in the United States.

Mrs. EVANSON. I have seen, Senator, too much of indifference on the part of parents where children have suffered needlessly because their parents did not have the money, but in many cases were indifferent. They will grow out of it, they said. I have seen too much of that.

The CHAIRMAN. They are afraid that the case does not need the attention at the time and they are willing to take chances on the child recovering whereas if we had a compulsory system, it would be very simple for the child to be examined and there would be no great burden upon the doctor to look at the child and to determine whether or not it needed care.

So it seems to me that the only question involved here in this hearing is the provisions which we undertake to put this system into effect. You are not a lawyer, I take it.

Mrs. EVANSON. No; I am a farm wife.

The CHAIRMAN. You have no extensive legislative experience and are not familiar with the proper legislative phraseology.

Mrs. EVANSON. That is right.

The CHAIRMAN. So you are not attempting to pass on the particular provisions of the bill.

Mrs. EVANSON. No.

The CHAIRMAN. But you are approving the President's program.

Mrs. EVANSON. That is right.

The CHAIRMAN. And you are approving this bill because the President has indicated that he is back of it, and that this is intended to implement his program.

Mrs. EVANSON. That is right.

The CHAIRMAN. And give to the American people a compulsory health insurance system.

Mrs. EVANSON. That is right.

The CHAIRMAN. Thank you very much.

The next witness will be Dr. Harold Aaron.

You may state your name and the organization that you represent, Dr. Aaron.

STATEMENT BY DR. HAROLD AARON, M. D.

Dr. AARON. I am Harold Aaron, M. D. I appear here as the medical adviser of Consumers Union of United States, a nonprofit organization supplying technical information on goods and services to more than 100,000 American families. I am a family practitioner and have practiced medicine in hospitals and clinics as well as in private practice since 1929.

I am a fellow of the American Medical Association; fellow of the New York Academy of Medicine; diplomate of the American Board of Internal Medicine; and associate of the American College of Physicians. I have contributed to medical literature and have written articles and books for the layman. I have been medical adviser to Consumers Union of United States since 1938 and write regularly for its publications.

In this statement I shall confine myself to observations on title II of the National Health Act of 1945, Senate bill S. 1606, since that part of the bill deals with "personal health service benefits," a subject which I believe I am qualified to discuss. I am particularly interested in section 205 which establishes methods and policies for administration of personal health services in a system of prepayment compulsory insurance. Part (f) of this section prescribes that—

The methods of administration * * * shall * * * encourage high standards in the quality of services furnished as benefits * * * through the adequacy of payments to practitioners, assistance in their use of opportunities for postgraduate study, coordination among the services furnished by general or family practitioners, specialists and consultants, laboratory and other auxiliary services * * *.

S. 1606 WOULD PROMOTE HIGH QUALITY OF MEDICAL CARE

Everyone will agree that any system of paying for medical-care costs should "encourage high standards in the quality of services furnished." The American Medical Association contends that present-day methods of payment—that is, fee-for-service and voluntary sickness insurance plans—enable most people to obtain high quality medical care. It has been my experience that our present methods of payment for medical care are a serious barrier to high quality services for the majority of the people and I believe that a system of prepayment compulsory health insurance, as set forth in title II of this bill, would remove or lower this barrier.

As medical science advances, it becomes more and more important to coordinate the services of family practitioners, specialists, laboratories, and hospitals. High quality medical care cannot be obtained

without such coordinated services. However, employment of specialists, consultants, laboratory, and other services cost money—more money than most people can afford to pay. And that is one reason—and a very important one—why most people do not obtain high quality medical care at the present time.

I have with me a few case reports from the hundreds in my files which illustrate how essential coordinated services are for high quality medical care and how difficult or impossible it is for the average person to purchase such services under present methods of payment. Here is one such case:

Mr. C, a teacher, has a wife and two children and earns \$70 a week. He came to me on November 10, 1945, complaining that he had been suffering from bad headaches for 2 months and that they were interfering with his work. He had already tried aspirin and a variety of patent headache remedies without success. As a first step, I gave him a thorough physical examination; among other things, I checked his eyes, sinuses, and reflexes; examined his heart and lungs through a fluoroscope, and tested his blood and urine. But I could find no obvious cause for the headaches. I prescribed a medicine for symptomatic relief, gave him general directions about diet and rest; and hoped that the headaches would respond to such a regimen. He failed to obtain any relief, however, and I was compelled to refer him to various specialists who could give him the special tests and services essential to modern medical diagnosis.

I referred him to an otorhinolaryngologist who irrigated his maxillary (cheek bone) sinuses but found no infection to account for the headaches. He suggested an X-ray study of all the sinuses to disclose a possible focus of infection. The X-rays were taken by a roentgenologist who reported that they showed no disease anywhere in the sinuses. Having eliminated the sinuses as a cause, and with the headaches as severe as ever, I referred him to an oculist, who, after thorough examination, found no disorder of the eyes to account for the headaches. Since disease of the brain and its surrounding structures is an important cause of headaches, I then referred him to a neurologist who, after a routine neuropsychiatric examination, recommended an X-ray study of the skull and the cervical spine of the neck. He returned to the roentgenologist who found in an X-ray of the spine, changes indicative of an inflammatory process. I recommended application of heat, massage, and exercises of the neck. After 2 weeks of such treatment the headaches were still unrelieved. I then referred Mr. C to radiotherapist for a series of X-ray treatments of the spine, a mode of therapy that is frequently successful in relieving headaches due to "arthritis" of the spine. This treatment finally succeeded in relieving the headaches.

The tabulated cost of specialist and X-ray services for Mr. C was as follows:

Otorhinolaryngologist -----	\$15
Oculist -----	15
Neurologist -----	25
Roentgenologist:	
Sinuses -----	15
Skull and spine-----	30
Radiotherapist (6 treatments) -----	60

Mr. C has spent a total of \$160 for these special consultations and services—services that were necessary for the diagnosis and treatment of a single common ailment. His total expenditure during 1945 for medical care for himself and his family amounted to \$235. If some member of the family had needed an operation, had been afflicted by a chronic disease or had needed a protracted series of inoculations, such as those for hayfever, the expenditure would have been much greater. I cite Mr. C's case as an example of what is often involved in good medical care and to show why, under the present methods of payment, it is beyond the means of most people.

More common than the type of case cited are those instances where the family income does not permit the purchase of specialist and other services. Mr. G, another case in my records, whose income was \$3,000 a year, put off consulting me because he was in debt and felt he couldn't afford any doctor bills. When he could put it off no longer and came to my office, a history and physical examination disclosed that he was suffering from severe and far advanced stomach ulcer. He died after an emergency operation for a penetrating duodenal ulcer. His death was almost certainly unnecessary since early diagnosis would have permitted effective treatment.

I am sure that the records of almost every physician will show such cases. And there are far too many cases where the lack of timely medical care resulted in chronic ailments and disability at a high cost to the American people.

VOLUNTARY PLANS COVER ONLY PART OF THE COSTS

The American Medical Association concedes that most families—that is, those earning less than \$3,000 a year—require help in meeting the costs of surgical or catastrophic illness and proposes voluntary insurance plans as a method of meeting these costs. It is true that voluntary insurance plans are available and that they would pay for at least part of the cost of care in a hospital. But these plans would not pay for any of the costs that Mr. C, for example, had to bear during the year in getting treatment for himself and his family.

I might point out that Mr. C belongs to the Associated Hospital Service plan or the Blue Cross. He pays \$26 a year for which he and his family are protected against part of the costs of hospitalization. But the plan does not pay physicians' and surgeons' fees in either hospital, office, or home. And he would get no help in paying for a diagnostic survey by specialists either in or out of the hospital.

Mr. C also subscribes to the United Medical Service, Inc., a plan sponsored by the New York County Medical Society. He pays a premium of \$25 a year for which he and his family would receive limited care by a general practitioner while hospitalized, as well as maternity care and major surgery up to \$150. There is no provision for care during the first 3 days of any hospital admission, or for diagnostic tests or use of specialist and consultant services. If a major operation such as gastrectomy were performed, he would receive \$150 toward the fee, which might be anywhere from \$300 to \$500 for a person with moderate income. And, of course, the policy would not pay for the diagnosis and treatment of the many common illnesses that do not ordinarily require hospital care and which com-

prise the majority of all illnesses. Dr. Roger Lee, president of the American Medical Association, in his book, *The Fundamentals of Good Medical Care*, published by the committee on the costs of medical care in 1933, estimated that less than 15 percent of a physician's services are given in a hospital. Today with penicillin and the sulfanilamides available the percentages of illness that can be adequately treated at home or in the office is much greater. But the voluntary prepayment sickness insurance plans do not help the patient pay for such services at home or in the doctor's office. Nor do these plans make it possible for him to obtain a periodic physical examination or a doctor's services during early stages of illness or before serious symptoms set in. In other words, voluntary plans not only fail to meet the cost of ordinary illness, which as I have already shown can be very high, but they would not promote preventive medicine.

Mr. C paid \$51 for voluntary insurance policies in 1945. During that same year he had to pay an additional \$235 for services for common ailments because they were not covered by these policies. For the diagnosis and treatment of his headaches alone he had to pay \$160 or more than three times the cost of his voluntary insurance plans. There are few American families that can afford such a high price for good medical care. Mr. C is financially well off compared with most families. His earnings of \$3,600 a year are greater than those of most wage earners. Many of my patients are low-income working people, and I know that they cannot pay for coordinated services of specialists, consultants, and laboratories without great financial sacrifice. Many put off going to doctors because of the cost of the services. They cannot go to a hospital clinic for a diagnostic survey unless they prove indigence and comply with the residence requirements set up by most hospitals for clinic care.

It is a significant fact that in a city such as New York with the largest number of practitioners, specialists, and hospitals in the world, a high percentage of its population does not get high-quality medical care. It is true that indigent families can get care in clinics and in hospital wards but with these families the care ceases when they get home from the hospital, and clinic doctors do not make home calls. (It is not difficult to visualize the quality of care received by the population in other cities and in rural areas, which are far less plentifully supplied with doctors and hospitals than is the city of New York.)

FINANCIAL BARRIER TO ADEQUATE MEDICAL CARE

Most wage earners and many professional people cannot afford to buy high-quality medical care on the usual fee-for-service basis. Nor can they afford to pay \$51 a year for a voluntary sickness insurance policy which provides such limited protection. It is clear, therefore, that present methods of payment for medical service and present voluntary insurance schemes do not make it possible for most families to obtain that coordination of services by family practitioners, specialists, laboratory, and other auxiliary services, without which high-quality medical care is impossible.

In common with an ever-increasing number of physicians, I am convinced that high-quality medical care can be obtained only if the

financial barrier to such care is removed by a system of prepayment compulsory insurance. If S. 1606 is enacted into law, Mr. C and the great majority of American families could obtain all the services necessary for high-quality care at a price that they could afford to pay. If the total tax on salaries and wages were 3 percent as suggested in the bill, Mr. C would pay 1½ percent or \$54 a year for complete medical care by a physician of his choice. He would be able to obtain diagnostic, specialist, and laboratory services for all common and serious ailments in home, office, and hospital for the same money. He would not have to pay \$235 a year again for high-quality care. By distributing the costs of sickness over the entire population, the magic of averages would save millions of families from serious financial crises when illness strikes and would enable most families who do not now get high-quality medical care to obtain such care for the first time.

Senator DONNELL. Doctor, you are the medical adviser of Consumers Union of the United States?

Dr. AARON. Yes, sir.

Senator DONNELL. What is that organization?

Dr. AARON. A technical organization, nonprofit, which supplies information on goods and services to those who subscribe or belong to the organization.

Senator DONNELL. Who subscribe or belong to it?

Dr. AARON. That usually means both.

Senator DONNELL. Is it a corporation?

Dr. AARON. If I am not mistaken, it is incorporated in the State of New York.

Senator DONNELL. And when was it organized?

Dr. AARON. Well, I came into the organization in 1938. I believe it was organized in 1936.

Senator DONNELL. Do you know how many persons either subscribe or belong to it?

Dr. AARON. At the present time, about 105,000 people subscribe to it, or families, if you will.

Senator DONNELL. By "subscribe," do you mean they subscribe money to it?

Dr. AARON. They pay for a membership in the plan, in the union, for which they get a bulletin; a monthly report.

Senator DONNELL. What is the annual charge that the subscribers pay?

Dr. AARON. It varies from \$4 to \$5. When you come in in a group, I think it is \$3.50. I think if you do not come in with a group it is about \$4 or \$4.50. I am not altogether sure of the exact figure.

Senator DONNELL. So there is an annual income of this organization of somewhere in the neighborhood of \$425,000, is that right?

Dr. AARON. Approximately; yes, sir.

Senator DONNELL. Who are the officers of that organization, Doctor?

Dr. AARON. Well, I do not have a statement of all of the officers. I have a list of the executive committee which authorized me to appear here.

Senator DONNELL. Will you tell us who is on that committee?

Dr. AARON. Myself; Dr. Frank Beube, who is a dentist, an assistant professor of dentistry at the College of Physicians and Surgeons

of Columbia University; Mr. Jerome H. Hellerstein, an attorney; Dr. Emanuel Klein, a psychiatrist, formerly on the New York Psychiatric Board; Dr. Edward Reich, who is an educator; Mr. Bernard Reis, a certified public accountant, and executive secretary of the American Investors' Union; Miss Adelaid Schulkind, the League for Mutual Aid; Dr. Colston E. Warne, professor at Connecticut College; Arthur Kallet; and Miss Madeline Ross.

Senator DONNELL. What is the address of the organization?

Dr. AARON. 17 Union Square, West.

Senator DONNELL. You say you are authorized and directed, I take it, by this executive board to come here to testify?

Dr. AARON. The executive committee of the board.

Senator DONNELL. And that consists of these ladies and gentlemen that you have mentioned there?

Dr. AARON. That is right.

Senator DONNELL. How many on there, about 10, is it?

Dr. AARON. Ten.

Senator DONNELL. Do you know whether or not the organization holds meetings or conventions of its members or delegates?

Dr. AARON. We have a yearly convention.

Senator DONNELL. When was the most recent one held?

Dr. AARON. The most recent one was held in June of last year.

Senator DONNELL. Of 1945?

Dr. AARON. Yes.

Senator DONNELL. Where was that held?

Dr. AARON. That was held in, let me see, my memory is playing me tricks. I think it was in New York City, the New School of Social Research.

Senator DONNELL. Approximately how many people attended it?

Dr. AARON. I do not know. Approximately about 50 or 60. It was a very hot day.

Senator DONNELL. Fifty or sixty people?

Dr. AARON. Yes.

Senator DONNELL. And they represented this approximately 105,000 members?

Dr. AARON. No. They did not represent these 105,000 members. We get the will of the 105,000 members through an annual questionnaire which we send to all of our members every year, asking them for their opinion about the services, the way we have been giving them service, what criticism they have, and so on. And we tabulate the answers; that is, the questions and the answers, and we also tabulate at the same time their votes for members of the board. That represents the opinion of the membership.

Senator DONNELL. Well, now, these approximately 50 people who came together in May, you say it was?

Dr. AARON. About June.

Senator DONNELL. Of 1945, how were they selected?

Dr. AARON. They were not selected. They were invited. The membership is invited to attend our annual meeting, through our statement in the April and May issues of the reports, notifying the membership that there will be such a meeting, and by the statements sent out embodying questions and answers on products and services.

Senator DONNELL. And that invitation went to all of the members?

Dr. AARON. Yes.

Senator DONNELL. It would be about 105,000?

Dr. AARON. Last year it was not that many. At the time that we held our meeting, I think it was about 80,000.

Senator DONNELL. About 80,000?

Dr. AARON. Yes.

Senator DONNELL. Well, then, that invitation went to about 80,000 people?

Dr. AARON. Yes.

Senator DONNELL. And 50 or thereabouts came?

Dr. AARON. About 50.

Senator DONNELL. You say it was a very hot day?

Dr. AARON. Yes, sir.

Senator DONNELL. That held down the attendance, you think, to some extent?

Dr. AARON. Surely.

Senator DONNELL. Did these 50 people come from far distances, or were they, in the main, from New York City?

Dr. AARON. I have no way of knowing.

Senator DONNELL. Well, if they came from very far off, the heat on that particular day would not have had very much to do with it?

Dr. AARON. Probably so.

Senator DONNELL. It would appear reasonable that most of them came from New York City, would it not?

Dr. AARON. I am not sure.

Senator DONNELL. Were you there?

Dr. AARON. Yes, sir.

Senator DONNELL. Where did they hold that meeting?

Dr. AARON. New School for Social Research at the Auditorium.

Senator DONNELL. Were any resolutions passed there at that time by those 50 people?

Dr. AARON. No, none with respect to this health measure, if that is what you are asking, Senator.

Senator DONNELL. Has the executive board of 10 persons passed any resolutions with respect to S. 1606?

Dr. AARON. No resolutions were passed, because they are all in favor of it and have said so in the discussion that preceded my delegation to come here to speak.

Senator DONNELL. How are these 10 people selected, this executive board?

Dr. AARON. By the board of directors.

Senator DONNELL. By the board of directors?

Dr. AARON. By the larger group, the board of directors.

Senator DONNELL. How many people on the board?

Dr. AARON. I would say about 20. About 18 or 20.

Senator DONNELL. How is the board of directors of about 20 selected?

Dr. AARON. By the membership.

Senator DONNELL. By the membership of 105,000 now?

Dr. AARON. That is right.

Senator DONNELL. And how often are these board of directors selected?

Dr. AARON. Every year there is an election.

Senator DONNELL. An election?

Dr. AARON. For 3 years.

Senator DONNELL. And that is an election held by mail?

Dr. AARON. By mail.

Senator DONNELL. Of the whole membership?

Dr. AARON. That is right.

Senator DONNELL. These 20 that are on the board of directors, are they all located in New York City?

Dr. AARON. No, sir.

Senator DONNELL. How many of them are in New York City?

Dr. AARON. I have no way—I do not know the exact percent, the proportion. I should say that probably the majority are from New York City. We have to hold our meetings in New York, because that is where the organization is located.

Senator DONNELL. Then this board, the larger board of the two, the 20, selects the smaller board, the board of 10?

Dr. AARON. Right.

Senator DONNELL. That is the board of 10, it is that board that has directed you to come here?

Dr. AARON. Right.

Senator DONNELL. Doctor, I wanted to ask you just one or two other questions.

You spoke in your testimony here about the New York County Medical Society. That is on page 3 of your testimony. About Mr. C. who subscribes to the United Medical Service, Inc., a plan sponsored by the New York County Medical Society.

Are you a member of that society?

Dr. AARON. Yes, sir.

Senator DONNELL. It contains approximately how many members?

Dr. AARON. Oh, I think, about 6,000, six or seven thousand.

Senator DONNELL. Do you know whether or not, in May 1941, there were approximately 7,848 practitioners in the Borough of Manhattan?

Dr. AARON. There probably were.

Senator DONNELL. Do you know whether or not all of the practitioners in the Borough of Manhattan belong to the New York County Medical Society?

Dr. AARON. No, sir; only half belong.

Senator DONNELL. Only half belong?

Dr. AARON. Yes, sir. That is, on the average. Over these past few years, I have an idea, based on reading of statements by the Comitia Minora, the membership of the county society, that about half of the total practicing physicians in Manhattan County belong to the county society.

Senator DONNELL. And you think, then, that there are about 6,000 that now belong to the society?

Dr. AARON. I think, with the return of the veterans and so on, it amounts to about six, possibly seven thousand.

Senator DONNELL. Did you attend a meeting of the New York County Medical Society held on the evening of April 22, a few years ago?

Dr. AARON. Yes, sir.

Senator DONNELL. You spoke about the Comitia Minora; that body proposed a resolution at that meeting, did it not?

Dr. AARON. Yes, sir.

Senator DONNELL. In the resolution, it

"declared that the compulsory health insurance feature of the Wagner-Murray-Dingell bill was "contrary to our national spirit and traditions of self-government."

That is correct, is it not?

Dr. AARON. That is right.

Senator DONNELL. There ensued a lively debate over that subject?

Dr. AARON. Yes, there did.

Senator DONNELL. The resolution was adopted by a vote of 503 to 152?

Dr. AARON. My figures were 502 to 154. I was the teller.

Senator DONNELL. You were a teller?

Dr. AARON. Yes, 502 to 154.

Senator DONNELL. I am glad to get it right, Doctor.

Dr. AARON. Yes, sir.

Senator DONNELL. At this meeting, I will ask you to state whether or not the resolution condemned the proposal on the ground that it would—

"obliterate local community initiative and responsibility in matters of health and medical care, promote decentralization of power, particularly the taxing and controlling power of the National Government and create a gigantic self-perpetrating bureaucratic machine that will inevitably become the master rather than the servant of the people.

Dr. AARON. Those are very familiar words.

Senator DONNELL. And those were the words, substantially, in that resolution, were they; is that right?

Dr. AARON. Yes, sir.

Senator DONNELL. And did the resolution, also point 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; is that right?

Dr. AARON. That is.

Senator DONNELL. That was in the resolution?

Dr. AARON. Yes, sir.

Senator DONNELL. I will ask you whether or not there were several addresses delivered before the National Physicians Committee for the Extension of Medical Service meeting at the Waldorf Astoria Hotel, on the same evening. Do you know about that?

Dr. AARON. I read about it.

Senator DONNELL. You were not there?

Dr. AARON. I was not there.

Senator DONNELL. We will not ask you about that, then.

You do know Dr. Schwitalla; do you know, of St. Louis?

Dr. AARON. I think he is a member of the board of trustees of the American Medical Association.

Senator DONNELL. I am not certain. He possibly is; I should not be surprised. He is dean of the St. Louis University School of Medicine, you know, and you know of him by reputation?

Dr. AARON. Yes, sir.

Senator DONNELL. And Dr. Cary of Dallas, a former president of the American Medical Association, and now the president, I believe,

of the National Physicians Committee. You know him by reputation, do you?

Dr. AARON. I know his name, but I do not know what kind of a reputation he has.

Senator DONNELL. I mean, you know the man. You know him by reputation, I say, regardless?

Dr. AARON. I know him by reputation in that he is identified with the ruling policies of the American Medical Association.

Senator DONNELL. You have heard of Dr. Morris Fishbein, editor of the Journal of the American Medical Association?

Dr. AARON. Yes, sir.

Senator DONNELL. Would you tell us, please, whether or not your organization has had any polls of its membership on the subject of S. 1606?

Dr. AARON. No, sir.

Senator DONNELL. They have not had any polls on that subject?

Dr. AARON. No, sir.

Senator DONNELL. Has there been any poll with respect to S. 1050, the larger Wagner-Murray-Dingell bill?

Dr. AARON. I think I can give you an idea, Senator, of what our members feel about compulsory health insurance.

Senator DONNELL. Could you tell us, first, whether there has been a poll on S. 1050?

Dr. AARON. No, sir.

Senator DONNELL. Has there been a poll on S. 1161?

Dr. AARON. No, sir.

Senator DONNELL. Has there been any questionnaire sent out to them with respect to compulsory health insurance administered by the Federal Government?

Dr. AARON. No, sir.

Senator DONNELL. Well, then, has there been any other letter or inquiry made of them of any kind?

Dr. AARON. There has been.

Senator DONNELL. Asking their opinion as to the advisability of instituting compulsory national health insurance?

Dr. AARON. We have not sent out such a letter or poll or made such a poll or inquiry, but we have a pretty good idea of how; that is, how our members feel about health insurance. It is an inference, it is true, not a direct statement. It is an inference, and I think it is, therefore, appropriate to cite it. That, during the past 3 or 4 years, we have been publishing articles on the various Wagner-Murray-Dingell bills.

Last year I was up for nomination again as a board member for the Consumers Union, and I received the highest vote of all of the candidates.

They know—that is, the subscribers of our Consumers Union know—that I write the articles on health care.

Senator DONNELL. Are those signed articles?

Dr. AARON. Most of them are signed, yes, sir; and they know that I write those articles, and yet I think they indicated their confidence in my position in the organization and what I have said about health services by giving me the highest of all of the votes. Perhaps I should not say this; this may be confidential. I received more votes than the president of our organization.

Senator DONNELL. Who is the president?

Dr. AARON. Prof. Colston Warne.

Senator DONNELL. What was the date on which this vote was announced?

Dr. AARON. It was approximately, some time in June, at the time of the annual meeting.

Senator DONNELL. 1945?

Dr. AARON. Yes.

Senator DONNELL. That was long before S. 1606 was ever introduced into Congress; that is right, is it not?

Dr. AARON. Yes. It might, I think—one can make a plausible inference; it indicates that our subscribers were sympathetic, at least, to the point of view I expressed about the previous Wagner-Murray-Dingell bill, S. 1050.

Senator DONNELL. Have you confined your articles in this publication to that one subject?

Dr. AARON. No, sir; I have also written on general health subjects, such as common ailments of various kinds, such as hay fever, skin disorders, et cetera.

Senator DONNELL. And have you written those in language that was nontechnical, so that the average consumer could understand them?

Dr. AARON. Exactly, and I have always tied in these articles with the quality of medical care that was available. I have pointed out, for example, in discussing hay fever, or any common ailment that you wish, how important it is to get various coordinated services in order to get the highest quality of medical care for that particular ailment.

Senator DONNELL. In all of these articles, have you mentioned with approbation compulsory Federal health insurance?

Dr. AARON. Yes, sir; I have.

Senator DONNELL. In every one of them?

Dr. AARON. Practically every one of them.

Senator DONNELL. You have also discussed these various other matters, too; that is, the matters of disease, et cetera, as you have mentioned; is that right?

Dr. AARON. Surely. I do not think they are separable, as a matter of fact.

Senator DONNELL. How many such articles had you sent out prior to June, the June date, in 1945, when this vote was announced?

Dr. AARON. From 1938 until 1945 I have published an article every month practically, excepting the November issue, which is a Christmas issue, and we discuss mainly products that are available for the Christmas season.

Senator DONNELL. Doctor, it may well be that your readers were attracted not only by your discussion of the compulsory health insurance, but also by your general views expressed in these articles; that is true, is it not?

Dr. AARON. It certainly is.

Senator DONNELL. And the combination of their admiration for and regard for you as derived in large part from their knowledge of you in these articles, you think, contributed in very large part to the large vote you secured?

Dr. AARON. Contributed to a considerable extent. I do not know what percent.

Senator DONNELL. Do you know how many votes were cast for you?

Dr. AARON. Yes, sir. There were about 12,000. I do not know the exact number.

Senator DONNELL. At any rate, there has been no poll or vote of any kind—

Dr. AARON. No, sir.

Senator DONNELL. Expressly on the subject of compulsory health insurance?

Dr. AARON. We plan to do it.

Senator DONNELL. By your membership?

Dr. AARON. No. We plan to do it.

Senator DONNELL. That is all.

The CHAIRMAN. Does your organization advise its members with reference to misrepresentation of goods or services?

Dr. AARON. Yes, sir, we do.

The CHAIRMAN. You will analyze any product and the advertisement in connection with it and advise your members?

Dr. AARON. We do, sir.

The CHAIRMAN. Have you had letters from members of your organization inquiring about national health service?

Dr. AARON. We have had letters from doctors. We have a considerable number of doctor subscribers, and I would say almost 90 to 95 percent of all of the letters from doctors, which this year amount to a grand total of 10, I should say, 9 out of 10 letters have disapproved of our stand on compulsory health insurance. However, almost unanimously the letters from nonphysician subscribers have approved of our stand and have, in addition, cited instances in which, because of the present methods of payment for medical costs, they have not been able to obtain good medical care and we often get letters from the subscribers asking us: "Where can I get treatment for this arthritis? I have been to my doctor. He has given me a series of injections and now he has thrown up his hands. What can I do about it?"

We have letter after letter of such in our files and, unfortunately, we are not allowed to give; that is, to make recommendations about medical care to our subscribers. We have to give them general information. We tell them that if they cannot get such coordinated, high quality service from their own physician, they will have to seek it elsewhere in a clinic or a large university medical center.

The CHAIRMAN. Are you acquainted with an organization known as the National Physicians Committee, which is affiliated with the American Medical Association?

Dr. AARON. Yes, sir.

The CHAIRMAN. That organization carries on a campaign of so-called education in connection with this problem of national health care?

Dr. AARON. Yes, sir; right.

The CHAIRMAN. Are you familiar with their publications?

Dr. AARON. Yes, sir.

The CHAIRMAN. What do you think of them with reference to whether or not they give a fair and honest interpretation of the program?

Dr. AARON. I think they give a complete misrepresentation of the purposes, aims, and scope of S. 1606, and, particularly, title II, dealing with compulsory health insurance.

I remember, for example, one statement that appeared in the New York County Medical Society's bulletin which said that the bill will not provide for the indigent, and we sent a letter to the county society, but it did not consider it fit to publish the letter, pointing out that the indigent are cared for through contracts with local agencies, local, State, and county agencies.

I am familiar with other publications of the National Physicians Committee, and I know that in almost every page there is some bit of misrepresentation or distortion of the actual facts.

The CHAIRMAN. That is all. Thank you.

Senator DONNELL. Do you know, Doctor Kaufman, who testified a day or so ago?

Dr. AARON. No, sir.

Senator DONNELL. You are not acquainted with him?

Dr. AARON. No, sir.

Senator DONNELL. Very well.

The CHAIRMAN. You also are acquainted with Dr. Allan Butler, of Harvard?

Dr. AARON. Yes, sir; he is a very distinguished physician. He has made many contributions to medical science, as well as to the social thought of those few doctors who will listen to him.

The CHAIRMAN. Is it your impression that there is quite a wide membership, quite an extensive membership, in the American Medical Association who are not in accord with the policy of the American Medical Association in sponsoring this program of the National Physicians Committee?

Dr. AARON. I do not know how high a percentage that is, Senator Murray.

I do know this, that from my experience and work with other doctors, they are so busy in practice, that they really do not have the time to sit down and read S. 1606.

I know it is a fact that the Comitia Minora, of the New York Medical Society, which framed this resolution which was passed on Monday, many of the members admitted that they did not read S. 1606, and if the Comitia Minora, which deals with the important function of providing policy for its society, does not read the bill which it is condemning, I assure you that the rank and file of doctors, who are busy and have not yet been influenced through the county and medical societies, to the need for studying the social aspects of medicine, I assure you that the bulk are not familiar with the bill, either.

The CHAIRMAN. How does the language of that resolution there compare with the general language of the National Physicians Committee?

Dr. AARON. I think it was copied from one of the pamphlets of the National Physicians Committee.

The CHAIRMAN. As you say, many of these practitioners are so busily engaged with their practice, they do not have the time to make a careful study of the bill?

Dr. AARON. Yes, sir.

The CHAIRMAN. That is all.

Thank you very much, Doctor.

We will recess until tomorrow morning at 10 o'clock.

(Thereupon, at 5 p. m., Thursday, April 25, 1946, the committee recessed until Friday, April 26, 1946, at 10 a. m.)

NATIONAL HEALTH PROGRAM

FRIDAY, APRIL 26, 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, Smith, and Donnell.

The CHAIRMAN. The hearing will come to order.

I ask to have incorporated in the record a statement on behalf of the Coordinating Council of the five medical societies in greater New York.

(The statement referred to is as follows:)

THE COORDINATING COUNCIL OF THE
MEDICAL SOCIETIES OF THE COUNTIES OF
BRONX, KINGS, NEW YORK, QUEENS, AND RICHMOND,
New York, April 24, 1946.

Senator JAMES E. MURRAY,

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

MY DEAR SENATOR MURRAY: The attached statement on S. 1606 is respectfully presented to you by the undersigned, on behalf of the Coordinating Council of the Five County Medical Societies of Greater New York, representing 15,000 practicing physicians in this city.

We shall appreciate your admitting this statement to the record of your committee in whatever method may be advisable. We would appreciate also the privilege of designating a representative of the council to appear before your committee with reference to this statement.

Sincerely yours,

WILLIAM B. RAWLS, M. D.,
Chairman, Coordinating Council.

ROY B. HENLINE, M. D.,

President, Medical Society of the County of New York.

FRANK LAGATTUTA, M. D.,

President, Medical Society of the County of Bronx.

TURMAN B. GIVAN, M. D.,

President, Medical Society of the County of Kings.

VINCENT JUSTER, M. D.,

President, Medical Society of the County of Queens.

MILTON S. LLOYD, M. D.,

President, Medical Society of the County of Richmond.

STATEMENT TO BE PRESENTED BEFORE SENATE COMMITTEE ON EDUCATION AND LABOR ON SENATE BILL 1606

The Coordinating Council of the Five County Medical Societies of the city of New York, representing more than 15,000 practicing physicians, desires to state its position relative to the proposal for national compulsory sickness insurance embodied in the Senate bill 1606.

The fundamental purpose of the organized medical profession is to furnish the highest quality of medical care to every citizen. Under a freely evolving voluntary system of medical care the American medical profession has provided

better medical care to the people of the United States than is available to any other people in the world.

The proposed program for national compulsory sickness insurance would necessarily involve a Nation-wide system of control and supervision over a profession which has distinguished itself for social responsibility and self-discipline.

No proof has been or can be produced to show that a federally controlled plan of national sickness insurance would improve the quality of medical care for the people.

On the contrary, the quality and effectiveness of medical care would inevitably deteriorate as a result of its subjection to the requirements and regulations of lay administrators who, at best, would be incompetent to administer professional matters, and at worst would be antagonistic to the medical practitioners serving under this program.

We would respectfully call the attention of your committee to the impressive progress now being made in all parts of the United States in the development of hospital and medical care insurance plans on a voluntary nonprofit basis. The medical profession, through the American Medical Association, has recently taken steps to correlate all these programs operating throughout the United States and to stimulate their development and public acceptance of them. Despite substantial progress, these plans are still in the early stages of development. They have been shown, during the past decade of trial and error, to be actuarially sound, and they are meeting the admitted social and economic need for protection of lower-income families against the devastating effects of unexpected serious or prolonged illness or disability.

These voluntary medical and hospital insurance plans are not represented to you as a comprehensive health and medical program. On the contrary, they represent a specific remedy for a major well-defined shortcoming in our existing system of medical care, namely, the need for protecting citizens and their families against the economic consequences of catastrophic illness. The voluntary hospital and medical program meets this need with the least possible interference with the traditional plan of medical service. These voluntary plans also offer the great advantage of flexibility and diversity, so that not only are they susceptible of continuous improvement and extension but also they are most easily adaptable to the peculiar needs and conditions found in various sections of the country.

To impose a nationally controlled uniform program of medical and hospital care upon this rapidly evolving, adaptable, and flexible program of voluntary action would be premature and might well prove disastrous to the development of an indigenous comprehensive medical care plan for the United States.

The citizens of the United States should be given an opportunity to weigh carefully the broader issues involved in the proposals for national compulsory sickness insurance in Senate bill 1606. In particular, they should consider with the utmost care the implications of this measure in respect to the basic democratic theories as to the relationship between the individual citizen and the Federal Government. The idea of security at any cost is derived chiefly from those European nations which have preferred security to freedom and have been willing to sacrifice the former for the sake of the latter. The plan embodied in this bill represents an encroachment by the Federal Government upon functions and responsibilities which have been traditionally reserved by the people in the several States to themselves and their local governments. Our democratic traditions have always required the maintenance of the principle of local autonomy in community government.

Furthermore, as one of the most eminent authorities in public health in the United States has recently reminded us (Wilson G. Smillie, M. D., Journal A. M. A., vol. 128, No. 14, Aug. 4, 1945) : "We are not a homogeneous but a diverse people. * * * No Nation-wide plan could be devised which would be flexible enough to suit all situations equally well." This point was emphasized by the committee on the cost of medical care whose majority reported in 1929 that "The problem is complicated and differs from one region to another. No panacea is available; no solution is applicable today to all areas of the country."

The provisions of this bill that would establish national compulsory sickness insurance, introduced a wholly new concept of the proper function of the Federal Government in the field of health and medical care. Although the bill asserts the principle of local autonomy in administration, it provides that the collection and disbursement of funds shall be a function of the Federal Government. Hence, the autonomy existing in any locality will be dependent upon the sufferance of

the Federal disbursing agency. The necessities and exigencies of administration of such a plan on a national scale would inevitably produce an irresistible and accelerating tendency toward uniform regulations and practices for the entire country and increasing centralization of management and control in the hands of the national authorities. To argue to the contrary, we submit, runs counter to all experience in comparable matters.

We would call your attention to the fact that we have avoided, in this presentation, the use of the term "health insurance." Although the proposals under consideration by your committee are frequently referred to as "health insurance" we assert that this term is a misnomer. No measure of this kind has ever insured, nor can it ever insure, better levels of individual health. The relative frequency and severity of sickness among the lower income classes is quite as marked in countries where sickness insurance has long been on the statute books as in those countries which do not have such legislation. In England, for example, the average number of days lost by sickness among the insured population increased steadily and rapidly during the first years of insurance and it has not declined since.

Moreover, "health insurance" is insupportable as insurance. In nearly every case the funds derived by pay-roll taxation as premiums for the program have had to be supplemented by direct subsidy from the State.

Although it is claimed for compulsory sickness insurance that it will encourage preventive medicine, actually no compulsory sickness insurance system has ever seriously proposed regular comprehensive health examinations. The cost would be prohibitive. Moreover, experience shows that few insured persons actually seek medical care early in case of threatened illness, in spite of the lack of the "financial barrier" to such care. There is evidence in some instances of a general lack of confidence in the judgment of physicians practicing under the Government plan.

Compulsory sickness insurance on a national scale as here proposed is, at best, an experiment on an unprecedented scale, both as to the geographic extent of the plan and the scope of services to be rendered. As an experiment it would presume to supplant an existing system which is constantly evolving new and better forms of service and which has produced benefits and values to the American people that are in many respects unequalled elsewhere in the world.

The Coordinating Council of the Five County Medical Societies of Greater New York approves in principle all the major recommendations of President Truman's recommended national health program, except for the proposal for national compulsory sickness insurance. The great majority of practicing physicians are strongly opposed to national compulsory sickness insurance because they believe it would be contrary to the interests of the public and the profession.

The CHAIRMAN. The first witness this morning is Hazel Corbin. Is Hazel Corbin here?

STATEMENT OF MISS HAZEL CORBIN, REGISTERED NURSE, GENERAL DIRECTOR, MATERNITY CENTER ASSOCIATION

The CHAIRMAN. Miss Corbin, will you state your name and the organization that you represent.

Miss CORBIN. Hazel Corbin, Maternity Center Association, New York.

The CHAIRMAN. Do you have a prepared statement you wish to follow?

Miss CORBIN. I have, Senator Murray.

The CHAIRMAN. You may proceed.

Senator DONNELL. Miss Corbin, do you have a copy of that for us to follow?

Miss CORBIN. I am sorry, I have not. I will leave this when I finish with it.

Senator DONNELL. That is all right.

MATERNAL DEATHS CAN BE ELIMINATED

MISS CORBIN. Maternity care in the United States is as varied as a patchwork quilt. The best obstetric services in the world are found here. Medical science has reduced needless deaths of mothers in childbirth to the vanishing point.

Amazing as it may seem, there were many obstetrical services last year in the best hospitals where maternal mortality was almost zero. These institutions had a wartime staff, and though depleted, they had experts in key positions in essential departments. They were well equipped and prepared to meet with the most modern facilities any emergency or need that might arise. These institutions did not accomplish this remarkable feat just once, but have been in the habit of producing maternal death rates of nearly zero for several years—and these improved death rates mean improved health rates—healthy mothers—happy homes. And let us never forget that where mortality is high, sickness rates, invalidism, morbidity is also high. Women cannot enjoy their family and make life happy unless they feel well.

The logical conclusion is that needless maternal death can be banished everywhere in the United States. That all mothers do not get good and safe and satisfying care is very evident. Last year nearly 200,000 women had no care from any qualified medical attendant whatsoever when their babies were born—and that was not just because of the war shortage of doctors. The maternal death rate in many communities and in some States is as high as the worst national rate ever recorded in our history. The latest Census Bureau statistics—that is, for the year 1943—show that New Mexico, Arizona, Colorado, and other States have maternal death rates far in excess of our national maternal death rate in 1936, which was then considered by statisticians as the highest among the civilized countries, with which we draw comparisons.

In Mississippi, New Mexico, and Texas the Negro maternal death rate was double that for the whites.

In Virginia and New Jersey it was three times the white rate. This is not evidence that Negro mothers are more prone to death in childbirth. On the contrary, in New York City during 1944, where 99 percent of all mothers were hospitalized, the maternal death rate for white mothers was 17 per 10,000 live births. For Negro mothers it was 21. You see, when good care is provided to Negro and white mothers alike the end result is nearly alike.

SENATOR DONNELL. Pardon me. May I ask you, Miss Corbin, in New York you say the relative figures were what?

MISS CORBIN. Seventeen and twenty-one.

SENATOR DONNELL. Seventeen and twenty-one.

MISS CORBIN. Per 10,000 live births.

SENATOR DONNELL. Oh, for 10,000. I see. Thank you.

MISS CORBIN. In one southern county, during 1944, the maternal death rate was 84 per 10,000 live births. One-third of all the mothers in the county—the poorest third—a large majority Negro—were delivered by nurse-midwives of the county health department. These nurse-midwives are public health nurses who have special training

in obstetrics. The material mortality for this group of mothers was exactly zero. The stillbirth rate for the county was 45.9 per 1,000 live births. For cases attended by nurse-midwives the stillbirth rate was only 14.

What better proof do we need of the dictum of the distinguished Dr. Herman M. Biggs that public health is purchasable? The safety and health of American mothers and their babies is purchasable.

It is essential to provide good maternity care to all, not on the basis of their ability to pay, of where they were born, of who they are, but rather on the basis of their need. Often Mrs. A who has no need for any special care is in a position to take advantage of the very best care available, while Mrs. B who is in urgent need of particularly skillful care, gets no care at all, or care that is so poor that we hate to think about it.

What is the care to which every American mother should be entitled?

She needs care by a doctor who is qualified by experience and training to care for a woman during pregnancy, labor, and delivery, and for the weeks that follow, until she is fully recovered.

She needs nursing care and instruction which will prepare her for her new role as mother and parent.

She needs access to special consultation services if complications develop.

She needs easy access to a bed in a hospital which has a separate maternity department with a separate staff and equipment to care for mother and baby every hour of the 24.

Her life and health and her baby's life and health are too important to risk in a poorly run, poorly staffed, ill equipped hospital, without sufficient control or supervision to make it a safe place for any woman to have her baby.

She needs an adequate diet so that when she goes into labor to do the hardest piece of work that a human body is ever called upon to do, she has physical stamina and reserve.

She needs access to the newest and best methods and drugs developed for her health and safety—the sulfas, penicillin, streptomycin, plasma, blood transfusions, X-ray pelvimetry—no matter what it costs.

Needless maternity deaths can never be wiped out unless and until all of these needs are met for every mother regardless of her financial status, in the slums of the big city, in the mountain fastnesses of the South and West or on the lonely prairie farm. To extend today's average mediocre maternity care to all mothers is not enough. That should never be the purpose of any sound public health legislation. We must make the best available everywhere. This does not mean marble halls or metal gadgets or a room with a view. It does mean adequately prepared and adequately paid doctors and nurses and others who provide the care, inside and outside of the hospital.

As far back as 1933, the famous maternal mortality study in New York City, conducted by the committee on public health relations of the Academy of Medicine, pointed out that two-thirds of all the deaths studied could have been prevented if the care of the mother had been proper in all respects. Nearly 62 percent of the needless deaths were ascribed to the physician.

The attendant failed to give proper care—
said the report—

Physical examination was careless and incomplete * * * the prognosis of delivery was frequently incorrect. Labor was often improperly conducted * * * attendants were tardy in obtaining proper consultation. There was failure to treat severe complications with all the means which should have been available * * *. The hazards of childbirth in New York City are greater than they need be. Responsibility for reducing them rests with the medical profession.

The medical profession took this challenge seriously and the standards of obstetric practice were vastly improved. Significantly, in 12 years the maternal death rate has been reduced by more than two-thirds in New York City. To be sure, New York's best maternity service ranks with the best in the world, but we must not confuse ourselves with the thought that every New York mother can have this best.

The New York Academy study was only one of a series of studies of maternal mortality made in the United States. All of them indicated that the wiping out of needless maternity deaths and injuries from our national mortality statistics was possible and practical. We had the facts and the figures. What was needed was a thoroughly integrated plan of action.

NECESSARY FACILITIES FOR ADEQUATE MEDICAL CARE

Dr. Edwin F. Daily, Director of the Division of Health Services of the Children's Bureau, in the American Journal of Obstetrics and Gynecology (January 1945) estimated the facilities that would be needed to provide every expectant mother with adequate maternity care. He believed that good care could be provided to all by the training of 7,500 additional fully qualified obstetricians.

In 1942—
said he—

there were only about 2,500 doctors who limited their practice to obstetrics and gynecology. All obstetric care and teaching in the United States could be provided by about 10,000 specialists in obstetrics if they and the hospital facilities were geographically located so as to be accessible for 2,500,000 maternity patients each year—

he said.

About 30,000 additional hospital beds are needed to care for every patient in a hospital. Every hospital should have proper facilities for obstetricians on the staff to provide prenatal care for all the patients living near enough to come to the hospital for this purpose. In some of the less populated areas, the maternity patients should be able to receive prenatal care in health centers near their homes. The smallest maternity unit of the general hospital or small maternity hospital should have at least 20 beds which would provide accommodations for between 500 and 600 maternity patients per year. Twenty maternity beds would serve a population of approximately 25,000. Two obstetricians could provide all maternity care for most areas with this population.

THE EMERGENCY MATERNITY AND INFANT CARE PROGRAM

The emergency maternity and infant care program enacted by Congress during the war for the wives of men in the four lowest pay grades of the armed services was a step along the road toward planned maternity care. If it did anything, it showed us the utter lack of a general plan for maternity care for all mothers throughout the coun-

try. It turned the spotlight on our hit-or-miss, catch-as-catch-can, willy-nilly method of providing maternity care.

While the emergency maternity and infant care program made available no additional services, it did serve to provide women with a higher quality of care than they would or could have secured for themselves.

For instance, in New York City, where I am most familiar with the detailed operations of the emergency maternity and infant care program, the organization which I represent was asked by the commissioner of health of New York City to provide consultation services which would aid the women entitled to care under the emergency maternity and infant care program in selecting the best care that was available for them at the time.

Providing this service entailed interviewing more than 20,000 women who were the wives of men in one branch of the service or another. We saw many who were not entitled to emergency maternity and infant care because their husbands were not within the four lowest pay grades, but they knew women who had had it and were so satisfied with the quality that they, too, wanted the same quality care.

Some who were entitled to emergency maternity and infant care and, through it, could have availed themselves of the services of a private doctor and a semiprivate room, preferred to go into the ward of one of our good hospitals because they had ward care before and liked it. Others to whom privacy was important and who got more confidence from being cared for by their own doctor in their own room, had that care.

Interestingly enough, some of the women who were entitled to have their bills paid under the emergency maternity and infant care program wanted to pay their own bills—and did. They believed that the Government's stamp of approval on a particular kind of care meant that it was quality care. When the Government buys care, it should mean quality care to everyone.

It is gratifying to compare the maternal mortality during these years of the Second World War with that of the years of the First World War.

Today, the maternal death rate is the lowest in recorded history, while in 1917, it was the highest.

The wives of the men who fought the Kaiser had to eke out a meager existence on their soldier husband's diminutive pay checks—frequently months late. As for good maternity care—that was out of the question unless some patriotic-minded doctor offered charity. There was no plan for providing maternity care for these women.

I remember those days well, for I was a nurse in the district. I visited many of the soldier's wives. Some were ill of preventable diseases. All were anxious and perturbed at a time in life when they should have been happy and expectant. We did our best to get them care by hook or by crook. We summoned our courage many times to ask a doctor to give more charity than we knew he could afford.

Today's care for the wives of men in the armed forces is much broader and better than it was during and after the First World War. Yet, how uneven and incomplete is even the best care today.

In community A, there is a hospital, but no prenatal clinic. Mothers are dismissed with their babies from 24 to 48 hours after delivery.

In community B, there is no hospital. Most mothers are cared for by general practitioners, with no access to specialists. These doctors do their best and often their best is excellent. Too frequently, however, there is needless death, injury, or suffering because when abnormalities and difficulties arise, there is no expert consultation available.

In community C, there is marvelous prenatal care—consultation with tuberculosis, heart, and related services—and the mothers get the very best of care, but after the baby comes they are dismissed from the hospital to whatever they call home—where no help is available.

In community D, there is no doctor, no hospital, no public health nurse.

There is one word which epitomizes this lack of coordination of community facilities for the care of mothers. That word is "discrimination." Sometimes facilities in a community discriminate against the poor because they cost more than the poor can pay. In some communities, the rich and poor receive the best that is available, the rich by paying the highest prices and the poor through free or low-cost services. The middle class is discriminated against because they cannot pay the prices the rich can afford and they are not eligible for the clinic care provided for the poor. They must take what they can pay for, even though they know it is of a lower standard than that provided for the poor. Truly, it is a patchwork quilt.

ENDORSEMENT OF PEPPER AMENDMENTS TO TITLE I

The Maternity Center Association, which I represent today, approved the proposed Maternal and Child Welfare Act of 1945—S. 1318—introduced into Congress by Senator Pepper, for himself and nine other Senators, and by Representative Mary T. Norton.

We favored this bill because we believed that it provided a plan which would eventually make good maternity care available to every mother and her baby.

We believed that it was sound because it provided for the training of additional medical and nursing specialists and other technicians in obstetrics.

We believed that there were ample safeguards for a high standard of maternity care. We have made our approval known to Congress.

We were, therefore, happy to learn that Senator Pepper has proposed a series of amendments to title I, part B, of the Wagner-Murray-Dingell bill, which would incorporate the basic philosophy and the basic provisions of S. 1318. It is our opinion that these amendments strengthen S. 1606 and doubly assure the creation and maintenance of high standards in obstetric practice throughout the country.

We were also pleased that under S. 1606, with Senator Pepper's amendments included, no means test would be required for maternity care. No pregnant woman would be forced to stand in line or to submit to interrogation as to whether she can or cannot pay. This, in our opinion, is a cardinal principle upon which sound health legislation must be based. It is not a new principle.

In the days when these ideas of social security were first taking deep root in our land, to be exact, on May 10, 1934, Dr. Thomas Parran, Jr., then Commissioner of Health of New York State, now Surgeon Gen-

eral of the United States Public Health Service, spoke at the annual meeting of the Maternity Center Association. He said at that time, and I quote:

Specifically, I would propose that the community through taxes should offer to pay the entire medical, hospital, and nursing costs of childbearing for every woman unable to provide the best of care for herself. As a means of getting continuous care by the same competent physician throughout pregnancy, labor, and the puerperium, this care should be made most freely available to those women who report their pregnancy to the health department not later than the third month. The greatest freedom of choice of the physician should be allowed which is compatible with securing competent medical service. Only those physicians who prove themselves incompetent or indifferent should be excluded. Such a plan would remove an immediate and often very grave economic barrier to bringing a child in the world. It would substitute good care under strict professional standards for the haphazard and criminally poor care now being received by so many women. Because they may not have paid the doctor's bill for a preceding childbirth or illness, there frequently is great reluctance on the part of underprivileged women to report to a physician for care early in pregnancy, especially in the rural districts, and in those cities where prenatal clinics and free hospital services are not available. Moreover, unless they are entirely destitute and desperate they shrink from going to the welfare officer for aid, because of the stigma surrounding an application for public relief. I propose that the medical, hospital, and nursing costs of childbearing, paid by public funds, be put upon the basis of the medical need rather than be measured by the yardstick of a pauper's oath.

It is, therefore, our hope that your committee will consider favorably the inclusion of the amendments made by Senator Pepper.

We hope, too, that an amendment may be added to require advisory committees on the State level.

Senator DONNELL. What was that? I did not hear that.

Miss CORBIN. We hope that an amendment may be added to require advisory committees on the State level.

Senator DONNELL. Thank you.

Miss. CORBIN. I am sure that all of us here this morning agree that healthy mothers and strong children in sound families are the greatest assets of our country. We cannot continue to provide some mothers and babies with the very best care, some with only average care, some with care so poor we do not want to talk about it, and some with no care at all.

Our plea this morning is for high standards of medical, nursing, and hospital care for all mothers and their children.

No nation can afford not to spend whatever it costs to save the life and health of a mother of a family, nor to permit its birth rate to be kept down because of the costs of child-bearing. What I mean when I say "high standards" is that we must recognize that there are not two kinds of people who get two kinds of care. We must have the same kind of care for every mother that you want for your wives or daughters. There is no grade A or grade B in safe maternity care. There is only one safe kind. Until this concept is the criterion by which we judge and accept standards for providing care to every mother, we shall not have really faced the issue squarely.

The CHAIRMAN. Any questions, Senator?

Senator DONNELL. Yes, sir; I would like to ask a few.

Miss Carbin, are you located in New York City?

Miss CORBIN. Yes.

Senator DONNELL. Are you connected with one of the hospitals there?

Miss CORBIN. The Maternity Center Association.

Senator DONNELL. The Maternity Center Association. What is the function of that association?

Miss CORBIN. To improve standards of maternity care and promote adequate care for all mothers.

Senator DONNELL. Does it operate itself in any hospitals?

Miss CORBIN. It operates a delivery service for mothers in the poor section of East Harlem and South Bronx.

Senator DONNELL. Yes. And approximately how many persons are organized into the Maternity Center Association?

Miss CORBIN. Employees?

Senator DONNELL. Yes, ma'am.

Miss CORBIN. Some 35 or 6 or 7 or 8; the exact number I do not have.

Senator DONNELL. Nearly all of those are nurses?

Miss CORBIN. Some twenty-odd are nurses. Physicians. Obstetricians.

Senator DONNELL. Yes, ma'am.

Now, Miss Corbin, you spoke about statistics in New York as between the white and colored mothers, and as I understood your point, there is not a very great disparity of the figures.

I observe, numerically, that is true, and yet from the standpoint of the percentage, I was interested to observe that the figure for the colored fatalities, as I understand it, of mothers, is approximately 23 percent greater than that for white mothers.

Am I right in that?

Miss CORBIN. It sounds right to me. I have not figured it.

Senator DONNELL. You said for 10,000 live births that there are 17 deaths of whites and 21 of colored. That was as I understood your testimony.

To what do you attribute that difference, even under the surroundings in New York? Why would there be a 23 percent disparity?

Miss CORBIN. Maybe there is a disparity in the quality of care.

Senator DONNELL. Do you think that explains it primarily?

Miss CORBIN. That would be my impression.

Senator DONNELL. I understood that you take the view—

Miss CORBIN. For care that is equal, you might expect the same mortality.

Senator DONNELL. You refer also to the provisions of S. 1606 and to the provisions of Senator Pepper's proposed amendment.

Do you have a copy of S. 1606 there before you?

Miss CORBIN. Yes, sir.

Senator DONNELL. If you will turn, please, to page 13 and following, Miss Corbin.

Miss CORBIN. All right.

Senator DONNELL. Part B of the act, beginning at page 13, pertains to grants to States for maternal and child-health services.

Do you favor the contents of the bill insofar as those contents are contained between pages 13 and 16 under the title there: "Part B, Relating to Maternal and Child-Health Services"?

Miss CORBIN. As amended.

Senator DONNELL. As amended by Senator Pepper's amendment.

Miss CORBIN. That is right.

Senator DONNELL. I do not have before me a copy of Senator Pepper's amendment.

Miss CORBIN. I have the amendment right here.

Senator DONNELL. Well, I think perhaps we may have a copy here. I am not sure.

Miss CORBIN. It is very brief.

Senator DONNELL. Would you mind telling us just what particular part of Senator Pepper's amendment you have before you that you regard as of special importance?

Miss CORBIN. Yes. Starting to read at the bottom of page 13, it says:

by establishing and maintaining adequate maternal and child-health services—

Senator DONNELL. Would you give us the wording of that.

Miss CORBIN (reading) :

in the community, by providing supplementary personal health services needed by maternity cases or children entitled to personal health service benefits under title II of this act, and any personal health services needed by maternity cases or children not entitled to such benefits.

Senator DONNELL. That is the amendment you favor.

I want to direct your attention to this: as I understand the amendment, from your reading of it, it does not alter the fact that part B is a plan for grants to States?

Miss CORBIN. That is right.

Senator DONNELL. That is correct, is it not?

Miss CORBIN. Yes.

Senator DONNELL. And the grants to States are of monetary sums to be paid to the States and are to be expended by the States pursuant to the State plans?

Miss CORBIN. That is right.

Senator DONNELL. As distinguished from Federal plans. That is correct, is it not?

Miss CORBIN. That is right.

Senator DONNELL. Do you regard that general philosophy as correct; namely, to have grants?

Miss CORBIN. For the State aid?

Senator DONNELL. For the aid to the States, Federal aid; yes.

Miss CORBIN. That is right.

Senator DONNELL. To carry out the plans administered by the State?

Miss CORBIN. That is right.

Senator DONNELL. Do you regard that as preferable to some plan under which the Federal Government would take over this matter of maternal and child-health services?

The question is not very clear.

Do you favor a plan under which, on the one hand, the Federal Government provides funds to the States to assist the States in carrying out State-operated plans as against a plan under which the Federal Government would itself operate a plan Nation-wide for maternal and child-health services?

Miss CORBIN. Definitely.

Senator DONNELL. That is, you favor the State plan that I have indicated, aided by Federal grants as against a Federal plan of federally operated maternal and child-health services; is that right?

MISS CORBIN. That is right.

Senator DONNELL. Yes, ma'am.

Now, Miss Corbin, Senator Pepper's plan, in that, what do you regard as the primary function of his amendment? What is the thing primarily added to S. 1606 by the amendment to which you referred?

MISS CORBIN. It seems to me it provided for high quality of care, which you might not get under the other.

It reads:

by providing supplementary personal health services needed by maternity cases or children entitled to personal health service benefits under title II of this act.

In other words, if it were not adequate there could be a supplementary service rendered, if I understand the language:

and any personal health services needed by maternity cases or children not entitled to such benefits.

Senator DONNELL. Now, Miss Corbin, you have not addressed yourself, as I understand it, this morning to title II of S. 1606?

MISS CORBIN. No, sir; I have not. Title I, part B, that is all I know anything about.

Senator DONNELL. As amended by Senator Pepper's proposed amendment?

MISS CORBIN. That is right.

Senator DONNELL. Yes, ma'm.

Now, I want to call your attention to one point I would like to get your judgment on under part B, title I, namely, the fact that the authorization for an appropriation is not limited to any express sum but is expressed to be as "a sum sufficient to carry out the purposes of this section."

Have you given any thought, Miss Corbin, as to whether or not it would be advisable, at least at the outset of this plan, to put some limitation on the appropriation there, rather than to leave it just a general authority to appropriate any amount that might be needed for carrying out the purposes of the part B?

MISS CORBIN. I do not think I am qualified to have a judgment on that. It seems to me it would have to be answered on the basis of the people cared for, and how much it was going to cost, and the people paying for it.

Senator DONNELL. You would rather not address yourself on the "closed" or "open" appropriation?

MISS CORBIN. If there was an adequate provision an open' appropriation would be sufficient, because we have never spent enough in this country. We do not know what it costs.

Senator DONNELL. Whom do you understand, under the wording of this act, would be the person who would determine what is a sum sufficient to carry out the purposes of this section?

MISS CORBIN. The Surgeon General.

Senator DONNELL. Would that be a matter for Congress or for one of the bureaus, as it is now worded in section 121 (a)?

MISS CORBIN. Well, I have not found any place here in the bill where it says where the money is provided, so I should suppose that after the bill is set up and the plan made for operating it, there would have to be some provision made for appropriating money, and that would be up to the Congress, I should hope.

Senator DONNELL. You also mentioned, as I understood it, that you hope that an additional amendment will be made to part B of S. 1606, namely, an amendment which will provide for advisory committees on the State level?

Miss CORBIN. Yes.

Senator DONNELL. I take it by that you indicate the thought that the problems may be different in the different States, and that it is advisable to have local advisory committees to cooperate in carrying out the purposes of that part of the bill; is that right?

Miss CORBIN. That is right.

Senator DONNELL. That is all, Miss Corbin.

Miss CORBIN. Thank you.

The CHAIRMAN. Have you directed your attention to title II of this act?

Miss CORBIN. No, Senator Murray.

The CHAIRMAN. In your experiences, what have you to say as to the need of some national health program in addition to the program for maternity care?

Miss CORBIN. In my prepared statement I showed that the care being given is very spotty and irregular, and the end result in terms of fatality and illnesses is pretty unfortunate, and it is not a new idea. We have been talking about the need for maternity care throughout the country ever since I have been working in the maternity center, which is 30 years, and we have not done much yet to produce any plan to provide care for everybody, whether they can pay for it or not.

Some people are able to get it and other people are not. There is not care available everywhere, even if you want to take advantage of it.

The CHAIRMAN. You think that the provisions for maternal and child-health services would not be enough, that there should be some general program for general health care in the country?

Miss CORBIN. Well, I think, myself, that you cannot give one special care. If you give maternity care, it involves every other care, too. A maternity patient is liable to have any disease.

The CHAIRMAN. Under the existing system of national health care in this country there is a situation where people are unable to secure modern health services because of their inability to pay, because of their poverty, or because their income is not sufficient to pay for it.

Miss CORBIN. And because of the distribution of services.

The CHAIRMAN. And because of the distribution of services. In some sections the services are not available at all.

Miss CORBIN. That is right, sir.

The CHAIRMAN. So that you do recognize the need of some national health insurance program which would bring down the cost?

Miss CORBIN. Some national program.

The CHAIRMAN. Yes. Some national program. That is all.

Senator DONNELL. Pardon me, Miss Corbin. As I understand it, though, by your response to Senator Murray's question here, you did not include the compulsory insurance feature, so that what you are saying is you favor some national health program?

Miss CORBIN. Yes; that is right.

Senator DONNELL. And you are not undertaking to express a view as to whether there should be a compulsory health insurance program?

MISS CORBIN. That is right. I think that is up to Congress.

SENATOR DONNELL. You are not expressing an opinion on that this morning?

MISS CORBIN. That is right.

THE CHAIRMAN. Have you observed the operation of the voluntary systems of medical care in the country?

MISS CORBIN. I beg your pardon. I did not hear that.

VOLUNTARY HEALTH INSURANCE

THE CHAIRMAN. Have you had any occasion to observe the operation of the voluntary systems?

MISS CORBIN. Oh, yes. Yes; all over the country I have seen them work.

THE CHAIRMAN. You are familiar with those systems?

MISS CORBIN. I am.

THE CHAIRMAN. Do you think that they are a complete answer to the need for medical care in this country?

MISS CORBIN. Well, they have not been yet.

I think that where the voluntary service is good, so far in this country, it is unmatchable by other services, but there are not enough, nor are they available on the basis that all people can have them.

THE CHAIRMAN. Can you tell us of some particular voluntary care systems that give complete coverage for the people?

MISS CORBIN. No.

THE CHAIRMAN. I mean, of all the different health services that are needed. Most of them are limited, are they not?

MISS CORBIN. That is right.

THE CHAIRMAN. Are not some of the voluntary systems too expensive for people to join?

MISS CORBIN. You were thinking of the voluntary systems as not the voluntary organizations that provide direct service?

THE CHAIRMAN. Like the Blue Cross.

MISS CORBIN. You were thinking of the Blue Cross?

THE CHAIRMAN. Like the Blue Cross.

MISS CORBIN. The Blue Cross system provides, in my State, maternity benefit of \$50 for the hospital, I think. That does not meet the hospital cost. That does not mean they could not do something about that to make it more adequate. We hope that some day they may.

THE CHAIRMAN. But then it would be necessary for them to increase the cost?

MISS CORBIN. I should think so.

THE CHAIRMAN. And then as they increase the cost, they would make it impossible for the poorer people to belong to that kind of a system. And in order to bring down the cost of medical care, it is necessary to have a very wide coverage in those insurance systems?

MISS CORBIN. That is right.

THE CHAIRMAN. And the voluntary systems usually are not able to provide that wide coverage which makes it possible to reduce cost?

MISS CORBIN. Well, at least on the basis of our experience thus far, they have not done it.

THE CHAIRMAN. They have not.

That is all.

Senator DONNELL. You do know, Miss Corbin, that the physicians and nurses of the country are giving attention to the problem of increasing the coverage by voluntary systems?

Miss CORBIN. Yes; I am aware of the effort.

Senator DONNELL. And I believe you said that where the voluntary systems have been worked out, and I do not recall the exact language, but that where there is a voluntary cooperation, that it has been, as you used it, unmatchable?

Miss CORBIN. When he asked that question, I was thinking of the direct service to patients.

Senator DONNELL. What was that?

Miss CORBIN. Where the services are offered at the voluntary standard it is good, yes, but when I understand the gentleman to ask me of the voluntary insurance plan, my answer to that was they have not entirely met the need. There is room for improvement. Maybe they will improve them.

Senator DONNELL. But, again, you are not here this morning undertaking to advise that Congress shall enact title II of this act, which provides for prepaid personal health service benefits, compulsory health insurance benefits?

Miss CORBIN. Title I, part B.

Senator DONNELL. And not title II?

Miss CORBIN. That is right.

The CHAIRMAN. You are not opposing, are you, part 2, title II?

Miss CORBIN. That is right.

Senator DONNELL. And you are not advocating it either?

Miss CORBIN. That is right.

The CHAIRMAN. You think that in view of the medical care problem in the United States, there is a great need for study of that?

Miss CORBIN. I think there is a tremendous need for study of any proposal, and an effort to arrive at something feasible to provide care.

The CHAIRMAN. And you know that in the years that have gone by, no effort was made by the American Medical Association to provide some kind of system which would bring down the cost of medical care to the average person in the country?

Miss CORBIN. I would say that we have seen no result of any effort that may have been made.

The CHAIRMAN. That is right.

The next witness will be Mrs. Mary H. Oxholm.

You may state your name for the record and the organization you represent.

STATEMENT OF MRS. MARY H. OXHOLM, CHAIRMAN, SPOKESMEN FOR CHILDREN, INC., NEW YORK

Mr. OXHOLM. I am Mary H. Oxholm, chairman, spokesman for Children, Inc., New York.

The CHAIRMAN. You may proceed with your statement.

SPOKESMAN FOR CHILDREN INCORPORATED

Mrs. OXHOLM. Spokesman for Children was incorporated under the laws of New York State October 3, 1945, with the purpose in view

of (1) studying the health and welfare needs of children; (2) drawing the attention of the public to our findings; (3) enlisting public support for legislation affecting children considered sound by our board of directors; and (4) opposing legislation that is considered detrimental to children.

The officers of Spokesmen for Children are Mrs. Theodor Oxholm, chairman, Mrs. Shepard Krech, treasurer, and Mrs. Louis S. Gimbel, Jr., secretary. The directors of our board are both lay and professional people who have a proven interest in maternal and child health and welfare. We have a Nation-wide membership of over 300 individuals. Educational material provided by Spokesman is being used by 26 other national organizations interested in children in the work carried on by their branches and affiliates.

I would like to say here, Mr. Chairman, that when we first asked for a hearing, we thought that both the Maternal and Child Welfare Act of 1945 and the National Health Act were going to be heard, and when we found that the Pepper amendments were being made, and that S. 1606 would be heard, I was authorized by our board to come and testify for title I, section B of S. 1606 only.

The CHAIRMAN. And you are confining yourself to that one section?

Mrs. OXHOLM. Yes.

The CHAIRMAN. All right.

ENDORSEMENT OF TITLE I

Mrs. OXHOLM. Spokesmen for Children has endorsed the Maternal and Child Welfare Act of 1945, S. 1818, and members of the organization are in favor of the maternal and child-health and services to crippled children section, title I, part B, of the National Health Act of 1945, S. 1606, H. R. 4730, although we regret that child-welfare services are not included in this section. We believe child-health and welfare services should go hand in hand; that plans should be made to care for the whole child, not just part of him.

The members of our board have had wide experience in many fields of child health and welfare and they are agreed that Federal guidance and financial aid such as are set forth in title I, section B, of S. 1606 are necessary to bring adequate health services to every child and expectant mother in this country within a reasonable length of time.

RURAL INTEREST IN HEALTH PROGRAMS

We have in mind particularly the rural areas of this country where leadership is often lacking and organization is difficult. Where good health education programs and maternal and child-health services have been offered to rural communities the people have tried them out, accepted them, and given them their full support.

A good example of this is Ulster County, N. Y.

And I would like to interrupt my testimony once more to say that I was born in Ulster County and have lived there most of my life. I know the people there very well. I knew them in the days before we had a health service when, if a child grew up there and its teeth were bad, why, poor teeth run in the family. No one thought anything of it.

In my own family, we used to think that drinking raw milk was all right until we found the cows had Bang's disease, and we decided on pasteurized milk.

All of us needed to know more about public health. I had a great deal to do with introducing the health service into Ulster County.

I have worked with the town board and the board of supervisors in the State health department, and I have a very great respect for our Government on all levels. I think it is a tremendous job, and they do a wonderful piece of work.

The CHAIRMAN. You think the bureaucrats are not so bad after all?

Mrs. OXHOLM. That is right.

I joined the Spokesmen for Children because I heard they were interested in maternal and child-health life, and I am so convinced of the goodness of it, of what is being done in Ulster County, that I wanted to work with an organization that would promote any legislation that might bring it to the other counties in this country that could be as fortunate as ours.

Twenty-odd years ago two of the towns in this county took advantage of the Shepard-Towner Act and each acquired its own public-health nurse and embarked on a good child-health program and generalized public-health-nursing service. One other town followed suit 2 years later, but it was not until 1938, when the State health department placed 2 public-health nurses in the county that the other 17 towns became aware of the need of a good public-health program. These two nurses gave a generalized service with special emphasis on maternal and child-health education. The people themselves became so interested in this work that within 3 years the board of supervisors took on nine public-health nurses, paid on a 50-50 basis by State and county tax funds, and established a generalized public health service.

The women of the county, who had formed lay committees to help the nurses, agreed to work on maternal and child health as a definite project. First, because with limited means they had to "start small"; and, second, because the beginning of good health starts with children and expectant mothers.

Child-birth consultations were begun in old buildings, church halls, vacant stores, usually with no more equipment than a tape measure, a set of scales, and a kitchen table. Local doctors, two of whom were pediatricians, agreed to work in the consultations. At first they were paid with State funds and then, as interest grew, by local town boards or the lay committees themselves.

There are 80,000 people in the county.

Now the county has 13 child-health consultations, 11 of which are permanent health centers, supported by town boards or lay committees. Prenatal clinics were also carried on for 2 years, but had to be abandoned due to the shortage of doctors.

Shortly after the child-health consultations were started the State sent a dental hygienist into the county to inspect the teeth of all the children that attended the consultations, chart the defects, and teach the mothers the importance of taking care of their children's teeth. The hygienist was followed by the State dental trailer, which began making regular yearly visits to the rural areas where there were no resident dentists to take care of the children's teeth. Where dentists were available, arrangements were made for the children to have work

done by them, also paid by the State through arrangements with the county dental society. In four communities the committees are now making arrangements to finance this work themselves and follow the children through their school years so far as their funds will allow. The lay committees have always furnished transportation for both the consultations and the dental work.

The people of Ulster County do not look on their public-health work as a charity, nor do they for one moment think they are getting it free. To them it is a public-health service, which they believe in, work for, and are willing to support.

They see in their health program the opportunity to raise a generation of sound, able-bodied children, and they are making it into a reality. The service developed during the war years, when the shortage of doctors and the hardships of rationing put every obstacle in its way, but public support overcame all these difficulties.

We cite this case because it demonstrates Federal aid, State leadership, local administration, and public support in successful partnership.

New York is a very wealthy State, yet some Federal funds were used by it to introduce public-health work in Ulster County.

ENDORSEMENT OF PEPPER AMENDMENTS

Spokesmen for Children has made a careful study of S. 1318 and the maternal and child-health provisions of S. 1606. We are in favor of Senator Pepper's amendments to title I, part B of S. 1606.

Furthermore, we would like to see this section amended to give more specific standards for health services and personnel. The success of a health program rests primarily on the workers who carry it out and it is of the utmost importance to put only well-trained workers in this field. Again, we refer to New York State where the standards are high and the people have been educated up to them and are convinced of their value.

I would also like to add here, New York State has a State advisory council on public health; and that our county public health committee, besides the supervisors and doctors, has two lay people on the committee, and the lay committees themselves have a very strong voice in what is done and what they approve of in the State.

We think advisory committees are a good thing.

For the sake of our children we believe every State should be encouraged to develop a maternal and child-health program and when necessary should be given Federal grants-in-aid to accomplish this goal.

The CHAIRMAN. Any questions, Senator?

Senator DONNELL. A very few.

Mrs. Oxholm, your organization was incorporated last October?

Mrs. OXHOLM. Yes, sir.

Senator DONNELL. Yes, ma'am. And its headquarters are in New York City?

Mrs. OXHOLM. Yes, sir.

Senator DONNELL. I noticed you referred to a successful combination of various different governmental operations including local administration, and that brings me to the question as to whether in studying S. 1606 and S. 1318, the latter being Senator Pepper's bill,

you have noted that the provisions in relation to maternal and child-health services contemplate grants-in-aid, as the concluding sentence of your statement read, by the National Government for the carrying out of State plans?

Mrs. OXHOLM. Yes, sir.

Senator DONNELL. And you favor that general idea, as I understand it, of grants-in-aid by the Federal Government reserving at the same time the State operation of a State plan; is that right?

Mrs. OXHOLM. Yes.

Senator DONNELL. Yes, ma'am. And you favor also, as I understand it, these local advisory committees, is that right?

Mrs. OXHOLM. Yes.

Senator DONNELL. I take it that is because, in large part, of the fact that you regard it as of importance that the people in the community have some direct voice in the operation of these matters and also these conditions vary from place to place throughout the Nation? Is that right?

Mrs. OXHOLM. That is right.

Senator DONNELL. Yes, ma'am.

That is all.

The CHAIRMAN. Your opinions are confined, of course, to title I, part B?

Mrs. OXHOLM. Yes, sir.

The CHAIRMAN. Grants to States for maternal and child-health services?

Mrs. OXHOLM. Yes.

The CHAIRMAN. You do not intend at all to say that some other system with reference to a general national health insurance program should not be considered?

Mrs. OXHOLM. I was not authorized to go into that.

The CHAIRMAN. You were not authorized to go into that and you do not intend to express any opinion on that whatever?

Mrs. OXHOLM. That is right.

The CHAIRMAN. You are merely confining your judgment and opinion?

Mrs. OXHOLM. Yes, sir.

The CHAIRMAN. With reference to this particular subject which you are discussing?

Mrs. OXHOLM. Yes.

Senator PEPPER. I am sorry I missed the early part of your testimony, Mrs. Oxholm.

Mrs. OXHOLM. Thank you.

The CHAIRMAN. The next witness will be T. Duckett Jones, president, Rheumatic Fever Council, American Heart Association.

You may state your name and the organization which you represent.

STATEMENT OF DR. T. DUCKETT JONES, REPRESENTING THE AMERICAN COUNCIL ON RHEUMATIC FEVER OF THE AMERICAN HEART ASSOCIATION

Dr. DUCKETT. I am T. Duckett Jones, and I am the representative of the American Council on Rheumatic Fever of the American Heart Association.

The CHAIRMAN. You may proceed with your statement.

THE AMERICAN COUNCIL ON RHEUMATIC FEVER

Dr. DUCKETT. The American Council on Rheumatic Fever was formed as the result of a conference called by the American Heart Association in January 1944, attended by representatives of health organizations concerned with rheumatic fever and rheumatic heart disease and representatives of the Army, Navy, United States Public Health Service, the Veterans' Administration and the Children's Bureau. The members of that conference unanimously adopted the following resolution:

This conference is strongly in favor of the extension of public programs supported by Federal, State, and local funds for the study, prevention, and treatment of this disease. Moreover, we believe it essential that additional funds be secured from private sources for the purpose of special studies to increase basic knowledge of the disease, for professional education, and for increasing public awareness of the problem. In order to accomplish the purposes mentioned above, this conference recommends that a council on rheumatic fever be formed under the leadership of the American Heart Association and that this council shall include representatives of interested organizations.

Following the initial meeting, the American Council on Rheumatic Fever of the American Heart Association was formed, and includes representatives of the following organizations: American Academy of Pediatrics, American Association of Medical Social Workers, American College of Physicians, American Heart Association, American Hospital Association, American Medical Association, American Nursing Association, American Public Health Association, American Rheumatism Association, and the National Society for Crippled Children and Adults.

THE PROGRAM OF THE COUNCIL

The initial program of the council is as follows:

1. Preparation of detailed plans for community care programs, i. e., public and voluntary rheumatic fever programs and advisory service to communities in the organization of such programs.
2. Preparation and distribution of criteria for the diagnosis of rheumatic fever and rheumatic heart disease and recommendations relating to treatment and convalescent care.
3. Preparation and distribution of recommendations relating to undergraduate and graduate education of physicians, nurses, medical social workers and teachers.
4. Plans for initiation or sponsorship of needed research by individuals or groups.
5. The evaluation of existing programs for the care of patients suffering from rheumatic fever and rheumatic heart disease.
6. Lay education for the support of such programs; early medical diagnosis; and the understanding of the family's role in the care of rheumatic fever patients.

This program is now under way.

The Council and representatives of its constituent organizations have not expressed an official opinion on S. 1606. However, on April 13, 1946, the Executive Committee of the Council unanimously passed the following resolution:

The Executive Committee of the American Council on Rheumatic Fever of the American Heart Association directs Dr. T. Duckett Jones to testify as the

representative of this Council at the hearings on S. 1606, and authorizes him to present information on the disease entity, rheumatic fever and rheumatic heart disease; the requirements for the proper care of patients suffering from this disease; and the existing deficiencies and needs for rheumatic fever and rheumatic heart disease patients.

THE PROBLEM OF RHEUMATIC FEVER

The importance of rheumatic fever and rheumatic heart disease as a health problem has not been fully appreciated. It seems advisable to present to a legislative group interested in planning for health services, a few simple statements which would clearly focus attention on the importance of this disease, and the lack of adequate facilities and services available to its sufferers.

Heart disease is the greatest cause of death in the United States. Rheumatic fever causes approximately 40 percent of heart disease at all ages, in the northern part of the United States. In children, rheumatic fever causes 90 percent of all heart disease. Rheumatic fever and rheumatic heart disease is the leading cause of death in children of school age. It causes almost five times as many as the combined total of deaths from infantile paralysis, whooping cough, diphtheria, scarlet fever, measles, and cerebro-spinal meningitis. In an actual survey the incidence of rheumatic heart disease in seventh grade school children in coastal industrial cities of a New England state (Connecticut) was found to be between 6 and 7 percent. All surveys show that rheumatic fever and rheumatic heart disease vary between 1 and 6 percent of the childhood populations in the United States. Approximately 20 percent of children who develop rheumatic fever die of this disease within 10 years of its onset, and an additional 45 to 50 percent have some degree of permanent rheumatic heart disease at that time. Further follow-up of these same patients for a longer period is showing additional deaths due to this disease. Recent data would indicate that the volume of rheumatic fever and rheumatic heart disease is in general greater than that of tuberculosis—the best estimates indicating that there are over one million sufferers from this disease in the United States. The average life expectancy of individuals with rheumatic heart disease is approximately 15 years less than that of the average individual without this disease.

Rheumatic fever has serious economic implications. While the greatest incidence of this disease occurs between the ages of 5 and 15, it can and does occur at any age. Not only is the death rate in early life high, but crippling heart disease in many adults prevents their leading normal active lives. Many homes are broken by the early death of young mothers from rheumatic heart disease. Thus, rheumatic fever increases poverty and the number of public charges.

The war experience did much to focus attention on this disease. Rheumatic fever occurred in the armed forces in association with epidemics of hemolytic streptococcal infections. In some military installations the volume of disease reached alarming proportions. Necessary and expensive programs of care had to be developed for those members of the armed forces developing the disease. Moreover, the cost of the care of and the compensation to veterans, who developed this disease while on active duty, will run into millions of dollars.

While the cause of rheumatic fever is unknown, we have sufficient information to proceed with programs of care. There is much diffi-

culty in the accurate diagnosis of this disease. Errors in diagnosis are made frequently—both errors of omission and commission. Physicians with special training and experience are needed in rheumatic fever programs. Few are now available. Diagnostic and case-finding services represent important factors in any program of care.

There can be little doubt but that rheumatic fever is closely associated with epidemics of hemolytic streptococcal infection. The streptococcal infection may be so mild as to go unnoticed. There is usually an interval of 2 or 3 weeks between the streptococcal throat infection and the appearance of the symptoms of **rheumatic fever**. Opinions differ as to how the hemolytic streptococcus may influence the onset of rheumatic fever, but most observers readily admit the close association. Unfortunately, we cannot prevent the occurrence of rheumatic fever in susceptible individuals, once the throat infection has taken place. Various observers have noted that as high as 50 percent of previous rheumatic fever sufferers who develop a streptococcal throat infection, may have a repetition of their disease. Each attack of rheumatic fever varies in its duration from several weeks to many months. The acute stage of the disease is often followed by some months of milder chronic illness. The chronicity of the disease and its repetitive nature, make the problem of care difficult. Since rheumatic fever occurs in crowded homes where exposure to streptococcal infections are enhanced, one of the important provisions of care should be to reduce such exposure of the individual patient.

Hospitalization for at least several weeks in a general hospital is usually required for the acutely ill patient. It is advisable to move patients from the wards of such hospitals as soon as possible, as here the exposure to epidemic infection is great. Some patients develop severe and chronic heart failure. Such patients may require protracted care in special hospitals or special care in a general hospital. Later, supervision of bed care of recovering patients may be arranged for in foster or convalescent homes (sanatoria, or the patient's own home. Throughout the period of active disease, there should be continuous medical supervision and nursing care.

A PROGRAM FOR COMBATING RHEUMATIC FEVER

An adequate program must include provisions for the care of the patient following the active state of the disease. Some of these may be briefly enumerated:

1. Medical Social Service. Since environment plays an important role in the initial or repetitive attack of rheumatic fever, no program can be complete without a strenuous effort to improve the environmental and social factors of the patients. Some observers believe this is as important as medical care during active illness.

2. The majority of these patients are unable to meet the cost of medical and nursing services. Many are members of families on welfare. In the majority of instances, it is essential to correlate and integrate the services of various community agencies—public and voluntary—in order to ensure good care and to avoid the waste of duplication of services.

3. It is essential that the child be given an opportunity to maintain his class standing in school. The chronicity and repetitive nature of

rheumatic fever make this a vital part of any program. School instruction has to be supplied in institutions and often in the patient's home. Since the patient may be handicapped in later life, he should receive the benefits of an education. Occupational therapy is essential to maintain the morale of a chronically bedridden patient and should be supplied.

4. Those individuals who enter adult life with reasonable degrees of permanent rheumatic heart disease need vocational guidance and training. The need for such training became evident in the armed forces. If trained for sedentary occupations, many patients may be spared the effects of exertion on their hearts. Moreover, they may become useful citizens and not public charges.

5. Multiple cases of rheumatic fever occur in a single family as in the case of tuberculosis. It seems advisable that we should study the family as a unit, attempting to improve living conditions and possibly decrease the incidence of the disease. At least an early diagnosis could be made on multiple family cases. As our knowledge increases, the family will be a likely unit in which to institute preventive measures.

Advice to the patient during his period of well-being or the inactive stages of rheumatic fever is essential. Constant follow-up and supervision from a medical and medical-social viewpoint is necessary if a program is to be successful. From the above, it seems that the repetitive and chronic nature of rheumatic fever with resultant rheumatic heart disease, makes this truly a catastrophic illness. The burden of cost cannot be met by the majority of individuals who are its sufferers. It is obvious that a broad plan with the provision and integration of many services and facilities are essential.

The broad outlines for programs of care of rheumatic fever and rheumatic heart disease patients have been given. These considerations have the general approval of most physicians with extensive experience in the care and study of such patients. Only on the basis of such information can the needs be reviewed.

Many agencies, public and voluntary, are interested in this problem. A small nucleus of voluntary agencies have for years striven to give a high quality of service to these patients. They have and are serving useful purposes. A small number of medical investigators have added to the scientific knowledge of the disease. These agencies have been limited by the lack of funds, the high cost of medical care and research, the absence of broad integrated and planned program, and in some instances by the articles of incorporation of the agency itself. Special hospitals, sanatoria, foster and convalescent homes, and agencies providing supervised care in the patient's own home are few in number. Several cities and States are developing broad plans. At the present time most of these are in the planning stage, and without immediate prospect of financial support. Nearly all general hospitals in the United States provide care for the acutely ill rheumatic fever patient. In the greater part of the country no service other than this is available. It has been mentioned that protracted stays in the general hospital are inadvisable for such patients because of the exposure to infection by the hemolytic streptococcus; the pressure of the need of such beds for other acutely ill patients; and the unnecessarily excessive cost per bed per patient for slowly convalescing patients.

Facilities and services needed by the patient following discharge from the general hospital are almost nonexistent. An exception to this is the direct service by a physician or nurse. This service is usually difficult to arrange and the necessary consultants as a rule unavailable.

THE WORK OF THE CHILDREN'S BUREAU

A most encouraging development has been the rheumatic fever program of the Children's Bureau of the United States Department of Labor. The details of this service are doubtless familiar to members of this committee or can be obtained from reports of the Secretary of Labor. These plans have been developed under the authority of title V, part 2, of the Social Security Act. The high quality of service of these plans deserves commendation. In addition to the benefit to individual children, we are provided with a small nucleus of workers at Federal, State, and local levels, with experience in this problem, administrative as well as other professional services. There are and have been distinct deterrents to the development of such programs. Due to inadequate financial support, those States which have developed programs in cooperation with the Children's Bureau, have been forced to limit such programs to a few counties or municipalities. Less than one-half the States have such limited programs. There is a demand for complete programs by States with and without existing programs.

THE IMPORTANCE OF RESEARCH

Health can be purchased only when medical knowledge permits the prevention or satisfactory treatment of disease. We know much about rheumatic fever and rheumatic heart disease. We need to know much more. No other important health problem has received such meager financial support for research. The investigators who have devoted their efforts to the study of this disease for any appreciable period of time are few indeed. All save two or three of these observers have suffered from the inability of haphazard financing of their research projects. The present method of financing research by means of short term grants-in-aid is of limited value in the study of chronic disease. This has held up progress and inhibited the acquisition of knowledge concerning rheumatic fever. It has been estimated that little, if any, more than \$100,000 has been expended annually in this country for some years in the study of this disease. There is an urgent need for research funds to be used by qualified agencies and individuals for increasing scientific knowledge and for evaluating methods of care and prevention.

One may well ask what possible benefits might accrue from legislation making possible suggestions in this testimony. A few of these may be briefly enumerated:

1. Professional services of a high quality should be offered all sufferers of this serious disease. The early application of known therapeutic and preventive measures would insure the best possible outcome for the individual patient. The prophylactic use of sulfa drugs is an example. If medical reports continue to indicate that this is a successful method for the prevention of hemolytic streptococcal infections, and repetitive attacks of rheumatic fever, without harm to

the individual, the ravages of this disease may be greatly reduced. To institute such preventive measures would presuppose the existence of a well-organized community program.

2. When individuals with significant rheumatic heart disease receive vocational training and become self-supporting, both the individual and society benefit.

3. Adequately financed research will produce benefits to sufferers from this disease.

The importance of the rheumatic fever and rheumatic heart disease as a public health problem has been presented. Requirements for the care of these patients have been outlined. Certain needs have been discussed. The problem is pressing and urgent. The American Council on Rheumatic Fever urges that public health agencies, in cooperation with the use of voluntary services and facilities, be aided and encouraged to meet the problem of rheumatic fever and rheumatic heart disease on the basis of established clinical and epidemiological facts, in accordance with sound administrative principles.

Finally, the attention of this committee is called once again to the initial statement in the unanimously adopted resolution of the conference which created the American Council on Rheumatic Fever:

This conference is strongly in favor of the extension of public programs supported by Federal, State, and local funds for the study, prevention, and treatment of this disease.

The CHAIRMAN. Thank you for your very able statement.

Senator DONNELL. I wonder if Dr. Jones would be kind enough for our record to give us a few words of his own background. This has been an exceedingly interesting statement, and he very modestly did not tell anything about himself. Would you mind?

Dr. JONES. I am director of research in rheumatic fever and heart diseases at the House of the Good Samaritan, Boston, Mass., and have been since 1929.

Senator DONNELL. Are you a physician?

Dr. JONES. Physician, and assistant professor of medicine at Harvard Medical School.

Senator PEPPER. Dr. Jones, we have been very much interested in your statement. Do you feel that the people of the United States are getting the medical care that they are entitled to have, for example, with respect to, say, rheumatic fever and heart disease?

Dr. JONES. I would not hesitate to say that I feel not only myself, but other members of the rheumatic fever council do not feel that they are, or they would not have directed me to come here to make such a statement to you.

Senator PEPPER. And do you look upon this bill as contemplating a plan or program by which the people who need medical care respecting rheumatic fever may obtain such care more adequately?

Dr. JONES. Senator Pepper, could I express that opinion as an individual, because I have not been directed by the council and they have not studied that.

Senator PEPPER. Your individual opinion.

Dr. JONES. I personally feel that it is the logical means whereby good programs of care, and at least a beginning in the eventual accomplishment in this problem can be made.

VOLUNTARY PLANS CANNOT SOLVE THE PROBLEM

Senator PEPPER. Doctor, do you feel that the voluntary plans will achieve that result, and give the people the care that they should have in this field?

Dr. JONES. Again personally.

Senator PEPPER. I mean that.

Dr. JONES. From my personal point of view, I work for voluntary agencies, and feel that voluntary agencies and services and facilities have a tremendously important part to play in any program.

I personally feel, however, that they will never successfully meet all of the pattern necessary in order to give a complete care program to individuals with these diseases.

Senator PEPPER. And one of the reasons is that generally the people by experience with voluntary plans, the people who need it most, do not join, or join and stay in a little while and then drop out.

Dr. JONES. Well, I should say that so far as this disease is concerned, that the majority of the individuals getting the disease are either in the lower middle income level or in the actually lower income level, both of which groups have difficulty in meeting voluntary insurance patterns, and that those plans are as yet not complete enough to give full coverage and it is my opinion that they probably will not be able to. That is a personal opinion.

Senator PEPPER. Thank you very much.

Senator DONNELL. Dr. Jones, you state, of course, that you are giving your personal opinion.

Dr. JONES. That is right, sir.

Senator DONNELL. And that the authority that has been conferred upon you by the council for which you appear is limited by the resolution that you read. That is correct, is it not?

Dr. JONES. That is true, because the council has not met and has not considered the bill.

Senator DONNELL. Now, Doctor, are you undertaking to discuss the provisions of title II of this act, 1606, namely, the compulsory health-insurance provisions of the bill?

Dr. JONES. Well, I feel that as an individual that I perhaps should.

Senator DONNELL. Would you mind telling us your general observations on that title?

Dr. JONES. Well, very much against my long background of voluntary agency association and with a good deal of study of the general features of health plans and of methods of financing health plans, I have come to the conclusion that it will not be possible so far as this disease is possible to have a voluntary pattern which will be sufficiently complete to give you a full coverage. I would like to cite one instance.

We have one of the longest followed groups of heart disease and rheumatic fever patients in the country. This institution, the Good Samaritan, has been caring for these patients since 1921, and we have made a strenuous effort to follow all of our patients for years to aid those patients as much as we could, to work out the natural factors of the disease.

One of our mothers we have followed for many years, who is now in her late thirties, presented herself at one of our follow-up clinics about 2 weeks ago with the following story:

She has two children, 13 and 9, and prior to a year ago they had been in the lower economic level with her husband moderately well supplying the needs of the family. They were paying into two voluntary insurance plans \$12 each quarter. That gave them certain medical services, as well as hospital service.

About a year ago the husband developed malignancy. He had several operations for which the hospitalization was paid by voluntary insurance plan, on a semiprivate basis. The surgeons also were remunerated moderately for their service.

At the end of his thirty-fourth operation with the almost certain expectancy of death within 2 or 3 years, he had to receive deep X-ray therapy. The cost of that service was between \$50 and \$75.

Meanwhile, having been out of work for over a year, the husband was no longer able to care for his family, and they were receiving \$25 a week from local relief. Under the voluntary plan which they belong to, expenses for the husband's care had been met up to that deep X-ray therapy. Here is an individual with two small children on relief, with the husband in a serious malady unable to work, with a charge which the hospital expected her to meet because she had not been a recipient of public charity part of the hospital, and with absolutely no funds to meet it.

I assure you that even if it were possible through very devious channels of voluntary patterns, particularly through the very able cooperation of social service, to dip up that money, it seems to me that that woman should not have been subjected to that severe anxiety, and feeling that she was not doing her part. She has reasonably severe heart disease, and certainly the greatest contribution that she can make to society is not only to take care of her husband as long as she can, but to see that the children have every opportunity to become good citizens.

I think that things were made very difficult for her in a trying period when she has a health problem of her own of first magnitude.

Senator DONNELL. Doctor, a little while ago you mentioned as I recall it that you favor the idea of a wide and official study of the rheumatic fever problem, and of the cure of it by national, State, and local funds. I think you mentioned something to that effect.

Dr. JONES. The care of it.

Senator DONNELL. I beg your pardon?

Dr. JONES. The care of it, not the cure of it.

Senator DONNELL. That is the care of persons afflicted?

Dr. JONES. That is right.

Senator DONNELL. By the use of national, State, and local funds.

Dr. JONES. That is right.

Senator DONNELL. Do you have in mind that there is an advantage in the use not only of national funds, but of State and local funds? Is that right?

Dr. JONES. Well, sir; I would express the conviction that it is the advisable thing for local communities to participate in public programs to what extent they are able.

Senator DONNELL. Yes, and may I ask you, Doctor, have you studied the provisions of S. 1606, particularly the portion of the bill embraced in title I, which relates to grants to States for health services? Have you read that?

Dr. JONES. Yes, sir.

Senator DONNELL. And you observe there, I take it, that the thought is that the Federal Government shall contribute grants to the respective States for the carrying out of State plans. That is correct, is it not?

Dr. JONES. That is correct, yes.

Senator DONNELL. And may I ask you, generally speaking, do you favor that general type of approach to the relation between the Federal and local governments, the State governments that is to say, grants by the Federal Government accompanied by the operation of State plans approved as a condition to their receiving the Federal grants?

Dr. JONES. I should say certainly personally I believe in it, yes, because I think it is essential that advisory committee aid, and the setting of criteria and standards be maintained at a Federal level, rather than at a State level.

Senator DONNELL. But you do recall it as important that the States make their contributions and that they be interested in the operation and participate in the operation of these plans?

Dr. JONES. I think they should be insofar as possible well controlled by the States, rather than by the Federal Government.

Senator DONNELL. That is what I was getting at.

Dr. JONES. Yes.

Senator DONNELL. Doctor, in regard to this title II of this bill, the compulsory health-insurance plan, have you examined that particular portion of this bill with a view to its applicability to the hospitalization problems attendant on this particular disease, rheumatic fever?

Dr. JONES. Well, not with special attention to that. I think I know in general the provisions.

Senator DONNELL. Does the treatment, the proper treatment of this particular disease require extended hospitalization in numerous cases?

Dr. JONES. It does in a considerable majority of them, if not hospital, at least institutional care, such as foster and convalescent homes, or special hospitals, sanatoria.

Senator DONNELL. By a considerable period, could you give me an illustration; take a child who developed this disease. I realize you cannot generalize on this and make it applicable to all cases, but his confinement in a hospital or a convalescent home for a period of 6 months is not infrequent in cases of that kind?

Dr. JONES. I should say it was quite frequent, and consistent.

Senator DONNELL. And consistent?

Dr. JONES. Yes.

Senator DONNELL. And frequently does it even require longer periods than 6 months of hospitalization or presence in a convalescent home or other institution of that type that you mentioned?

Dr. JONES. We have occasional patients that require from 2 to 3 or 4 years of special hospitalization.

Senator DONNELL. Doctor, just how does this rheumatic fever manifest itself, generally speaking? Does it result in the incapacity of a child to get around and walk around, or does it require him to be in bed a large part of the time.

Dr. JONES. Well, sir, I think that we would have very much better knowledge of the disease and a great deal more funds if it were a visible crippling. It is not that.

Senator DONNELL. It is not?

Dr. JONES. The acutely ill child gets on the whole acute illness with high fever, varying degrees of joint symptoms, and then in at least two-thirds of them, reasonably quick evidence of the involvement of his heart. The severe forms of the disease develop heart failure, and I think that is a reasonably small proportion.

However, the disease in its milder forms and after that acute stage is over is often reasonably as symptomatic. They do not suffer very much. They are kept in bed largely for long periods of time to protect their hearts and to put them at nearly complete rest as possible during the period when active disease is going on in the heart itself, with the hope of at least, at least the hope, of curtailing the degree of residual permanent heart disease.

Senator DONNELL. And I understood you to say that in many instances that will require 3 or 4 months or more.

Dr. JONES. I should say that the average is 4 to 6 months.

Senator DONNELL. From 4 to 6 months.

Dr. JONES. But every case may vary and it is difficult to predict.

Senator DONNELL. Four to six months of hospitalization or presence in the convalescent home or similar institution.

Dr. JONES. In a place say for the degree of the illness that the patient has.

Senator DONNELL. Do you have a copy of this bill before you?

Dr. JONES. Yes.

Senator DONNELL. Will you be kind enough to turn to page 59 of the bill, under the head of limitations of benefits?

I observe there that subdivision (C) of section 210 states that the maximum number of days in any benefit year for which any individual may be entitled to hospitalization benefit under section 201 or 202 shall be 60, provided however that when the Surgeon General finds that moneys in the act are adequate he may increase the maximum with respect to hospitalization benefit provided under section 201 or section 202, or both, to not more than 120 days for the following calendar year.

Do you regard that provision as adequate for coverage of the cases of rheumatic fever patients?

Dr. JONES. I should think it would be probably inadequate, but so much better than anything we have at the present time, if it could not be altered, I would not oppose it.

Senator DONNELL. You would be of the opinion, however, that it would be improved by increasing the length of time.

Dr. JONES. Improved by increasing the length of time? Yes.

Senator DONNELL. Have you given a special study to this matter of the compulsory health insurance phase of this bill S. 1606, or have you confined your study largely to the other portions of the bill which pertain to grants by the Government to the States for carrying out of State plans?

Dr. JONES. I think it must be obvious that I am personally best informed on title I, part (B). That is the part that is of greatest interest to me. I have read the other. I am not an authority in

any way on administrative procedures, either voluntary or public. I should be glad to answer any question personally with the limitation of my ability as defined.

Senator DONNELL. And also with the understanding that your answers would be purely your personal answer.

Dr. JONES. That is right.

Senator DONNELL. As distinguished from that of the council for which you speak.

Dr. JONES. That is right.

Senator DONNELL. Have you studied from any personal observation the operation of the British system of compulsory health insurance?

Dr. JONES. It has been some time since I have. I have done it in the past, but I have not recently reviewed the circumstances, and I am not familiar with it.

Senator DONNELL. You are not familiar with it?

Dr. JONES. With the exact terms of their present plan.

Senator DONNELL. Are you familiar with the present day operations of the British plan?

Dr. JONES. I am not.

Senator DONNELL. You have not kept up, you have not studied the present day operations of that plan?

Dr. JONES. No, sir; I would say this, if I might, that for a period of fully 15 and maybe 20 years, the British have been so far ahead of us in the organization of the public plans for the care of these patients that it is rather surprising that we have been slow in coming to them.

Senator PEPPER. And they have recently offered into Parliament and perhaps passed an adequate general over-all health plan, have they not?

Dr. JONES. I am not aware of the provisions of that. I know they have submitted it.

Senator DONNELL. Are you informed, Doctor, as to whether or not there has been great opposition on the part of the British Medical Society to this extension to which Senator Pepper refers?

Dr. JONES. I have no opinion on that, sir.

Senator DONNELL. You are not acquainted with the expressions, if any, by the British Medical Society on that question?

Dr. JONES. No, sir.

Senator DONNELL. Doctor, one of the associations which is a component part of, or a contributor to, I have forgotten the particular technical word, to the council which you represent is the American Medical Association, is it not?

Dr. JONES. Yes, sir.

Senator DONNELL. You are a member of the AMA, are you?

Dr. JONES. Yes, sir.

Senator DONNELL. As has been developed in the testimony here, it includes something over 125,000 of the physicians of this country; that is substantially your understanding, is it not?

Dr. JONES. Yes.

Senator DONNELL. And you know that, do you not, Doctor, that the AMA has expressed itself in very definite terms as opposed to compulsory health insurance?

Dr. JONES. Yes.

Senator DONNELL. Doctor, are you engaged in the private practice of medicine in addition to the work that you have described here this morning?

Dr. JONES. I am in a rather peculiar position, so far as that is concerned. I am a full-time worker, but I have the privilege of consultation. I see a very limited number of individuals in consultation, largely because I felt that if my services and experience with the unusual opportunity that I have had are worth anything, that they should be available to people of all financial patterns.

Senator DONNELL. Do you regard it as important, Doctor, that in the study and attempted solution of the rheumatic fever problem, that there be a wide expansion of the hospital facilities of our Nation?

Dr. JONES. I do not think there is any question but that facilities are certainly needed.

Senator DONNELL. You are familiar with the terms of S. 191, the Hill-Burton bill, generally?

Dr. JONES. Yes.

Senator DONNELL. Looking to the provision of at least to some extent adequate hospital facilities.

Dr. JONES. I would say personally that I feel that unless that bill or some of the provisions of that bill are passed that anything which comes from this bill would be nullified.

Senator DONNELL. And then the provisions of the portion of this bill to which you have devoted primary attention, namely, title I of the bill, grants to States for health services, are intended to implement the hospital program by providing Federal grants to States making the obligation upon the States to make provision likewise and to submit plans to be operated by the State, which plans, however, meet the approval of the Federal Government. That is correct?

Dr. JONES. Yes.

Senator DONNELL. That is all.

The CHAIRMAN. You have stated that the AMA is opposed to this plan for compulsory system of health insurance.

How long has this rheumatic fever disease been recognized as a serious threat in this country?

Dr. JONES. Well, sir, I think that for a period of time it has been a problem. It has been sharply focused, I believe, in about the last 20 years, and since about 1930 we began to gather knowledge relative to its association with epidemic streptococcus infection, and there has been increasing focusing of attention on it. Indeed, the Children's Bureau programs and their operation has done a great deal to stimulate interest and information concerning the disease.

The CHAIRMAN. No plans have been set up in the States by State governments in conjunction with medical societies for the handling of this problem?

Dr. JONES. No, sir.

The CHAIRMAN. I see.

Dr. JONES. I believe there are two or three contemplated, and there may be one in Detroit which comes nearer that pattern than anything, but I do not know if it is really operative now.

The CHAIRMAN. It would be a voluntary system, would it, or a State system?

Dr. JONES. Well, it is apparently, I think it is a voluntary local thing, but I think that they would like to have the approval of the public agency, and the aid of the public agency. So far as I know, there is no voluntary plan involving insurance, which has been developed for the care of these individuals.

The CHAIRMAN. Doctor, while the American Medical Society is unalterably opposed to the plan for a national health insurance system as envisaged in this bill, the American Medical Association itself has never offered to the American people any solution of this problem, has it?

Dr. JONES. In relation to rheumatic fever, no, sir.

The CHAIRMAN. In relation to the entire problem of bringing the modern medical care within the reach of the people of this country of the great masses of them that are at present unable to avail themselves of it.

Dr. JONES. Well, I would say the recent suggestion of the American Association apparently is felt by its constituent legislative body to make it possible to develop a national health program on a broad plan. It would at least seem to me from what I have read in the last 3 or 4 months that that was true. They have put out statements relative to the action of their house of delegates, I think at the December or recent meeting in relation to the development of voluntary plans, insurance plans throughout the country.

The CHAIRMAN. They are sponsoring voluntary plans?

Dr. JONES. That is right, sir.

The CHAIRMAN. Well, your experience with voluntary plans has led you to believe that voluntary systems will not ever be able to accomplish what is necessary to be accomplished?

Dr. JONES. I believe that the cost of the care and the variation of variety of facilities and services which are essential to give these patients good service really means that it would be impossible on a voluntary pattern entirely to develop adequate services. I am firmly of the belief that it is essential that both voluntary and public work closer together in the development of such a plan.

The CHAIRMAN. Well, it is only in comparatively recent times that the American Medical Association has given any consideration to this problem or taken any public interest in this problem of reducing the cost of medical care so as to make it available to people who are at present unable to avail themselves of it.

Dr. JONES. Well, I think that is historically correct, sir.

Senator DONNELL. You do know, however, that the AMA is addressing itself to the problem of a solution through voluntary means of a general health problem; you know that to be true, do you not?

Dr. JONES. I certainly am aware of the fact that through a period of the past 10 or 15 years, sir, there has been very decidedly a change in the attitude of the AMA in relation to the acceptance of its responsibilities for the development of national planning.

I would like to state that I am not here in the role of being for or against the stand of the American Medical Association.

Senator DONNELL. I understand.

Dr. JONES. I want that to be perfectly clear. I am here as a representative of the rheumatic fever council to express opinions relative to rheumatic fever, and I have agreed to express other personal opinions, but not as an antagonist or protagonist of the AMA.

Senator PEPPER. Perhaps some members of the AMA are unfortunately having to learn by personal experience how great the need is for greater medical facilities. I have in mind for example a doctor friend in my State who opposed me very aggressively in my last campaign because he understood I was for this outrageous bill, this thing called socialized medicine. A little while afterward, unhappily, the doctor who had a very active practice and a very good income, was stricken with tuberculosis himself. He then went to the State tubercular sanitorium at Orlando, Fla., and for many, many months, perhaps a year or two, I do not know, it has been quite a while, enjoyed the services of that institution that is built by the PWA, and is supported by public funds from the counties, at the rather limited expense of \$1.25 a day all the time he has been there. He got the best medical care that could be given for tuberculosis, and the facilities of living and everything, for \$1.25 a day. I was pleased to be advised by friends that the doctor had changed his mind about this thing called socialized medicine, as it were, and that he expressed the regret that everybody could not have the advantage of public facilities of such a character at low cost.

Senator DONNELL. Had he ever expressed himself prior to his experience as being opposed to the maintenance of the hospital at Orlando, Fla.?

Senator PEPPER. No, but he had strongly and stoutly defended the idea that if the patient got sick, he should go to a doctor or to a hospital and pay the fees.

He defended with all of the vigor of his personality and intelligence the right of the patient to choose his doctor, to choose his hospital, and to pay the fees for the services that he got, but when he went down to the tubercular hospital, I doubt if he knew the name of a single doctor there that treated him, and I think he has been pleased at the quality of the service that he has had.

Senator DONNELL. That is operated by the State of Florida, is it, Senator, the Orlando institution?

Senator PEPPER. That is right. It is supported by the counties of the State who pay for the patients who are there but it was built by a muchly bemeaned institution of the Federal Government and over the protest of many, an organization called the PWA, and I think the old WPA might have helped a little bit.

Dr. JONES. Could I add just one remark in final? I am the son of a physician who is now an elderly man, who has practiced for over 50 years in a moderate sized city in Virginia. He has been very distinguished as a physician and is still serving his community, I think, about as actively as any young man, even, in the community, and during the war years he carried a terrific load and responsibility.

I have never known anyone who was so devoid of personal financial aggrandizement through his profession. I began to get a little worried 2 or 3 years ago as I have become more and more convinced that in order to secure proper care for rheumatic fever and heart disease persons it was essential that we recognize the fact that we are in a changing society and with changing needs, and we had to organize to meet such a change.

I was afraid that someone would go to him and quote me as a public utterance something which might make him feel that I was perhaps of not a very good attitude in relation to altruistic purposes

in medicine as he thought I should be. So I approached him with that, and in his characteristic way he rather scoffed at me. You do not need to bother discussing that with me. I have only one criterion for evaluating such things as to how a service is to be given, and that is, is it good for human beings, and I think that is or should be probably the crux of the pattern which decides our activities.

Senator DONNELL. That involves a very considerable question, according to the view of the AMA, as to whether it is for the best interests of the public, does it not?

Dr. JONES. I grant you that.

Senator DONNELL. And as related to the Orlando institution the Senator Pepper speaks of, I call attention to the fact, first, that there is no argument has been made here so far as I recall in this committee hearing as against grants by the Federal Government to State Governments in aid for the construction of hospitals, and in the second place, that the operation of a State tubercular hospital at Orlando, through the payments by patients coming from the counties, is a long step away from compulsory health insurance operated by the Federal Government of the United States.

Dr. JONES. Yes. I should like to say as an individual that I feel that if nothing else were accomplished, if some of the provisions of this bill which would extend the purchase of health, that is public health, in various parts of the United States, in relation to measures in which there is no argument by any member of the medical profession as to the public responsibility for the institution of care and prevention, and so forth, that it will have accomplished a great deal, because I feel firmly that the amount of unpurchased health, public health, in the United States at the present is quite lamentable and I say that rather feelingly because I have reviewed sanitary or health surveys in the past 5 years from many parts of the United States, appraisal patterns in relation to health facilities and services conducted in given communities, and teaching of preventive medicine to medical students.

The CHAIRMAN. While the people in this country are pretty well satisfied with this plan of grants-in-aid to States, and the building of hospitals, and facilities for medical care, the fact remains, does it not, that the American Medical Association has always opposed any programs which would tend to deprive them of the right to fix their own fees and to get what they consider they are entitled to in the way of compensation for any treatment that they give? Is that not true?

Dr. JONES. I suppose, sir; I think that it is getting on awfully argumentative grounds so far as I personally am able to evaluate it.

The CHAIRMAN. I do not want to press you. I will withdraw the question.

The next witness will be Dr. George J. Hecht.

STATEMENT OF GEORGE J. HECHT, PRESIDENT, PARENTS INSTITUTE, INC.

Mr. HECHT. May I correct that, please? I am not a doctor. I am just a plain mister. I am and have been for 20 years president of Parents Institute, Inc., of New York City, which is a magazine published by us. We publish three magazines for parents, and for 20-

years I have been in close touch with the needs and desires of parents. My magazines are Parent magazine which currently reach more than 900,000 homes, and another magazine, Baby Care Manual, and a third magazine called "Your New Baby," and I am also publisher of 10 magazines for children, so we have contacts altogether with the readership of our magazines going to something like 10,000,000 a month, so I know the needs and interests of children.

The CHAIRMAN. While you may not be a doctor, I am sure that your testimony, in view of your experience, will be very valuable to this committee. We are very glad to have you here.

Mr. HECHT. I am excited about this, so do you mind if I stand up?

The CHAIRMAN. That is all right.

TITLE I SHOULD BE LEGISLATED SEPARATELY

Mr. HECHT. Mr. Chairman, I feel that the children of America are being made in this bill, the football of medical politics. I feel that the maternal and child welfare provisions of this bill, namely, title I (B) is virtually a rider, having little to do with the main purpose of the bill, namely, compulsory health insurance.

As you all know, I am sure, this bill will have very little chance of passing this session of Congress. It is a highly controversial bill, and I understand that Senator Barkley on the floor of the Senate has said that it is the intention to adjourn the session by the end of July or beginning of August.

The CHAIRMAN. I might call your attention to the fact that the American Medical Association took the same view with reference to the workmen's compensation act, they asserted that it would never become law, and they fought it bitterly for many years, and it was fought in every legislature of the United States, and yet it was finally passed, and today the American Medical Association and every person in the United States would oppose any attempt to repeal that law. That is true of nearly every progressive piece of legislation ever enacted in this country. It is always opposed at first by people who claim it will be communistic or socialistic. So we are very glad to have your views on this particular bill.

Mr. HECHT. I shall be glad to see this bill come for a vote. I am just saying that this bill is an extremely controversial one. I have heard there has been a lot of testimony for and against, and I presume after this hearing is over, the House of Representatives will have a hearing and I do not see how it is possible for this bill, much as I would like to see it come for a vote, to actually be enacted, voted upon this session.

The CHAIRMAN. Of course.

Mr. HECHT. I have a point to make on this.

The CHAIRMAN. Let me make a point right there. That is very relevant. It took years in this country to pass the TVA. It took many, many years to pass the national income tax measure which was very valuable to the people of this country, and I assume that every measure of this kind is necessarily controversial, because it affects the interests of so many people, and naturally they will oppose it.

Mr. HECHT. I am not opposing this bill. I am saying that the children of America cannot wait.

The CHAIRMAN. You want to pass it right away; you do not want to wait.

Mr. HECHT. I am here to discuss section I (B) of this bill, and I feel that Uncle Sam is neglecting his children.

Title I (B) of this bill as amended by Senator Pepper has very little controversy. Virtually all the child welfare experts of America are for it, and I understand that an informal gentlemen's agreement has been made with Senator Pepper that if it appears that there is little chance that this whole bill can come up for vote this session, that the child-health provisions of this bill will be recommended out of this committee in the hopes that the noncontroversial phases of it would get some action this session.

I am here to put in a plea for a committee-sponsored bill on behalf of child health, crippled children, and child welfare, such as is embodied in section I (B) of this bill, as amended with the additional amendments that Senator Pepper proposed.

Senator DONNELL. Pardon me, Mr. Chairman. Mr. Hecht, this is not said in any sense against your position at all. So far as any gentlemen's agreement in the committee is concerned, this is one member of the committee that does not know of such an agreement.

The CHAIRMAN. I am chairman of the committee, and I never heard of any such a gentleman's agreement. I would like to have you give us some particulars on that.

Mr. HECHT. I have heard that was so; even if it is not so, on behalf of the children of America, I ask you to try to get through at this session some of the progressive child health measures that have been proposed in S. 1318, or in title I (B) of the National Health Act, as amended by Senator Pepper.

Senator PEPPER. Mr. Hecht, just let me add this to avoid—perhaps to clarify your mind—and to avoid your appearing to be in error. I know what you have in mind is that you and many other people are anxious to see the maternal and child welfare bill adopted. That is an independent bill which a group of Senators, of which I am one, introduced some time ago, and there was some discussion among the sponsors of that bill, organizations out in the country, as well as of the Senators who sponsored the bill, as to whether they would forego hearings upon that individual bill, in view of the fact that the subject was covered in this bill.

My recollection is that I stated in my testimony upon this particular bill, that I thought the general attitude of the sponsors of the maternal and child welfare bill was that if possible we wanted to integrate that bill into this bill and to that end we introduced such an amendment to the maternal and child welfare bill section of this bill, and I believe I stated at the time of my testimony that if this bill passed, that would eliminate perhaps the necessity of our pressing our separate bill. If this bill did not pass or passage did not seem imminent, we might call up our separate bills and try to push that as a separate measure, and he probably has heard such general discussion of that. That is what led him to say there was a sort of understanding.

Mr. HECHT. Thank you for that clarification.

Senator PEPPER. I am sure the Senators on this are favorably disposed to getting legislation of that character adopted in a reasonable way.

Mr. HECHT. It would seem to me that Congress would welcome the opportunity in this session prior to election time to do something for children, and I urge that either S. 1318 or title I (B) of that National Health Act as amended be recommended out of committee for action this session as promptly as possible.

Senator PEPPER. Your thought is that if the Committee—you favor this bill, do you not?

Mr. HECHT. I do not propose to discuss either for or against anything but title I (B).

Senator PEPPER. You do favor title I (B) of this bill?

Mr. HECHT. Yes; but I do not think it goes nearly far enough. I was about in my testimony to tell you what I think should be done.

I would like to see title I (B) extended, not only with the amendments that you have proposed at the initial hearings, but I also think that the child welfare provisions of S. 1318 under which \$20,000,000 for the first year was appropriated for child welfare to provide good care and temporary and permanent care for children in need of foster homes and in danger of becoming neglected and delinquent should be incorporated.

The **CHAIRMAN.** I am sorry that I have to leave the meeting at this time, and I want to assure you that I will read your testimony with great interest.

Mr. HECHT. Thank you

The **CHAIRMAN.** Senator Pepper will take charge of the meeting. (Senator Murray left the room.)

Senator PEPPER. Proceed, Mr. Hecht.

PUBLIC SUPPORT FOR TITLE I

Mr. HECHT. I think the child health and maternal welfare provisions of this bill and the child welfare provisions of S. 1318 meet with wide-spread and public support. We have featured articles about this bill on repeated occasions in our magazines, and we have heard from all over the country that this bill has the public support of child welfare authorities and most important of all, of the parents-themselves.

If you would like to see a list of people who have agreed to sponsor S. 1318, I have the original letters from individuals and organizations here.

Senator PEPPER. Have you got a list of them?

Mr. HECHT. Yes; some of them have testified already.

Senator PEPPER. We would be glad to have you put that list in the record.

(The list referred to is as follows:)

Leonard W. Mayo, president, Child Welfare League of America.

Judge Anna M. Kross, chairman, Youth Conservation Commission, General Federation of Women's Clubs.

Leland Foster Wood, secretary, Commission on Marriage and the Home, The Federal Council of the Churches of Christ in America.

Mrs. Hazel L. Rice, executive secretary, The United Council of Church Women.

Sidonie M. Grunberg, director, Child Study Association of America.

Lillie M. Peck, executive secretary, National Federation of Settlements, Inc.

Mrs. Mary S. Fisher, chairman, Department of Child Study, Vassar College.

Harold E. Jones, director, Institute of Child Welfare, University of California.

Eugene E. Barnett, general secretary, International Committee of the Y. M. C. A.

L. M. Birkhead, national director, Friends of Democracy, Inc.
Lester B. Granger, executive secretary, National Urban League.
O. F. Hall, secretary, American Country Life Association.
Dr. Hugh Chaplin, pediatrician, New York, N. Y.
O. Latham Hatcher, president, Alliance for Guidance of Rural Youth.
James Lee Ellenwood, secretary, New York State Executive Committee, Y. M. C. A.
Arthur T. Jersild, professor of education, Teachers College, Columbia University.
Raymond Swing, radio commentator.
Mrs. Richard J. Bernhard, board member, National Child Labor Committee.
Dr. O. L. Miller, pediatrician, Charlotte, N. C.
Leon H. Richman, executive director, Jewish Children's Bureau of Cleveland.
Felix A. Grisette, managing director, North Carolina State Planning Board.
Mabbett K. Reckord, general director, Illinois Children's Home and Aid Society.
H. Y. Price, Jr., assistant director, Executive Council of Texas Social Welfare Association.
Mr. Jeanetta Welch Brown, executive secretary, National Council of Negro Women.
Mabel Skilton, executive secretary, Nutrition Clinics, Inc., Boston.
Boris Shishkin, economist, American Federation of Labor.
Jerry A. Freeman, national executive secretary, Veterans Political Committee, Inc.
Mrs. Dorothy Norman, columnist, New York Post.
Mrs. Joseph Low, legislative representative of National Council of Jewish Women.
Lea D. Taylor, director, Chicago Commons.
C. E. A. Winslow, professor of public health, Yale University School of Medicine.
George J. Hecht, publisher, The Parents' Institute, Inc.
William A. Neilson, former president of Smith College.
Miss Alice Gannett, director, Goodrich House, Cleveland.
Prof. Ernest R. Groves, Institute for Research in Social Science, the University of North Carolina.
Joseph K. Folsom, professor of sociology, Vassar College.
Mrs. Edwards A. Park, supervisor, Baltimore City War Nurseries.
Helen Smith, director, Vocational Advisory Service.
Sophia Lyon Fahs, editor childrens' materials, American Unitarian Association.
Mrs. Adele S. Mossler, director, Play School Association.
Mrs. Margaret S. Lewisohn, director, Public Education Association, New York.
John A. Fitch, professor, New York School of Social Work.
Mrs. Helen Gibson Hogue, executive secretary, the Girls' Friendly Society, U. S. A.

Among the organizations that have endorsed the bill are the United Council of Church Women; the National Federation of Settlements; the Maternity Center Association; the American Federation of Labor; the Committee on Industrial Organizations; Spokesmen for Children, Inc.; National Organization of Colored Graduate Nurses; Association of Army and Navy Wives; the Veterans Political Committee of the United States; the Child Study Association of America; the Nutrition Clinics, Inc.; the Council for Community Action; the National Council of Negro Women; and the Texas Social Welfare Association.

Mr. HECHT. I shall be glad to do so, but I can assure you that the support is widespread, and that the people who really need that, that is the people who have no vote, the children and their parents, who are not organized, like the American Medical Association is organized, are, as far as I can see any way, completely behind Federal grants-in-aid to the States for child health, material welfare and child welfare. Grants-in-aid is not a new principle; grants-in-aid to the States has been going on for years to the land-grand colleges, for roads and for flood control and aid to the blind and dependent children under social security. So there is nothing new there.

The Children's Bureau is carrying on much of this work now under social security, and under the emergency appropriations during the war. This proposal in the bills is an extension with further appropriations, dividing the thing intelligently among the States, where it is most needed.

CHARTS ON MATERNAL AND INFANT DEATH RATES •

I have prepared, with your permission—I would like to put in evidence a couple of charts. As far as I know no such charts have been prepared. The statistics in these charts come from the United States Census Bureau, Department of Commerce, and if you want the data on it, here is the material from which these charts have been prepared. They have been put in these charts in a little different form; so far as I know it has never been done before.

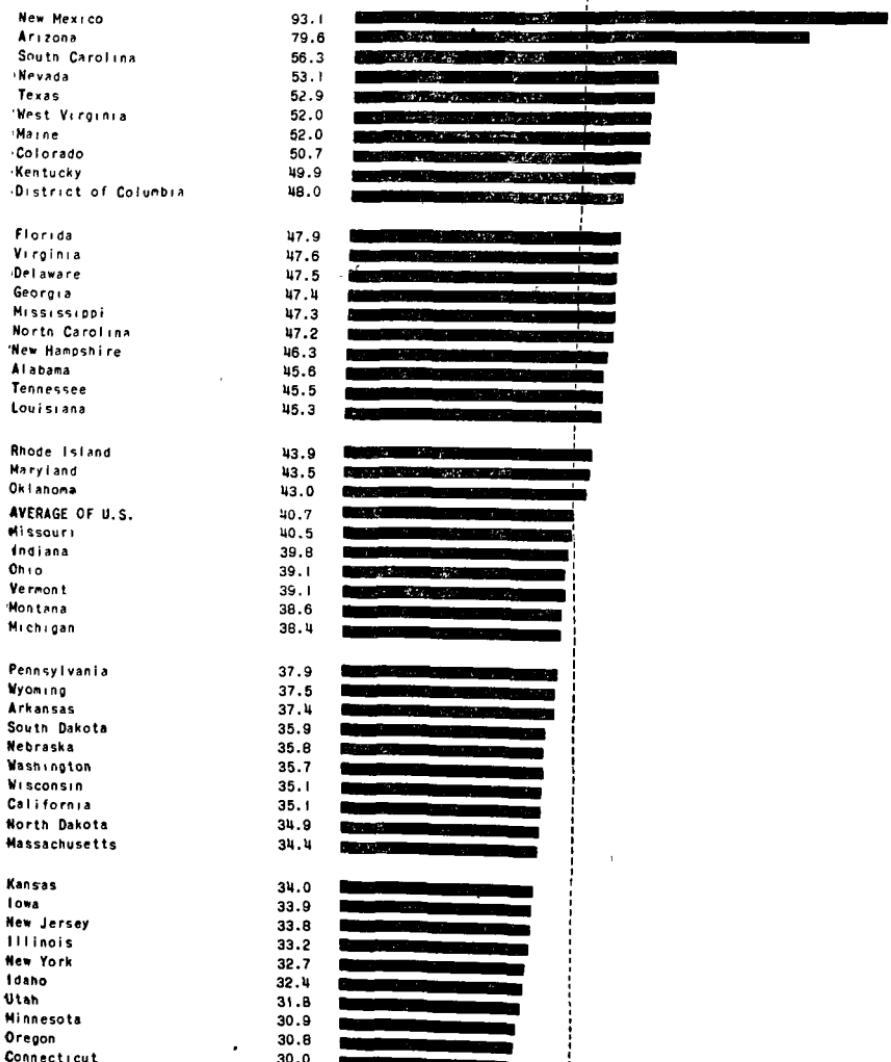
Here is a chart showing the death rate from childbirth causes. Here is the national average, and here is the State of the Union. New Mexico, that has the worst record, and down here is the State in the Union that has the best record. That is Minnesota.

It made news the other day in the New York Times, that there was a 6-percent difference in the inductions under selective service from one State to the national average, and that was news in the New York Times. Here is the clipping on it.

Yet the death rate from one State to another—this was 6.6 percent, there is 300 percent difference in the death rate from childbirth causes from Minnesota, where the death rate is 1.4 percent, to New Mexico, for example, where the death rate is 4.7, and so you see a great many of the States, the poorer States, where people of less means live, cannot afford or do not give as much child-health service to their people as the more fortunate States.

(The chart referred to is as follows:)

*1943 Adjusted Rates from the Bureau of
the Census



Senator PEPPER. So that the record will be clear, the statistics that you are giving us now relate to the death of mothers from causes related to childbirth.

Mr. HECHT. They are.

Senator PEPPER. Or mothers and children?

Mr. HECHT. Well, the census does not specify that.

Senator PEPPER. What is on that pamphlet?

Mr. HECHT. Death from childbirth causes.

Senator PEPPER. I see.

Mr. HECHT. I have another one of infant deaths. I presume that it is for mothers.

Senator PEPPER. That is what caused me to ask the question.

Mr. HECHT. This is the Census Bureau report, which I will be glad to put in evidence if they want it, and on which these figures are taken; the 1943 figures. I think they are largely deaths of mothers.

Senator PEPPER. That is right.

Mr. HECHT. But there is a 300 percent difference between the States. If a woman is lucky enough to live in Minnesota, or Oregon, her chances are three times as good that she will not die in childbirth as if she lived in New Mexico, or South Carolina, for example.

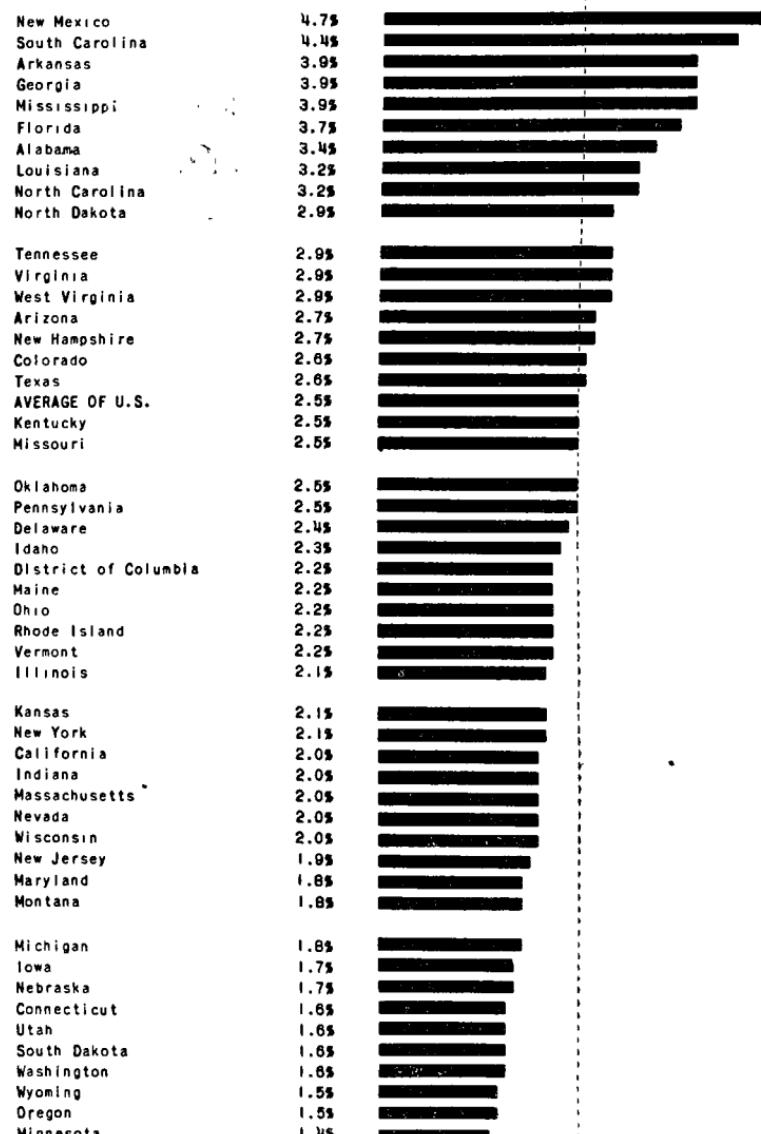
Senator PEPPER. I have made some inquiry and have been advised that that does relate to mothers.

Mr. HECHT. I have a similar, or somewhat similar chart on the death rate of infants, under 1 year of age. This comes from the United States Census report, and here is the printed document from the Census Bureau, from which this was compiled, but I put it graphically in this way.

In the report you cannot see it, because the States are given in alphabetical order, and it does not show there. Here you will see that in New Mexico, believe it or not, there are 93.1 deaths per thousand live births, nearly 1 child out of every 10, or in other words, nearly a hundred children out of every thousand live births in New Mexico in 1943, died in the first year. In sharp contrast to that, the State of Connecticut only had 30 deaths, infant deaths, during the first year for every thousand live births, and I think this is a graphic picture of the differences between the States.

(The chart referred to is as follows:)

1943 Statistics from the U.S. Bureau
of the Census



Mr. HECHT. We believe in equal opportunity in America. Our Declaration of Independence and the Constitution talk a lot about that, and yet we are not giving equal opportunity to survive to some of those of the infants who happen to have the misfortune of being born where the child-health provision of the State are not adequate, and it seems to me that it is about time that somebody gets excited about seeing that Government appropriations, grants-in-aid are made to the States to see that to some degree this thing is leveled out.

I also have some statistics that I think are of interest, some of you may have seen the full page advertisement that we ran in the Washington Post, and in the New York Times bearing the heading "Children Need Uncle Sam's Attention, Too," and for this advertisement I obtained from the United States Children's Bureau some data which I think should go on the record. I will read the high points.

Five hundred thousand children have rheumatic fever or heart disease. I think that was testified to this morning at greater length.

A quarter of a million children are handicapped with asthma, 35,000 with diabetes, 200,000 with epilepsy, 175,000 with tuberculosis, requiring medical care. Twenty million children need dental care. Four million children have lost one or both parents. Sixty thousand of them are known to be orphans of servicemen who died in World War II. Ten thousand children are living in institutions for dependent and neglected children. Seventeen thousand children are deaf, and nearly a million have impaired hearing. Hearing aids are needed by many of them. Fifteen thousand children are blind. Fifty thousand children have impaired sight.

Nearly 4,000,000 children have defective vision requiring correction by glasses. Two hundred fifty and thousand children yearly come to the juvenile courts. Thirty-one thousand babies die needlessly every year before their first birthday. Over 20,000 children now on State registers cannot get help because services or money are lacking. Three thousand babies die needlessly every year from childbearing.

Twelve hundred counties have no services of a full-time public health nurse. One doctor can manage about 1,500 patients, but 553 counties in the United States have only 1 doctor to 3,000 or more people; 81 counties in the United States have no practicing physician at all; 656 counties have no public health nurse.

Senator DONNELL. Is that 656 or 956?

Mr. HECHT. Did I say that?

Senator DONNELL. You said 656.

Mr. HECHT. It is 956 counties have no public health nurse. These figures were furnished by the Children's Bureau at my request. I think they are pretty good evidence that children need Uncle Sam's attention, and I urge you as strongly as I know how to continue your hearings on this national health bill. Debate it all you will, but because there is little chance of this being enacted during this session, for the sake of the children of America who have for too long a period not had the spokesman to appear at the hearings and to make their cause heard, I appeal to you to recommend out of this committee for Senate consideration either S. 1318 or title I (B) of 1606. With the amendments proposed by Senator Pepper to which I urge you to add the \$20,000,000 appropriation the first year for child welfare service, such as I have spoken about.

Senator PEPPER. Before giving Senator Donnell a chance to ask any questions, I want to thank you very much for coming here to add your support and your great influence to aid for maternal care and the mothers and children of the country, and to tell you that as one of the sponsors of S. 1318 we do not expect to let that matter lag. We will determine at an early date when separate hearings should be held on that bill, in case we should deem separate hearings necessary. It may be that as you suggest, the hearings that have been had on this part of this bill will eliminate the necessity of having separate hearings, and that the committee will be in a position to pass upon this part of this bill in case we should desire to submit it to the Senate as a separate bill.

Senator DONNELL. I do not have any questions.

Senator PEPPER. I want to be sure now that the chart that was offered gets into the record.

Mr. HECHT. I have some extra photostatic copies of those charts. I have some others here, and I will be glad to give them to you.

Senator PEPPER. I want to offer, then, if there is no objection, Senator, in connection with this subject that we have been having hearings on, which is now completed with this witness, namely, this is part (B) of title I, and I would like to offer at the conclusion of Mr. Hecht's testimony for this record, a statement that I made in the Senate in support of S. 1318, which summarizes a good bit of data on that subject.

Senator DONNELL. You did not mean that hearings have been concluded on this portion of S. 1606, did you?

Senator PEPPER. Not necessarily, but these witnesses were all called for this particular thing. There will be other witnesses.

Senator DONNELL. There may be other witnesses.

Senator PEPPER. Yes; I think we will have other witnesses.

Thank you very much for coming.

The committee will take a recess until Tuesday, April 30, at which time, at 10 o'clock, in room 424-B of the Senate Office Building, the hearings will be resumed.

(At 12:15 p. m., the committee adjourned.)

NATIONAL HEALTH PROGRAM

TUESDAY, APRIL 30, 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, Morse, and Donnell.

The CHAIRMAN. The hearing will come to order, please.

The first witness this morning is Charles G. Bolte of the American Veterans Committee.

Mr. Bolte?

Mr. BOLTE. Good morning, sir.

Mr. Chairman, if I may, I should like to introduce Dr. Richard Weinerman, the chairman of the health committee of our Washington chapter—

The CHAIRMAN. All right—

Mr. BOLTE. Whom I have asked to come up with me to answer any technical questions there may be.

The CHAIRMAN. The record will first show your name and the organization you represent.

STATEMENT OF CHARLES G. BOLTE, CHAIRMAN, AMERICAN VETERANS COMMITTEE (A. V. C.), ACCOMPANIED BY DR. E. RICHARD WEINERMAN, CHAIRMAN, HEALTH SUBCOMMITTEE, AMERICAN VETERANS COMMITTEE

Mr. BOLTE. Mr. Chairman, I appreciate having the opportunity to testify on a subject of such far-reaching importance as the proposed national health program. My name is Charles Bolte and I am national chairman of the American Veterans Committee.

The American Veterans Committee is an organization of World War II veterans which is working for a more democratic and prosperous America and a more stable world. One of the cornerstones of a more democratic America is adequate medical care for all its citizens regardless of financial status.

Veterans are naturally very much concerned about health, as much as—and perhaps a bit more than—many other citizens. For we have recently been through an experience in which the threat to physical security was a constant one, and in which the ready availability of good medical care was one of the prime factors responsible for victory.

It has been heartening to return home and find that certain farsighted Senators and Representatives have drawn up a program

which would in effect afford adequate protection for us and our families against the ever present enemies of disease and ill health. We only wish that this same farsightedness had been extended some time ago to solve many other veterans problems, particularly housing and jobs.

AMERICAN VETERANS COMMITTEE RESOLUTION ON HEALTH

The A. V. C. has given careful consideration to the contents and the implications of S. 1606. It has been analyzed by the veteran doctors and economists and specialists on veterans' legislation serving on our technical subcommittees. Discussions have been sponsored in our chapters throughout the country. The response has been overwhelmingly in favor of the national health program now being discussed before this committee. As an example of our membership thinking on this matter, I would like to offer for the record the resolution on health passed by the Washington chapter of A. V. C.

If I may insert that.

The CHAIRMAN. Yes.

(The resolution referred to is as follows:)

Whereas the health of the Nation—and particularly of rural America and economically depressed segments of the urban population—is far below the standards already attainable according to the best abilities of modern medical science; and

Whereas there is an absolute and relative shortage of doctors, dentists, nurses, hospitals, public-health services, and welfare agencies, particularly in the poorer States where they are most needed; and

Whereas the fundamental barrier not only to the full utilization of existing facilities and services but also to the further establishment of those needed, is the high unpredictable cost of medical care; and

Whereas this barrier can be effectively removed by the device of universal, Nation-wide health insurance, making comprehensive care available to all regardless of ability to pay, by spreading the risk and sharing the costs; and

Whereas voluntary prepayment schemes have been shown to be incapable of meeting the needs of the groups that require the most improvement; and

Whereas the veterans are only partially covered by the GI laws and have, in general, the same family health problems as all other citizens; be it herewith

Resolved, That the American Veterans Committee support to its fullest ability proposals and activities—legislative and otherwise—that seek to attain the following objectives:

- (1) National hospital planning and construction;
- (2) Community-wide establishment of public-health services;
- (3) Quality medical care for the indigent;
- (4) National, compulsory, prepaid system of personal medical-care benefits;
- (5) Extension of social-security protection—as pertains to health;
- (6) Federal assistance to medical research and education.

And be it further

Resolved, That the national health bill of 1945 (S. 1606), as the most important single piece of health legislation for the Nation's welfare, be given direct, immediate, and maximum support by the official representatives and the entire membership of the American Veterans Committee.

That the mental health bill (S. 1160), as a necessary interim measure to solve the pressing current problems of mental illness in the country, be supported by the American Veterans Committee.

Finally, that further support be given to the Hill-Burton hospital construction bill (S. 181) and to the proposed Murray amendments that are so basic to its value.

Mr. BOLTE. In addition, I have with me 18 to 20 telegrams from A. V. C. chapters from Rhode Island to Washington and Detroit to Dallas, Tex.

SELECTIVE SERVICE REJECTIONS

Let us face the fact that the health of our Nation is badly in need of improvement. We who were picked to wear the United States uniform have every reason to be upset by the shocking number of men rejected by the selective-service examiners. It was not pleasant to find middle-aged fathers and essential industrial workers as our overseas buddies—there because almost half of our young men had failed to meet the minimum physical standards of the service and because the quota had to be filled with others.

I must say that I was amazed to hear that a witness before this committee stated that rejections due to uncorrectable defects should not be considered in evaluating lessons of these selective service findings.

Is it not apparent that the cases of total defects that he would have us discount are all too often the end results of inadequate medical care in previous years?

I wondered, too, if this witness remembered that the Army finally had to accept many of the unfit, and—by giving them good corrective treatment—succeeded in rehabilitating almost 2,000,000 of them.

VETERANS' ADMINISTRATION DOES NOT MEET TOTAL HEALTH NEEDS OF VETERANS

Veterans are happy for the services provided through the Veterans' Administration. We are pleased that the quality and organization of those services are being so thoroughly improved under the able leadership of Generals Bradley and Hawley, for whom we have abiding respect. But it must be clearly realized that the best Veterans' Administration program possible can meet only a fraction of the total health needs of the millions of our veterans. Let me try to make this point very clear.

The veterans' facility program is geared to offer medical service primarily to the veterans with a service-connected disability. For an illness or injury not directly attributable to military service, treatment can be received only if the veteran travels to the facility—which may be a distance of 100 miles or more—and if he proves his inability to pay for private care. This involves the humiliating pauper's oath, and I can think of nothing less dignifying to the veterans. In addition, the acceptance by the VA of a non-service-connected case depends on the availability of a bed.

Despite the excellent construction and surplus-property acquisition programs of the Veterans' Administration, they would be the first to admit that hospital facilities are going to be insufficient to meet all service-connected needs for some time to come, let alone the needs of those disabilities not acquired in the line of duty.

A further point is that ambulatory or out-patient care is not at all available for the non-service-connected cases, and if any treatment is to be secured for such conditions the veteran is obliged to leave his home and be admitted into the hospital, regardless of the nature of his complaint. It seems quite unlikely to us that the Veterans' Administration can ever hope to cope with the civilian medical troubles of the veteran.

We are very much aware of the fact that the great bulk of an average veteran's medical problems has no relation to his military service. Like any other citizen, he suffers from the day-to-day illnesses of pneumonia, stomach trouble, kidney disease, accidents, and the like. The chronic diseases of later years are just as worrisome to the veteran as to anyone else.

We are convinced, however, that the Veterans' Administration must continue to play a very important role in furnishing the special, often long-term care required by those who do have service-connected disabilities. We believe that national health insurance would relieve the Veterans' Administration from the worry of the non-service-connected cases.

Then General Bradley could forge rapidly ahead in establishing a network of first-rate hospitals across the country. These hospitals might become the highly specialized centers for plastic surgery, orthopedics, eye care, psychotherapy, and physiotherapy that would be tremendously valuable to the disabled veteran.

This function of the veterans facilities in serving the special needs of those afflicted in the line of military duty should be made more specific in the bill, even though there is nothing now in the bill that usurps the functions of the Veterans' Administration. Then the veteran could obtain full services for his "civilian" ailments and yet be able to go to a veterans' hospital for care of service-connected disabilities if he so chose.

Of intense concern to the veteran is the fact that the GI laws give absolutely no protection to his family. We can imagine no veteran feels his family to be medically secure because he himself can go to a veterans' facility when his old gunshot wound bothers him.

We are working fathers and husbands and sons who want a health system that extends to our kids and our wives and our dependent parents. We want no charity, such as the spokesman for the American Medical Association seemed to think should be given to all those who could not afford to buy medical care at present rates. But we do know insurance when we see it. We can appreciate a system that enables us to prepay a small percentage of our wages into a common pool which will be sufficient to finance the medical care we require and can obtain under this program, from the doctors and hospitals of our own choice. This plan covers the whole family and holds good for any sickness that may arise. I think this is one of the kinds of security for which we fought.

While we were in uniform, those of us who were in the lowest four grades enjoyed the security of knowing that our wives were provided for during childbirth through the emergency maternity and infant care program. This Government-administered system was a life-saver to many servicemen. Under it doctors carried on their own services and were assured of the fees.

Some veterans were very frankly amazed and hurt on their return from overseas to learn from their wives that the medical profession had actually fought this EMIC program, and continued to attack it even after it had proven its importance. As yet this program has not "undermined our American way of life," as opponents of such matters always seem to warn.

ARRANGEMENTS WITH STATE MEDICAL SOCIETIES

Recently, there have been some arrangements worked out with State medical societies by the Veterans' Administration whereby the veteran entitled to care by the Veteran's Administration can be treated in his own community by a doctor agreeing to the plan. While this is certainly a step in the right direction as far as the local veteran is concerned, it still leaves out the mass of non-service-connected conditions and still fails to protect the family.

Actually, there are many specific things about this new development that we do not like.

First of all, the medical societies in Michigan and New Jersey—two of the original States to set up the plan—have demanded a fee schedule that is higher than the one put out this year by the Veterans' Administration. Moreover, these funds are being turned over, without adequate safeguards, to private organizations that lack "consumer" participation.

Further, we note with surprise that those who have been so upset about the fact that S. 1606 allows freedom of choice only of participating doctors are quite happy with the identical provision in these AMA-sponsored plans. We feel that such plans are not the answer, and we urge logical extension of this same principle of home-community medical care to cover all of the veterans' nonmilitary health needs. This can only be done through a comprehensive system of national health insurance, such as is provided in this bill.

The biggest problem is cost. Modern medical care is just too expensive for the average veteran to purchase in the full amounts and types that may be needed at the time of sudden, unexpected illness. Health insurance, with payments scaled to income, is the answer to this basic problem.

Mr. Chairman, if we learned anything in the Army and Navy it was that foresight and preparation pay off. Surprise is surely the key weapon of the military, and up till now it has been the key weapon of disease. But health insurance robs the sudden illness of its ability to catch us financially unprepared. It readies us to meet the enemy on our own terms and with the necessary weapons of defense. Under the provisions of the Wagner-Murray-Dingell bill and its companion hospital construction bill, each citizen is not only relieved of the economic fear of a surprise attack of illness, but he has access to comprehensive and modern services with which to fight back. This sounds to us like good sense—as well as good tactics.

WHY VOLUNTARY PLANS DO NOT MEET THE NEED

We are convinced that we cannot depend on the so-called voluntary plans for our total health needs. These depend for their survival on the uncertainties of personal choice to join or stay out, and seem doomed from the start to a precarious and actuarially unsound existence.

Those of us who need health protection the most often cannot join because of the high total of premiums that pile up when we try to join enough of the voluntary plans to get something like complete coverage.

If we pay what Blue Cross and Medical Society plans require, we are covered only for limited hospitalization and for certain emergencies and surgical treatment, and these substantial payments still do not cover the chief day-to-day phases of medical care such as home and office care by a family practitioner.

Finally, neither these precarious voluntary schemes nor even the hospital program of the Veterans' Administration makes provision for preventive medicine—and we feel that it is far more important to head off disease than it is to try to patch up the results of it.

Under a national health program, everyone will be able to call for medical advice at the very onset of trouble and thus minimize the damage. Moreover, periodic health examinations will become possible if the financial barrier is removed from between the doctor and the patient.

With more hospitals and public-health services and clinics and laboratories made accessible to the people, America can be made truly health conscious, and will be able actually to satisfy its continuing desire for the widespread prevention of disease.

We cannot understand those who claim that the national health bill makes no provision for preventive medicine. Certainly, the counter-suggestion of voluntarily plans and charity medicine can never give such guaranties.

Some people have attacked this bill, as they attack all legislation, by calling it socialism and political medicine. Such nonsense doesn't scare the veteran one bit.

Most of us found that the medical care we got in the service was as good or better than we ever got before—minor "gripes" notwithstanding. The main reasons it was good were that we got it when we needed it. We got all of it the doctors felt to be necessary to the case, and we did not have to limit our treatments to those that we could pay for at the time.

Another reason was the good organization of medical service around groups of doctors in fully equipped installations. We want to see this modern pattern of medical care more widely available in our civilian lives—and this bill opens the door to its possibility. As a matter of fact, an American Medical Association poll revealed that 58 percent of all Army medical officers would prefer to return to group practice.

S. 1606 does not put all doctors on a salary as in the military; it only means that their bills would be assured of payment for the insurance fund, according to methods of their own choosing.

Perhaps the doctors will choose the old fee-for-service pattern, but it seems to us that they did a pretty swell job even when on salary. I say this because there is a lot of talk about this bill meaning regimentation and the lowering of standards. This does not make sense to us; we believe that by removing the dollar sign in the physician-patient relationship this bill will greatly enhance the quality of medical care.

This is basically the peoples' problem. The doctors are responsible for good quality of service and deserve good pay. But the job of organization and distribution and bookkeeping is the people's responsibility, and if they think this bill is sound it should be passed and the doctors will soon see the emptiness of their fears.

Incidentally, I am told that so far not one lay group except the American Bar Association has come here to oppose this bill.

THE PROGRAM MUST BE NATIONAL

The program cannot be left to the individual States, for the poorer ones cannot manage by themselves. A national plan pools all resources so that every citizen has equal health protection, and no one is penalized by the accident of residence in a less wealthy State.

There is one final point which has received little attention. The veteran doctors and dentists have been meeting untold difficulties in their attempt to reconvert to civilian work. Hospital training opportunities are available to only a segment of those who want them. The return to practice has been handicapped by all kinds of troubles—lack of equipment, inability to get old patients back, reluctance to relocate in the smaller communities that need doctors but that cannot adequately support them.

Furthermore, many rural communities lost more than their quotas of medical men to the services, and are now facing the prospect of remaining without them, as these veterans seek practices in the more prosperous and better-equipped urban centers.

We feel that S. 1606 and S. 191 together can provide the most basic solutions to these pressing problems of veteran doctors and dentists. This would be done by establishing new training facilities, providing funds for education and research—and the health bill gives special priorities to veterans in this connection—and by creating effective medical purchasing power and more adequate facilities in the rural and poorer communities to which veteran doctors might then be attracted.

We urge that no time be lost in making this bill law. We feel confident that all veterans who are presented with the true facts about the program—as were A. V. C. members the country over—will be heartily in favor of it. The unscientific and often distorted statements made in attack upon the health bill did not stand the test of our careful examination of it. Nor do we think that the average doctor would fail to come to a different conclusion if he were presented with objective evidence, and if he were free to speak his mind—which he is certainly not free to do today.

Security against the burden of illness and disability is one of the things for which we fought—not the “blueberry pie” of the ad writers nor the Nash-Kelvinator concept that everything at home must be entirely unchanged and unimproved from the day we left. The American Veterans Committee is convinced that the passage of the national health bill will be one assurance that the fighting has not been in vain.

The CHAIRMAN. Any questions, Senator?

Senator DONNELL. Yes, sir. I would like to ask him some questions.

Mr. Bolte, where do you live, please?

Mr. BOLTE. In New York, sir.

Senator DONNELL. New York. What is your profession or business?

Mr. BOLTE. I am the national chairman of the American Veterans' Committee. That is a full-time job.

Senator DONNELL. A full-time job?

Mr. BOLTE. Yes, sir.

Senator DONNELL. What was your business before you went into the war?

Mr. BOLTE. I was a student and a newspaper reporter.

Senator DONNELL. Where were you a student?

Mr. BOLTE. Dartmouth College.

Senator DONNELL. Dartmouth College?

Mr. BOLTE. Yes, sir.

Senator DONNELL. Are you a graduate of Dartmouth College?

Mr. BOLTE. Yes, sir.

Senator DONNELL. What year did you receive your degree?

Mr. BOLTE. 1941.

Senator DONNELL. That is a bachelor's degree?

Mr. BOLTE. Yes, sir.

Senator DONNELL. Do you have subsequent degrees?

Mr. BOLTE. No, sir.

Senator DONNELL. You went into the war in what year?

Mr. BOLTE. I went straight in in June of 1941.

Senator DONNELL. 1941?

Mr. BOLTE. Yes.

Senator DONNELL. You mean you went into training in 1941?

Mr. BOLTE. Yes.

Senator DONNELL. Of course, we did not get into the war until December of 1941, as you recall.

Mr. BOLTE. Yes, sir.

Senator DONNELL. You say you were a newspaper reporter, also?

Mr. BOLTE. Yes, sir.

Senator DONNELL. What paper were you on?

Mr. BOLTE. I worked on the college paper, and I worked during summer vacations on my paper at home, Greenwich, Conn.

Senator DONNELL. What was that paper, please?

Mr. BOLTE. The Greenwich Press.

Senator DONNELL. The Greenwich Press. Have you worked on any other newspapers?

Mr. BOLTE. No; unless you would count a regimental paper.

Senator DONNELL. That is important. And you worked on that?

Mr. BOLTE. Yes, sir.

Senator DONNELL. And you have never been engaged in the practice of medicine and have not studied medicine?

Mr. BOLTE. No, sir.

Senator DONNELL. You worked at Dartmouth, and there your work was along what line?

Mr. BOLTE. I majored in English and English literature and history.

Senator DONNELL. Did you study economics?

Mr. BOLTE. Yes, sir.

Senator DONNELL. But you did not major in that subject?

Mr. BOLTE. No, sir.

THE AMERICAN VETERANS' COMMITTEE

Senator DONNELL. Mr. Bolte, the American Veterans' Committee was organized when?

Mr. BOLTE. Well, sir, it started with a correspondence among men who were still in service in January of 1943 and it became formalized and had a name and opened an office in July of 1944.

Senator DONNELL. And where was that office located?

Mr. BOLTE. In New York.

Senator DONNELL. In New York. When did you become the chairman of the committee?

Mr. BOLTE. In July 1944.

Senator DONNELL. July 1944.

Mr. BOLTE. Yes, sir.

Senator DONNELL. I see. And you have been in that capacity ever since?

Mr. BOLTE. Yes, sir.

Senator DONNELL. Has it been a full-time position all during that period?

Mr. BOLTE. It did not become a full-time position for me until October of 1944.

Senator DONNELL. 1944. Yes, sir.

How large an organization is it at this time.

Mr. BOLTE. The membership is now slightly over 50,000, sir.

Senator DONNELL. Slightly over 50,000 throughout the United States, is it?

Mr. BOLTE. Yes, sir; and overseas. We have members still in service.

Senator DONNELL. You have approximately how many chapters in the United States?

Mr. BOLTE. About 400 in the United States.

Senator DONNELL. About 400, and they are scattered pretty well all over the country. That is correct, is it not?

Mr. BOLTE. All the way from Portland, Maine, to San Diego, Calif.

Senator DONNELL. Do you have an annual meeting of the Veterans' Committee?

Mr. BOLTE. We have our first convention in Des Moines this year.

Senator DONNELL. Has the committee passed its judgment on S. 1606?

Mr. BOLTE. Yes, sir.

Senator DONNELL. When was that done?

Mr. BOLTE. The national planning committee of the organization voted its support of the bill last Tuesday, a week ago today.

Senator DONNELL. That was the national planning committee?

Mr. BOLTE. Yes, sir.

Senator DONNELL. How large a body is the national planning committee?

Mr. BOLTE. It has 15 members.

Senator DONNELL. Fifteen members. And that is the committee which adopted the resolution indicating the position of the American Veterans' Committee itself?

Mr. BOLTE. After receiving the resolutions from the chapters around the country; yes.

Senator DONNELL. I see. Have you received resolutions from each and all of the chapters or just a portion of them?

Mr. BOLTE. I really do not know, sir. Not all of them, I do not believe. I am not sure of the number.

Senator DONNELL. Has there been a copy of this bill sent out to the various chapters all over the country?

Mr. BOLTE. What we did on this particular one was to have the program and research division prepare an analysis of the bill and explain how it would work, summarize the arguments advanced for and against it, and send this out to each chapter and ask the chapter to discuss the bill at an open meeting with notice given to the members in advance, take the vote, and send us the numerical figures of the vote.

I have here some resolutions which explain how they work. One small chapter had a vote of 19 in favor and 5 against.

Senator DONNELL. What chapter was that?

Mr. BOLTE. That was one in the New York post office.

Senator DONNELL. New York City?

Mr. BOLTE. New York City, yes.

Then there was a chapter in New Haven, Conn., which had a meeting and voted, after a discussion, 200 for the bill, none against.

The Washington chapter, which now numbers something over 1,100, voted unanimously.

Senator DONNELL. How many persons were present at that meeting?

Mr. BOLTE. Do you recall, Doctor?

Dr. WEINERMAN. Yes, sir. I was there. About 400, Senator.

Senator DONNELL. About 400?

Dr. WEINERMAN. It was not actually unanimous. I think there were two dissenting votes.

Mr. BOLTE. I am sorry.

Senator DONNELL. Substantially so?

Mr. BOLTE. I brought one or two resolutions along, which opposed. I think I only found three chapters which were against.

Senator DONNELL. What were those chapters that were against?

Mr. BOLTE. Mansfield, Ohio—

Senator DONNELL. Yes.

Mr. BOLTE. Voted to oppose.

Senator DONNELL. What was the vote; do you recall?

Mr. BOLTE. It is not given here.

Senator DONNELL. All right. Mansfield, Ohio.

Mr. BOLTE. The Exeter Chapter in East Greenwich, R. I., apparently had a small meeting. Fourteen against, none for, and four abstained. Those seem to be all I have with me. These were taken at random from our files.

Senator DONNELL. How many chapters have voted in favor of it, approximately?

Mr. BOLTE. I do not actually know.

Senator DONNELL. You do not actually know?

Mr. BOLTE. I know the program and research reported that the vote was about 90 percent in favor of the planning committee. The planning committee then proceeded on the mandate to endorse the bill and authorized me to appear here today.

Senator DONNELL. Do you have with you a copy of that summary for and against sent out to the various chapters?

Mr. BOLTE. I am afraid I do not, Senator.

Do you have a copy?

Dr. WEINERMAN. No.

Senator DONNELL. Where did you get the arguments for and against inserted in this summary?

Mr. BOLTE. Our research director and his assistants maintain a very complete file of all of the things that are said for and against these current measures in which we are interested, and I presume on this they had access to various public statements, newspaper documents, pamphlets, and so on.

Senator DONNELL. You do not have with you, however, a copy of that document sent out?

Mr. BOLTE. No, I do not.

Senator DONNELL. Would you mind furnishing our committee a copy of that document?

Mr. BOLTE. By all means.

Senator DONNELL. Could you do that within the next 10 days?

Mr. BOLTE. Yes. I will see it comes right down.

Senator DONNELL. You spoke of your research director. Who is he?

Mr. BOLTE. Louis Harris.

Senator DONNELL. What is his profession or business?

Mr. BOLTE. He was just out of the Navy, and he was a student before entering the service. He worked at Philadelphia and Boston in business and was also doing research work before the war.

Senator DONNELL. Approximately how old a man is he, Mr. Bolte?

Mr. BOLTE. Twenty-eight, I should think.

Senator DONNELL. I see. Did he personally express an opinion, so far as you know, before the preparation of that summary, as to how he felt with respect to S. 1606?

Mr. BOLTE. I do not recall that he did; Senator, no.

Senator DONNELL. Now, Mr. Bolte, this statement that you have read here this morning, was this prepared personally by you?

Mr. BOLTE. Yes, sir.

Senator DONNELL. It was. Yes. Have you read this bill, S. 1606?

Mr. BOLTE. Oh, yes, sir.

Senator DONNELL. You have gone over it with care, yourself?

Mr. BOLTE. Yes, sir.

FREE CHOICE OF DOCTOR

Senator DONNELL. You speak in one place here about the freedom of choice of physicians. In your opinion, this bill provides freedom of choice of physicians?

Mr. BOLTE. I think it does, sir; yes.

Senator DONNELL. Let me give you an illustration in that connection. You have a copy of the bill there.

Will you turn to section 205 (j) on page 50. You will observe there this paragraph:

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 prac-

titioners may undertake to furnish general medical or general dental benefit, and such limits may be nationally uniform or may be adopted to take account of relevant factors.

Mr. BOLTE. You are familiar with that portion of the bill?

Mr. BOLTE. Yes, sir.

Senator DONNELL. Suppose we take a situation like this: take a community such as your home community up in Connecticut. How large a town, by the way, is that?

Mr. BOLTE. 35,000.

Senator DONNELL. 35,000. Now, suppose that there were 35 doctors in your city there. That would be an average of one per each thousand. I suppose some of those doctors are more outstanding in general reputation than others?

Mr. BOLTE. They are.

Senator DONNELL. Suppose that in that community it were determined by the physicians, a majority of them, that the per capita plan of payment would be adopted under S. 1606. You are familiar with the per capita plan?

Mr. BOLTE. Yes.

Senator DONNELL. As I understand it, under this subdivision (j), section 205, there would be assigned by the Surgeon General a certain number of patients or persons that might become patients of any given doctor. That is correct?

Mr. BOLTE. The maximum, yes.

Senator DONNELL. That is what I mean, the maximum.

Suppose we will take that in that community, that this plan under S. 1606 would go into effect. There would be a natural influx of people to the physicians best known or best liked. That is correct, in your opinion, is it not?

Mr. BOLTE. Yes.

Senator DONNELL. All right. Supposing that in the case of Dr. Smith, that his quota is filled comparatively soon. We would say that 1,000 were set aside for each one of these 35 doctors, and his thousand is quite promptly filled.

Now, the next person coming along will not secure his services if he wants to? He could not do it under this bill?

Mr. BOLTE. No, sir.

Senator DONNELL. To that extent, Mr. Bolte, there is some restriction on the choice of doctor; is there not, by the terms of the bill?

Mr. BOLTE. Well, in actual fact, Senator, I think it would work out much the same as it actually does in Greenwich now, where Dr. Smith is the most popular doctor, and he gets filled up at considerably less than 1,000, and he has his appointments all made for the day and throughout the week, and if he gets another patient who wants to come see him, he simply cannot take him, and refers him on to another doctor.

I think it would, in practice, work out much as it actually does now.

Senator DONNELL. However, Mr. Bolte, at the present time the matter of determination as to whether his actual capacity has been arrived at lies with Dr. Smith rather than with the Surgeon General of the United States, does it not?

Mr. BOLTE. Well, sir, I think it is apparent to me from the bill that the bill when enacted will result in very close cooperation and con-

sultation in all these matters, both locally and nationally, with the National Medical Advisory Committee, and so on, which confers with the Surgeon General on all of these policy matters. And I am sure that locally it would be worked out in the same fashion, through consultation and not in the form of a dictate handed down by the Surgeon General.

Senator DONNELL. That, however, is not an answer to the question I asked you, Mr. Bolte, which was, at the present time, today, right now, the determination of whether or not the capacity of Dr. Smith to receive patients has been reached rests with Dr. Smith rather than with the Surgeon General of the United States. That is correct, is it not?

Mr. BOLTE. Yes, sir.

Senator DONNELL. Whereas under this bill, the ultimate determination in the case I have cited, rests under the terms of subdivision (j), section 205, with the Surgeon General; that is true, is it not?

Mr. BOLTE. In consultation with these other groups.

Senator DONNELL. There is nothing in section (j) which says the Surgeon General is required to consult, or even if he is, that they have any power of decision. It rests in the Surgeon General, does it not?

Mr. BOLTE. I should consider that a very narrow construction.

Senator DONNELL. Well, that is what it says, that the Surgeon General may prescribe maximum limits. You observe that language?

Mr. BOLTE. Yes, sir.

Senator DONNELL. All right.

Now, let me call your attention, also, Mr. Bolte, to the fact that there is a provision—will you turn, please, to pages 35 and 36—and I call your attention to 203 (a) :

The Surgeon General of the Public Health Service shall perform the duties imposed upon him by this Act, under the supervision and direction of the Federal Security Administrator, and after consultations with the Advisory Council as to questions of general policy and administration—

and so forth.

The ultimate power of decision actually does not even rest with the Surgeon General, does it, in view of that language? That is to say, and I am quoting from the first line and a half of page 36, he acts—

under the supervision and direction of the Federal Security Administrator.

You observe that, do you not?

Mr. BOLTE. Yes, sir.

Senator DONNELL. Now, you know, do you not, Mr. Bolte, that under the law today the Federal Security Administrator is not required to be a doctor? You know that, do you not?

Mr. BOLTE. Yes, sir.

Senator DONNELL. Yes.

Mr. BOLTE. He is appointed by the President, who is elected by the people.

Senator DONNELL. But the Federal Security Administrator does not have to be a physician. That is correct, is it not, Mr. Bolte?

Mr. BOLTE. Yes, sir.

Senator DONNELL. Yes, sir. All right. Now, Mr. Bolte, you say you have examined this entire bill?

Mr. BOLTE. Just one point, Senator, before we leave that. I thought you were going to pursue it further.

Senator DONNELL. All right.

Mr. BOLTE. I think that must be construed as the most broad and general supervision, much as the President's own supervision and direction of the Federal Security Administrator himself.

A certain field of activity is given to the Administrator, and you have a chain of administrative authority and responsibility going down from the President to the Federal Security Administrator to the Surgeon General himself.

Senator DONNELL. However, the language, that is as I have read it: The Surgeon General, under the supervision and direction of the Federal Security Administrator.

Mr. BOLTE. I think that is probably a fairly general provision for such a broad grant of authority, is it not, Senator?

Senator DONNELL. I say, that is the language?

Mr. BOLTE. Yes.

Senator DONNELL. And I observe a little further down on that page, page 36, down in subdivision (c), and you will observe there this language:

In carrying out the duties imposed upon him by this title, the Surgeon General is hereby authorized and directed, after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, to negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any State or political subdivision thereof, and with other appropriate public agencies, and with private agencies or institutions—and so forth—

to utilize their services and facilities—

and so forth.

I will read the rest of it if you would like, but the point I make is that the language in lines 19 and 20 are:

with the approval of the Federal Security Administrator.

That is correct, is it not?

Mr. BOLTE. Yes, sir.

Senator DONNELL. Now, I call your attention to page 37, subdivision (d), which reads, does it not:

In carrying out the duties imposed upon him by this title—

and this title is

Prepaid Personal Health Service Benefits—

Mr. BOLTE. Yes, sir.

Senator DONNELL. Which we would term the compulsory insurance provisions of this bill.

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

You observe that to be as I have quoted there, do you not, Mr. Bolte?

Mr. BOLTE. I do, Senator, but I do not really understand your em-

phasis on "with the approval of the Federal Security Administrator." I do not know how you can run an administrative organization of any kind without the approval of your superior.

Senator DONNELL. I am not questioning the wisdom of having somebody have final authority, but the point I am making, Mr. Bolte, is that today, Dr. John Smith in Greenwich, Conn., decides whether he will accept Mr. Bolte as a patient, does he not?

Mr. BOLTE. I believe he still does under this bill, sir.

Senator DONNELL. I believe he does today. That is correct, is it not, right this minute, as you are testifying?

Mr. BOLTE. As I read the bill, he can still refuse to accept me as a patient, and I do not have to accept him.

Senator DONNELL. Yes. All right. But, as I was pointing out, under subdivision (j) on page 50 of this bill, the Surgeon General many prescribe maximum numbers of persons that Dr. Smith may take.

Mr. BOLTE. That is under the plan.

Senator DONNELL. That is what I am talking about.

Mr. BOLTE. That is what you are talking about. Of course, doctors retain the right to practice outside the plan.

Senator DONNELL. I understand.

Mr. BOLTE. I could go to Dr. Smith outside the plan and be a private patient, not coming under compulsory insurance at all.

Senator DONNELL. I am not so sure about that. That is a question. You think that you can?

Mr. BOLTE. I would think so.

Senator DONNELL. You think the doctor can both practice under the plan and outside of the plan?

Mr. BOLTE. Would you agree with me, Doctor?

Dr. WEINERMAN. I think that is in the bill. It allows full- or part-time participation.

Senator DONNELL. Suppose it allows full or part time. Do you have that particular section?

Dr. WEINERMAN. I will look it up if you do not think that is true, sir.

Senator DONNELL. If you will just call attention to that, please.

Well, perhaps this is what you have in mind, page 48, subdivision (g):

Payments from the account to general medical and family practitioners or to general dental practitioners, for services under this part, shall be made * * * on a combination or modification of these bases, as the Surgeon General may approve;

is that what you are talking about?

Dr. WEINERMAN. That refers to methods of payment. I am sorry I cannot put my finger on it, but I believe a doctor can come into the plan part time or full time. I think that is correct. I would like more time to find it.

Senator DONNELL. We will pass on for the moment, but it still remains true, does it not, Mr. Bolte, that subdivision (j) does say,

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.

It says that, does it not?

Mr. BOLTE. It says so, sir; but I must insist that it refers to the plan itself.

Senator DONNELL. Of course, if that be true. Perhaps you are correct.

We will come to that and see. If it does, however, it means then, does it not, that subdivision (j) in effect is nullified, if the Surgeon General may prescribe maximum numbers, and yet if you can turn around and walk in the other door and say, "I engage your services not under the plan but outside the plan." So that the doctor could receive you.

Maybe it is right, but if he could, this bill is defective in that it would permit, by the device of a doctor practicing for 15 minutes on you under the plan—rather, refusing to practice only for 15 minutes, on the ground he would exceed the maximum, and let you come in and practice outside the plan, the provision of prescribing the maximum limitation of beneficiaries would be in effect nullified? That is correct, is it not?

Mr. BOLTE. Well, sir, I think that is assuming an unlikely situation.

Senator DONNELL. Very well.

Now, Doctor, are you familiar with the British system of compulsory health insurance?

Mr. BOLTE. Just in general terms, sir.

Senator DONNELL. May I call your attention to a book previously referred to in the evidence here, which is the Medical Insurance Practice. It is a book of several hundred pages, 350 pages or thereabouts, possibly not quite that much, but more than that with the appendices, et cetera.

This book is gotten out by Harris & Sack. And is "a work of reference to the medical benefit provisions of the National Health Insurance Acts."

And I call your attention to this:

The acceptance of a fee from an insured person, not on your list, who specifically asks for treatment as a private patient, does not constitute a 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 a 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, if unfounded, allegations like that, and so forth.

Do you know, from any knowledge you have, whether or not over in Great Britain this plan of doctors practicing part time under the plan and part time out of it is well regarded by the doctors, or is, as this book indicates, usually to be deprecated?

Mr. BOLTE. I do not know what the feeling is in Britain, but I should think the situation in this country is different.

Senator DONNELL. You have not investigated personally the conditions in Britain?

Mr. BOLTE. No, sir.

Senator DONNELL. Now, Mr. Bolte, referring to this bill, S. 1606, it is divided. The first part of it is title I, which proceeds along the line of the theory of grants to States by the Federal Government. That is correct, is it not?

Mr. BOLTE. Yes, sir.

Senator DONNELL. And those grants are in aid of the State administration.

Mr. BOLTE. Under State plans.

Senator DONNELL. That is correct, is it not?

Mr. BOLTE. Yes, sir.

Senator DONNELL. As distinguished from the operation of a Federal plan?

Mr. BOLTE. Yes, sir.

Senator DONNELL. The operation under the Federal plan is what is involved in the compulsory health insurance provisions of the bill; that is correct, is it not?

Mr. BOLTE. Yes, sir.

Senator DONNELL. Mr. Bolte, do you, generally speaking, favor the idea of a local administration by a State of matters that the State has particularly close knowledge of rather than a Federal administration with respect to those particular subject matters?

Mr. BOLTE. In that context, sir, yes.

Senator DONNELL. Yes, sir.

Have you considered at all, in determining your position on S. 1606, the possibility of the plan of Federal aid by grants to State being carried out throughout this bill instead of only through the first half of the bill, or thereabouts?

Have you considered that plan as opposed to the plan of Federal operation of a compulsory insurance plan?

Mr. BOLTE. I know Dr. Weinerman has addressed himself particularly to that question.

I would like to have him comment on it.

Senator DONNELL. Very well, with the permission of the chairman.

The CHAIRMAN. Yes.

Dr. WEINERMAN. The first title of the bill, which provides Federal grants-in-aid to the States for the establishment of facilities and community services of direct nature, I think, is very admirable, and the States can utilize the money from the Federal Government to set up the public health programs and other things they need.

However, title II of the bill is an insurance title, and the basic principle of insurance is the attainment of the widest possible coverage. If we restrict within each State the number of people who would be covered by the plan, those who reside in that State, we would then lose the actuarial advantages of the widest possible coverage. We would penalize the poorest States and the people in them merely by reason of the accident of their residence, and we would be avoiding the basic concept of having a Nation-wide plan which would be the lowest possible premium for every person in the Nation, giving them for the least amount of money the most comprehensive services.

Within that general structure the States and localities are very clearly able to carry on the day-to-day participation and adaptation to local needs that is spelled out in the bill.

Senator DONNELL. Doctor, you referred to the actuarial phases of the bill, as contrasted with the State administered insurance assisted by Federal grants.

Dr. WEINERMAN. Yes, sir.

ESTIMATED COSTS OF HEALTH INSURANCE

Senator DONNELL. Have you made any study of what would be a necessary amount of cost to be provided under S. 1606 to make S. 1606 actuarially sound?

Dr. WEINERMAN. You mean the total cost of the program?

Senator DONNELL. Yes, sir; the total cost of the program.

Dr. WEINERMAN. Well, I should think, from the reading and the discussions I have done, that the total cost of the program would fairly well equate itself to the total amount of money that America spends for medical care today.

I am not prepared to show you the figures, but I think about 4 to 5 percent of the national income is spent on total medical needs. I think a fairly similar amount of money would be expended under the provisions of this bill which would provide needed medical care on a more equitable basis for everyone, with no more actual dollars being spent by the Government, or at least not very many more, and if I may add a sentence, that the amount of good that can be done, the amount of sickness corrected, and suffering prevented, would be worth the small difference that might arise.

Senator DONNELL. Doctor, you are familiar with the fact, are you not, that S. 1606 is largely taken from S. 1050?

Dr. WEINERMAN. Yes.

Senator DONNELL. What I may term the "parent" Wagner-Murray-Dingell bill?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. Have you investigated at all the question of the probable total cost of the entire program envisaged by S. 1050, including the health insurance plan embodied in S. 1606?

Dr. WEINERMAN. I have not investigated it personally. I believe there have been some studies. I do not think the official studies I have seen have been able to come to an exact dollar-and-cents conclusion, because the bill itself is not specific about the amount of coverage as regards dental, nursing, and laboratory, and other benefits, and I do not think any decimal points in figures could be relied upon.

I think the bill wisely provides the term "a quantity sufficient" shall be put into the fund.

Senator DONNELL. You are from New York, I believe?

Dr. WEINERMAN. No, sir; I live in Maryland.

Senator DONNELL. You live in Maryland. You possibly are not acquainted with Mr. Earl E. Muntz, of New York University, who made a study on this?

Dr. WEINERMAN. No.

Senator DONNELL. I will not pursue that at this moment.

Now, Mr. Bolte, at page 7 you refer to the use of the term "socialism" and "political medicine," as being nonsense.

And I notice that you speak about unscientific and often distorted statements, and so forth.

There are two statements along those lines.

And another place, on page 8, you say, referring to the talk about this bill meaning regimentation and lowering of standards, that "this does not make sense to us."

Mr. BOLTE. Yes, sir.

Senator DONNELL. You tell me that you have not studied the conditions over in Great Britain personally.

Has Dr. Weinerman made any study, perhaps, of the effect of the British system on the quality of service that has been obtained under the British system as compared with the quality existing prior to the institution of compulsory health insurance in Britain?

Mr. BOLTE. Senator, if I may, before the doctor answers that question. The statement about regimentation was based on our experience in the Army, under which doctors were much more closely controlled than they would be under this plan, and were really closely and centrally administered. And the factor that struck us in our personal experiences, and not with any medical experience or background, but simply from conversations, the factor that struck us was that the great majority of men got better medical care, and more medical care, than they had ever had before in their lives. They saw hospitals which they had never dreamed existed. They were better taken care of in every way, and the health of every man in the Army, outside of those who had the misfortune to get tangled up with the enemy, was improved by the experience.

Senator DONNELL. Of course, you realize that the doctors in the Army were men taken out of active practice, in the main, from all over the country.

Mr. BOLTE. Good doctors.

Senator DONNELL. Yes, sir; they were. They were good practitioners taken from this country.

Mr. BOLTE. Yes.

Senator DONNELL. Yes.

Mr. BOLTE. And the fact is that that was the first chance a good many men in the Army had ever had to get good medical care from practitioners.

HEALTH INSURANCE IN GREAT BRITAIN

Senator DONNELL. What I am getting at is the fact that the doctors would render excellent service in the Army, that fact does not, as I see it, answer the ultimate thought that I have in my mind, namely, the effect, if any, of the British system of compulsory health insurance upon the quality of care over a period of years as it has developed in Great Britain.

I take it you are personally not acquainted with the subject?

Mr. BOLTE. Not on the civilian side, but I was in the British Army and had the same experience there, that the men who were the doctors in the British Army and who took care of me when I was wounded and sick gave excellent service. They were all men from private practice in Great Britain, who had volunteered for the Royal Army Medical Corps, and they gave absolutely first rate, fine surgical and medical care.

Senator DONNELL. You have, however, not examined into the question of whether or not, generally speaking, the quality of physicians' services in Great Britain has been affected in its administration of medicine and surgery to the masses of the people in civilian life? You have not studied that?

Mr. BOLTE. Judging from experience, again, sir, in the Army, I would think that the system had certainly proved itself in the quality of care that the doctors did give in the Army.

Do you want to comment on that?

Dr. WEINERMAN. Might I?

Senator DONNELL. Certainly. Pardon me just a moment, though.

You have made a study of the British system to ascertain whether or not there has been a change for the better or for worse, generally speaking, in Great Britain as compared with the situation before the institution of compulsory health insurance?

Mr. BOLTE. No, sir.

Senator DONNELL. Now, Doctor.

Dr. WEINERMAN. I was fairly fortunate, because in the Army before the invasion and before we went to the Continent, I was stationed as an Army medical officer in England, I was fortunate enough to have been billeted in a private English home in a small community where I stayed for some months. Being a doctor and interested in these matters, I made a point to talk to both doctors and lay persons about the health insurance plan in England; and despite the fact that the medical profession in England today is opposed to further extension of the plan, which extensions are quite different from the principle of this bill, they have had, for many years, a health insurance plan which is more similar to this bill, and of which the British Medical Association and the doctors in England are very much in favor. They like their health insurance plan. The doctors I spoke to told me so. The people I spoke to pointed out over and over again that the thing that is important is that the cash barrier to the family physician had been removed. By prepaying the small amount that was required, they went to the doctor when they thought they had to go to the doctor. That was the biggest feature. That made for preventive medicine, possibly not to a complete extent, but far greater than ever had been possible before.

I think because of that, and because of the closer contact between patient and doctors, the quality of medicine in England was improved from what it had been.

Senator DONNELL. Doctor, I understood you to say that there is proposed in England an extension of the plan. That is correct, is it not?

Dr. WEINERMAN. Yes.

Senator DONNELL. And you are familiar with the fact that there has been a tendency on the part of the Government in England to add to the compulsory health insurance by bringing about this extension to which you refer. You know that to be true?

Dr. WEINERMAN. I read from reports of the British Medical Society in the past few weeks that they are favorably inclined to many of these proposals, these extensions. There are certain specific ones, like the selling of practices, that there is a difference of opinion on. This is the source of disagreement—not the extension of coverage to more of the British population.

Senator DONNELL. You are familiar with the fact that there has been an organized effort made by the solicitation of funds and otherwise among the doctors of England to oppose this extension, and the London Times, in a recent issue of March 22, notably, brought out

fully the great opposition that exists among the doctors in England to further extension of service?

Dr. WEINERMAN. I think it would be the same kind of solicitation of funds that I get in my mail.

Senator DONNELL. You are familiar with the fact that this opposition does exist among many members of the British Medical Society, and has been widely publicized in England?

Dr. WEINERMAN. I know the British Medical Society is opposed to many of the features.

May I add, they are quite favorably inclined to the concept of compulsory health insurance, such as we are considering here.

Mr. BOLTE. May I add a word?

Senator DONNELL. Surely.

Mr. BOLTE. I do recall reading, years ago, when the plan was introduced in England, I would think that the present opposition to the plan is very similar to the opposition that was brought forth when the plan was first announced there; and I concur with what Dr. Weinerman said, that the part of the plan accepted in practice, has won the approval of the great majority of the doctors.

Senator DONNELL. The plan in England covers approximately 40 percent of the population?

Dr. WEINERMAN. I am not familiar with that.

Senator DONNELL. You are not familiar with that. I think that is correct.

And you know that under the Wagner-Murray-Dingell bill, it is proposed at the outset to cover approximately 105 to 112 millions out of 140 millions in our population. You know that to be true?

Dr. WEINERMAN. Yes, sir. We are very pleased, Senator, that that gives our plan wider actuarial basis.

Senator DONNELL. You think that is more desirable?

Dr. WEINERMAN. It makes it more sound administratively and professionally.

ATTITUDE OF THE AMERICAN MEDICAL ASSOCIATION

Senator DONNELL. Are you a member of the American Medical Association?

Dr. WEINERMAN. This is the situation on that: I went into the Army immediately after hospital training. During my hospital training, I was not informed about my eligibility for the American Medical Association. I have been home now for just a few months, and intend to put in my request.

Senator DONNELL. To the American Medical Association.

You regard the American Medical Association as the outstanding organization of physicians in this country, do you?

Dr. WEINERMAN. It certainly is the over-all organization of physicians.

Senator DONNELL. And do you regard, Doctor, the efforts made by the American Medical Association in the knowledge which it gives in the Journal published from week to week or month to month, as the case may be; do you regard it as rendering a substantial and fine service to the medical profession in this country?

Dr. WEINERMAN. I can only answer that one way, sir. Its tech-

nical and scientific and professional functions are extremely admirable. I think it is certainly fine work, as fine as that anywhere else in the world.

However, the official A. M. A. attitude on social and economic matters is not always my personal opinion. I do not believe it is equally progressive and enlightening.

If I may illustrate this, Mr. Chairman, at this point, I have here the official Journal of the Pennsylvania Medical Society, April 1946, issue.

SOCIALIZED MEDICINE

Still just as hard to swallow

But it has been sugar-coated! It isn't the "General Welfare Pill" any more. Now we call it the "National Health Pill!"

WAGNER-MURRAY-DINGELL BILL

National Health Act of 1945 (S. 1606; H. R. 4730)

Introduced in the Senate by Senators Robert F. Wagner, of New York, and James E. Murray, of Montana. In the House of Representatives by Congressman John D. Dingell, of Michigan

If the recommendations contained in title II of this bill which pertains to medical care are enacted into law, they will (just as in the previous bills S. 1050 and H. R. 3293)—

1. Regiment over 130,000,000 American citizens, compelling you through compulsory taxation to pay and participate regardless of your needs or wishes. Thus subjecting the health of you and your family to bureaucratic control.

2. Take 4 percent of your pay. In reality it will require at least 8 percent to 15 percent of the total pay roll of the United States which must be raised by taxation from each citizen. Administrative cost alone under Government bureaucratic control will be greater than the cost of the medical service. It may mean the employment of 300,000 local panel clerks and inspectors.

3. Stifle initiative on the part of the doctors by making them subservient to bureaucratic control. Thus lowering the quality and effectiveness of your medical care.

4. Centralize control of your medical care in Washington, D. C., by making the Surgeon General of the United States Public Health Service a dangerously supreme authority, with dictatorial powers over the health of you and all other Americans.

Compulsory health insurance has been a dismal failure in any country in which it has been tried.

Freedom and the fostering of initiative has made the United States the greatest Nation in the world. Don't relinquish them.

Write your Senators and Congressman requesting a copy of this bill. Study it and then decide for yourself.

This issue must be decided by the people—the voters of the United States.

MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

And, in response to the Senator's questions about scientific excellency of the AMA, I would like to point out this full-page advertisement on page 753 and submit it for the record, if I might, in which "Socialized Medicine" is attacked in three or four paragraphs—at least two or three of which, I am sure the Senator himself would characterize as being untrue paragraphs.

Paragraph 2 of this advertisement claims that the bill would take 4 percent of one's pay, and on previous testimony, the Senator himself pointed out there is no such provision in this bill at all.

It goes on to say, people would be compelled to participate, which we all know is not true. It further states that compulsory health

insurance has been a dismal failure in other countries, which we know is not true.

In contrast with the excellence of the technical articles, I submit that such a full-page statement about this bill is not particularly scientific.

Senator DONNELL. This is gotten out by the Medical Society of the State of Pennsylvania, is it not, and signed by the Medical Society of the State of Pennsylvania?

Dr. WEINERMAN. I believe, sir, that the witness for the American Medical Association pointed out that the AMA is composed of its constituent State societies.

Senator DONNELL. But, I say, this particular advertisement was not gotten out by the American Medical Association, but by the Medical Society of the State of Pennsylvania and is so signed.

Dr. WEINERMAN. That is correct, sir.

Senator DONNELL. Reverting to the American Medical Association, Doctor, it contains approximately, or rather, in fact, in excess of 125,000 of the physicians and surgeons of this country, does it not?

Mr. WEINERMAN. It does, sir.

Senator DONNELL. And it has been endeavoring, in your opinion, to render a fine type of service along scientific lines?

Dr. WEINERMAN. It has.

Senator DONNELL. And medical lines?

Dr. WEINERMAN. It has.

Senator DONNELL. You do not regard its opinions and thoughts on matters of social and economic affairs as being of the same high quality?

Dr. WEINERMAN. That, and the fact that I do not believe they accurately reflect the opinion of every doctor, sir.

Senator DONNELL. Of course, Doctor, I take it it is impossible for any organization to reflect the opinion of everybody in it. But we do know the fact that the House of Delegates of the American Medical Association has expressly stated the opposition of the association to compulsory health insurance?

We know that, do we not?

Dr. WEINERMAN. May I comment on that?

Senator DONNELL. Just answer the question, first.

Dr. WEINERMAN. I would like to answer it.

Senator DONNELL. I will give you an opportunity to. Will you just state whether that is a fact or not, and then you may comment.

Senator PEPPER. It may not be a question you can answer "yes" or "no."

The CHAIRMAN. Just like the old one of beating up your mother.

Dr. WEINERMAN. I would like to answer the question.

Senator DONNELL. Very well. Answer in your own way.

Dr. WEINERMAN. When I was overseas, I was with a mobile surgical team, and because of that I had the chance to travel quite a bit about the continent of Europe, and the European theater, and I came in contact with hundreds and hundreds of doctors; medical officers.

I would say, quite frankly, the majority of them were opposed to such measures as this, but I would also say that an exceedingly significant number were not so opposed.

When these men come back to this country and return to their

medical societies, I would like to point out that even though a majority of them were in favor of such a bill as this, it would take 3 to 5 years for the house of delegates of the American Medical Association to so register that opinion, because the delegates are elected far in advance.

So, the opinion, I believe that we get from the A. M. A. today is the opinion of its members a few years back.

I am not saying it does not reflect membership opinion. I am just pointing out, it does not do it necessarily.

Senator DONNELL. Doctor, you know that the house of delegates meets periodically once every year.

Dr. WEINERMAN. I believe so, sir.

Senator DONNELL. You do not mean to say that the house of delegates of the American Medical Association would go back and see what somebody said 5 years ago before determining what its position would be on a current resolution offered at the meeting in a given year?

Dr. WEINERMAN. No, sir.

Senator PEPPER. You mean they would not go as short a time back as 5 years?

Senator DONNELL. No; I did not say that, and the Senator well knows I did not.

Dr. WEINERMAN. What I mean, sir, is the house of delegates and in many cases the officials—

Senator DONNELL. I may say, that argument is equally forceful with that which was mentioned of the hospital down in Orlando, Fla., a few days ago.

Go ahead, Doctor.

Dr. WEINERMAN. It is just that I believe that the delegates and even the officials of many constituent societies are elected for terms up to three and perhaps more years ahead. So, when they go to the house of delegates to represent their society, they represent the election that took place some years ago.

Senator DONNELL. Doctor, you are not seriously contending to this committee that the expressions of the house of delegates of the American Medical Association is not a current, up-to-date expression? You are not contending that, are you?

Dr. WEINERMAN. No. I believe it is a majority expression. But it does not allow for exact up-to-the-minute expression or for a large-minority expression.

Senator DONNELL. Let us get a little more modern time. Let us take April 22. This is April 30. Eight days ago. Let us take the stated meeting of the Medical Society of the County of New York, where there was a certain series of resolutions adopted by a vote of 503 to 152. My information is that this took place at the conclusion of a 45-minute debate.

That would be a modern, up-to-date expression by the New York County Medical Society, would it not?

Dr. WEINERMAN. Yes, sir.

May I have those figures again?

Senator DONNELL. 503 to 152.

Dr. WEINERMAN. I should think it is quite significant that 150-something of those doctors stood up in favor of such legislation when

the claim has been made that the vast majority, perhaps 90 percent of the doctors, are opposed. I think it is significant.

Senator DONNELL. It is quite significant, also, is it not, that 76 and a fraction percent voted for these resolutions. That is significant, likewise?

Dr. WEINERMAN. Yes.

Senator DONNELL. May I read a portion of this resolution; perhaps all of them:

Whereas public hearings are being held before the Senate Committee on Education and Labor on S. 1606, "A bill to provide for a national health program"—that is referring right now to these hearings, of which this is one?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL (reading):

Whereas title II would establish a system of national compulsory health insurance; and

Whereas national compulsory health insurance is contrary to our national spirit and traditions of self-government; it obliterates local community initiative and responsibility in matters of health and medical care; it promotes the centralization of power, particularly the taxing and controlling power of the National Government; it creates a gigantic self-perpetuating bureaucratic machine which will inevitably become the master rather than the servant of the people; and

Whereas the medical profession is supporting four of the five major points in President Truman's health program; namely, for the expansion of existing public health services, for better distribution of hospitals and health facilities, for additional support for medical research and medical education, and for protection against loss of family income in sickness or disability; and

Whereas in lieu of the President's recommendation of national compulsory health insurance, the medical profession and the voluntary hospital system are developing a Nation-wide program of voluntary hospital and medical care insurance locally administered on a nonprofit basis; Now, therefore, be it

Resolved by the Medical Society of the County of New York, That the society hereby expresses its opposition to the proposal for national compulsory health insurance as embodied in title II of the Wagner-Murray-Dingell bill, and earnestly solicit the support of the public for the effort of the medical profession to prevent the enactment of national compulsory health insurance, which, in the judgment of this society, would deteriorate the quality of medical care and jeopardize the health and welfare of the people and would substantially increase the cost of medical care of the people of the United States.

You agree that is an up-to-date expression of the opinion of the New York County Medical Society, do you not, Doctor?

Senator PEPPER. Senator, do you mean in time or content?

Senator DONNELL. I mean in both, of course.

Dr. WEINERMAN. That is the opinion of all those except the ones who dared stand up and vote for the bill.

Senator DONNELL. It is the opinion of over 76 percent of those who voted on the proposition 8 days ago. That is correct, is it not?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. Doctor, you also mentioned, in reading this advertisement of the Medical Society of the State of Pennsylvania, that you regarded it as untrue that 4 percent of the salaries would be taken. Let us see. Where is that in this advertisement?

Dr. WEINERMAN. Paragraph 2.

Senator DONNELL. Yes. The instruction is: "If the recommendations contained in title II of this bill, which pertain to medical care, are enacted into law, they will (just as in the previous bill, S. 1050

and H. R. 3293)" take 4 percent of your pay. You criticize that as not being correct?

Dr. WEINERMAN. I was basing that criticism on the statement of the Senator himself when he pointed out to a witness here that no provision for payment is included in this bill.

Senator DONNELL. It is undoubtedly true that there is not a single line, as I recall it, in S. 1606 which specifies the amount.

There may be some inference. But, may I call your attention to this advertisement:

Just as in the previous bills S. 1050 and H. R. 3293;

and may I call your attention to section 281 of S. 1050. This is referring to the program.

Dr. WEINERMAN. Sir, that advertisement specifically refers to 1606.

Senator DONNELL. Yes. And it also says, and I quote:

Just as in the previous bills S. 1050 and H. R. 3293.

Dr. WEINERMAN. That I agree with completely. I am pointing out, it is unfair of the writers of that advertisement to base opposition to the bill on the basis of a point that has no existence in fact.

Senator DONNELL. Doctor, let us see whether it does or not.

This advertisement says, referring to title II of the bill, and I quote again, so that there will be no misunderstanding,

If the recommendations contained in title II of this bill—

S. 1606—

Dr. WEINERMAN. Yes, sir.

Senator DONNELL (reading):

Which pertain to medical care are enacted into law, they will (just as in the previous bills, S. 1050 and H. R. 3293) take 4 percent of your pay.

You regard that as an unfair statement, do you?

Dr. WEINERMAN. I do, sir, even if it is related to S. 1050, which might take the 4 percent mentioned. S. 1606 does not include the Social Security benefits of the previous bill, and therefore cannot be construed as going to take 4 percent of income.

I think there is nothing in S. 1606 which refers to the amount of payment.

I believe I am correct on that. Therefore, I do not think it is fair for this advertisement to claim that 4 percent will be deducted and it does specifically refer to this bill.

Senator DONNELL. Very well, Doctor. On page 61 I want to call your attention to this language about the 3 percent. It is the only reference I know of in S. 1606 to 3 percent. This is the provision on page 61 under "Personal Health Service Account":

From such appropriations, the Secretary of the Treasury shall credit quarterly to the account amounts equivalent to 3 percent of the wages * * * and so forth.

That is the only provision.

Senator PEPPER. Right on that point, because it is better to bring these things out at once: That never contemplated that the whole 3 percent would be paid to the employee alone, did it?

Senator DONNELL. I think it is half by the employer and half by the employee. I think that is correct.

May I call this to your attention, also so that the record may have it at this point, quoting, at page 64:

The Social Security program as set up in this bill would require—now, that is the Wagner-Dingell-Murray S. 1050—

would require a Federal subsidy, based upon the most conservative estimates, in excess of 50 percent of the total annual expenditures.

Has it been your idea, Doctor, that the provisions of S. 1606, requiring this payment from appropriations into the fund, would be intended as the only amount which would be necessary to support the social insurance program of S. 1606?

Dr. WEINERMAN. Sir, I think it is quite clearly stated that there shall be additions from the Treasury.

Senator DONNELL. In fact, it has been testified here in this committee, as I recall it, that three plans have been contemplated.

One is that everything is to be derived from pay-roll tax. That is one plan.

Second, there is the plan of all of it coming from some specifically earmarked income tax.

The third is a combination of the two. You have read that testimony, have you not?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. So that you realize that the 3 percent that is mentioned in here, half of which, as Senator well says, is to come from the employer and half from the employee, is not intended or expected to cover the entire expenditure of the operation of S. 1606. That is correct, is it not?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. Now, Doctor, going back just a moment here to the American Medical Association, you regard these men who were serving in the Army as doctors as being men of standing, do you not, generally speaking, and as Mr. Bolte has said, excellent doctors?

Dr. WEINERMAN. Absolutely, sir.

Senator DONNELL. Now, those men certainly regard the American Medical Association highly, generally speaking, do they not?

Dr. WEINERMAN. Yes, sir; in those matters, I do too, sir.

Senator DONNELL. Well, now, certainly, Doctor, whether or not we agree as to the wisdom or lack of wisdom of the economic position taken by the American Medical Association?

Dr. WEINERMAN. That is the argument here, sir.

Senator DONNELL. I am coming to that. I say regardless of what we agree on that or not, we do agree, do we not, upon the fundamental integrity of the American Medical Association and of its effort, whether mistaken or not, to give an honest view to the American public upon the subjects upon which it expresses itself.

We agree upon that; do we not?

Dr. WEINERMAN. Senator, in answer to that, I would have to say this: That were I, a practicing doctor, knowing about S. 1606, as so many doctors do, only through my mail and through what I read in the medical journals, if I were as busy a practitioner as is the average doctor, and had no time to study the bill itself but only to read my mail and to read the medical journals, I do not think, Senator, I could truthfully say that I would have an unbiased opinion of the bill. And

that is the way most of the doctors have come to take a stand on this bill.

Senator DONNELL. Doctor, I do not think that answers just what I asked you; namely, as to whether we would agree on the fact that whether mistaken or not, the American Medical Association is attempting to give to the public what it considers to be an honest expression of opinion. We would agree on that; would we not?

Dr. WEINERMAN. Well, sir, I think we would agree that the A. M. A. is attempting to give to the people what it construes as its own interpretation of the bill.

Senator DONNELL. Yes; and it believes itself to be giving an honest expression of opinion. We have no doubt of that, would we?

Dr. WEINERMAN. I suppose so.

Senator DONNELL. You would agree to that, would you not, sir?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. You are yourself going to apply for membership in the American Medical Association, as you have stated?

Dr. WEINERMAN. Yes, sir.

NATIONAL PHYSICIANS' COMMITTEE

The CHAIRMAN. Right there, are you familiar with the National Physicians' Committee and the propaganda that they have put out on this proposed bill?

Dr. WEINERMAN. I am very much so, sir. I get their releases quite often.

The CHAIRMAN. Well, you know that that organization purports to give the views of the members of the American Medical Association?

Dr. WEINERMAN. I believe the American Medical Association's house of delegates officially endorsed the National Physicians' Committee.

The CHAIRMAN. Yes; and is the information that they give out of a misleading character with reference to this bill?

Dr. WEINERMAN. Well, Senator Murray, let me say that when I was in Germany I received a copy of a pamphlet put out by the National Physicians' Committee, with a picture on the front, of a Nazi doctor. And the import of this pamphlet was that nazism in Germany had ruined medicine; which is certainly correct. And it went into a long analysis of that.

But at the end of that analysis, without any transitional statement, as I recall, this pamphlet, put out by the National Physicians' Committee said, "Don't let it happen here."

Now, I considered that a proposal for the Nation's health put out by our President and three of our leading Representatives in Congress, which was so baldly equated to a Fascist ideology, sustained something of an insult, sir.

I don't believe that claiming that medicine in Nazi Germany is bad has anything to do with the Wagner-Murray-Dingell bill suggested here.

The CHAIRMAN. Are you familiar with other literature that has been circulated in this country by that organization?

Dr. WEINERMAN. Yes, sir; I am. I am familiar with the pamphlet called Political Medicine which I believe has been discussed.

The CHAIRMAN. And that pamphlet has been distributed to the American medical profession quite generally, has it not?

Dr. WEINERMAN. It has been distributed far more widely than that, sir. My wife bought some talcum powder for our baby the other day and got a copy of it in the package. [Laughter.]

The CHAIRMAN. That pamphlet has given the members of the American Medical Association a distorted view of this bill, has it not?

Dr. WEINERMAN. Well, I believe it could be honestly said, sir, that the material in that pamphlet was not correct.

The CHAIRMAN. And it was designed to deceive the medical profession itself, as well as the American people?

Dr. WEINERMAN. I cannot speak for the motives of the people who put it out, sir. I just know what it said.

The CHAIRMAN. Were you here the other day when Dr. Carey, who was the head of that organization, testified?

Dr. WEINERMAN. I believe I heard part of it, sir.

The CHAIRMAN. You heard his testimony here. You also know that they have been collecting funds from the members of the medical profession in this country, and leading them to believe that they can make these contributions without having them deducted from their income tax reports?

Dr. WEINERMAN. Oh, yes, sir.

The CHAIRMAN. The whole purpose of that organization seems to me to be designed to mislead and misrepresent the purposes of this bill.

Dr. WEINERMAN. I believe it has, sir.

Senator DONNELL. Doctor, do you know Dr. Carey, who was referred to? He is the head of the National Physicians Committee.

Dr. WEINERMAN. I am not clear, sir, about that committee. Is that the group of doctors who said they would strike if this bill went through? Or was it the Association of American Physicians and Surgeons?

Senator DONNELL. Doctor, I do not know that there is any evidence of that kind before this committee.

Dr. WEINERMAN. I am just asking, sir. I know there was one group of physicians that claimed they would go on strike if the bill were passed, and I was asking if that was the same group.

Senator DONNELL. I believe it is not, and I think, with all due deference, you had considerable doubt when you asked the question, or else you would not have asked that in question form.

Dr. WEINERMAN. I asked the question in good faith, sir.

Senator DONNELL. Now, do you know Dr. Carey, who is the chairman of that committee?

Dr. WEINERMAN. I do not.

Senator DONNELL. Did you know of the fact that Dr. Carey was this year, in February I believe, voted to be the most useful citizen of the city of Dallas, Tex., in the year 1945, and received the annual award for that purpose, which was widely publicized?

Dr. WEINERMAN. I heard that brought out in the testimony, sir.

Senator DONNELL. And did you know that the senior Senator from Texas, the chairman of the Foreign Relations Committee in the United States Senate, offered those documents into the Congressional Record; that they were printed there in the Appendix to the Record just a few

days ago, and that he himself made very complimentary remarks about Dr. Carey, the head of this committee? Did you know that?

Dr. WEINERMAN. Yes; I believe he inserted that in the Record the very day before the gentleman testified.

Senator DONNELL. No; I think it was maybe 2 or 3 days before. But he expressed the opinion. You know Senator Connally's reputation, do you not?

Dr. WEINERMAN. I do, sir.

Senator DONNELL. You know that he is the chairman of the Foreign Relations Committee of the United States Senate, do you not?

Dr. WEINERMAN. I have complete respect for him, sir.

Senator DONNELL. And he made a complimentary statement. You know that, do you not? And you know that on the board of trustees there is Dr. Carrington, the head of one of the national organizations, a very outstanding man?

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

Senator DONNELL. Do you know Dr. Boas, of the Physicians Forum?

Dr. WEINERMAN. I do not know him personally.

Senator DONNELL. Have you conferred with him in conference with respect to the testimony in this matter?

Dr. WEINERMAN. No, sir.

Senator DONNELL. You have not. Do you know of any organization of physicians of a Nation-wide nature other than the Physicians Forum, and one or two smaller ones that were mentioned here by Professor Peters here the other day, who have come out in favor of compulsory health insurance; I mean national organizations of physicians?

Dr. WEINERMAN. I know of no other organizations, sir, though I know of many individual physicians.

Senator DONNELL. Now, you referred to this pamphlet on Political Medicine. May I ask you this, Doctor: Have you made any computation as to how many persons will be required to be appointed throughout the United States in the administration of this bill, S. 1606?

Dr. WEINERMAN. I certainly have not personally, sir. I do not know if anyone has.

Senator DONNELL. Very well. You have not personally?

Dr. WEINERMAN. Oh, no.

Senator DONNELL. You realize it would require a very great number of persons to administer it, do you not?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. Yes. And Doctor, I believe it was mentioned by Mr. Bolte this morning that the Federal Security Administrator, under whose supervision and direction—I quote from the bill "The Surgeon General of the Public Health Service has performed his duties," is an appointee of the administration.

Dr. WEINERMAN. Of the President?

Senator DONNELL. Of any administration, the political administration in Washington.

Dr. WEINERMAN. I realize, sir, he is appointed by the President.

Senator DONNELL. Very well, by the President of the United States. And you realize also that the Federal Security Administrator, as Mr.

Bolte I think indicated his knowledge to be, is not required by law to be a physician at all?

Dr. WEINERMAN. I think that is very wise, sir.

Senator DONNELL. You know it, do you not?

Dr. WEINERMAN. Yes.

Senator DONNELL. Well, that is the question that I was asking you. Now, Doctor, did it occur to you that there may be the opportunity throughout this country for a vast administrative system that will be worked up under this bill of Federal officials appointed throughout the United States?

Did it occur to you that there may be some basis for the view of the National Physicians Committee that politics may enter into the administration of this system? Had that point ever occurred to you?

Dr. WEINERMAN. No, sir.

Senator DONNELL. It never had. May I ask just one or two more questions, Doctor?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. Where are you practicing now, at this time?

Dr. WEINERMAN. I am not, sir. I have just come back from overseas, and I have taken a position doing some research studies in rural health.

Senator DONNELL. A position with this American Veterans Committee?

Dr. WEINERMAN. No; I have just for the past few weeks been working for the Department of Agriculture.

Senator DONNELL. For the Department of Agriculture of the United States?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. So that you are employed with the United States Government. Is that right?

Dr. WEINERMAN. Just in the recent past, sir. My interest in this bill and my connection with A. V. C. quite predate my connection there.

Senator DONNELL. Are you acquainted with Mr. Isadore Falk?

Dr. WEINERMAN. I know who he is; yes, sir.

Senator DONNELL. Do you know him personally?

Dr. WEINERMAN. Well, I recognize him. I do not know him beyond that.

Senator DONNELL. You are aware of the fact that Mr. Altmeyer testified this S. 1606 was largely prepared by Mr. Falk?

The CHAIRMAN. I do not think that is the correct testimony, Senator.

Senator DONNELL. Well, what was the testimony, Mr. Chairman?

I stand corrected if I am in error.

The CHAIRMAN. I think it was to the effect that it is a matter of evolution; that the bill is the result of previous hearings and studies and advice contributed by many different people.

Senator DONNELL. I have no doubt, Mr. Chairman, that the advice has entered into it largely, but I think that the Senator, by reference to the testimony, will recall that Mr. Altmeyer testified that Mr. Falk had prepared a major portion of the bill. I think that is substantially the language of the testimony of Mr. Altmeyer.

The CHAIRMAN. I do not believe that is an accurate statement. Of course, we can see that testimony.

Senator DONNELL. Yes. Now, Doctor, just how does it happen that you are here today to be present with Mr. Bolte? At his request?

Mr. BOLTE. The doctor was one of the several people, Senator, in both our New York and Washington offices, who worked in studying the bill and helping me in the preparation of the testimony.

We had our program and research division in New York working on the analysis, and we have in our Washington chapter several technical subcommittees, as I mentioned in the testimony. And the doctor was one of the gentlemen who worked with me in the preparation and study, and so on.

Senator DONNELL. And did the doctor assist you in the preparation of the testimony which you have given here this morning?

Mr. BOLTE. Yes, sir.

Senator DONNELL. I understood you to say that you yourself, however, personally prepared the statement; is that right?

Mr. BOLTE. Oh, yes.

Senator DONNELL. But he assisted you in compiling the data and in discussions with you?

Mr. BOLTE. Yes, sir.

Senator DONNELL. That is all, gentlemen.

The CHAIRMAN. Are you familiar with the fact that Senator Wagner, at the opening of these hearings, pointed out that this bill would require no great increase of personnel in its administration; that the set-up that is already in existence would take over a large part of the administration?

Mr. BOLTE. That was my understanding, sir.

The CHAIRMAN. Any other questions?

Senator MORSE. Mr. Bolte, what was your rank in the Army?

Mr. BOLTE. I was a lieutenant, sir.

The CHAIRMAN. In our Army?

Mr. BOLTE. No; I was in the British Army.

The CHAIRMAN. All through the war?

Mr. BOLTE. Yes, sir.

The CHAIRMAN. Would you say, Mr. Bolte, that the experience of the veterans with medical service in the Army has tended to break down, at least among them, an emphasis upon the importance of having a particular doctor to treat them?

Mr. BOLTE. Oh, I certainly think it would, Senator. I tried to emphasize in my testimony the feeling that veterans had about medicine. I think the Senator's questioning rather tended to get us away from that major line of emphasis.

It seems that we have come out of the war with a feeling about medicine that most of us got better medical care in the Army than we ever had before.

We went up when we were sick; when we went on sick call, we had to go on sick call, and we did not have to worry about having the money to pay the bills, because we knew that the doctor was there and we knew that we got the very best of care.

And I think a great many of us have come out wanting to continue that care personally, and also to get it for our families. Because we just felt that we got better care in the Army than before, and we want that to continue without the cash intervening and being a draw-back, and making us get sick because we do not have the money to go to a doctor when somebody in the family first begins to become ill.

Senator MORSE. Would you say that the experiences that you have had with medical care in the Army have tended to educate the members of the Army, as a great many other citizens are being educated, to favor the clinic technique of medical treatment, where you pass from office to office within the clinic and come under the jurisdiction and care of qualified specialists on different ailments?

Mr. BOLTE. I think very much so, sir. I think it is an extremely important point. We did get the benefits of specialized care, which we might not have had before, just from having the one family practitioner.

We also got a tremendously increased development of what I referred to in the testimony as health consciousness; the importance of health and the importance of catching any illness or disease in its early stages, and actually an awful lot of us in the Army learned more about personal health and hygiene and the necessity of taking care of ourselves than we had before.

Senator MORSE. Do you think that the health education program that has been carried on in this country, particularly during the last 20 years, and the increased emphasis during the last 10, plus the experiences with medical care that the members of our armed forces have had during the war, has had a tendency among our people to not particularly decrease the importance of the family doctor but educate the people to the understanding that he is just, in most instances, the first adviser in the case of serious illness, and that he must be supplemented with clinical care?

Mr. BOLTE. I think that realization, Senator, has only grown up among those who have been able to afford constant access to a family practitioner, and beyond that to go on to a specialist.

Most people cannot afford, certainly, the specialists, and a great many cannot afford the regular family practitioner, and have had to have the welfare medicine, which, of course, is not at all similar to what is proposed under this bill.

ADVANTAGES OF CLINICAL TREATMENT

Senator MORSE. As I have said before, I have certain reservations as to this plan which I will discuss at greater length on the floor of the Senate later, but under this plan or some prepayment plan such as exists in my State and the State of Washington, do you think that one of the beneficial effects will be a greater development of the so-called clinical method of treatment, rather than the one-doctor method of treatment?

Mr. BOLTE. I should think it would, sir.

Senator MORSE. I perhaps ought to ask this of the doctor, rather than of you: Do you think it is a fair statement to say that the members of the medical profession itself are recognizing more and more the importance of division of labor, shall we say, among specialists within their fraternity, rather than having a doctor try to qualify himself on all types of illness and treat in general practice?

Dr. WEINERMAN. Senator, I agree with you completely. I would like to say that a Colonel Loeth, reporting to the American Medical Association, surveyed some 20,000 of the Army medical officers.

One of the questions referred to group practice; and, as I think Mr. Bolte has indicated in his testimony, half of all the doctors polled

indicated when they came back they would like to practice in a group. I think this opens the door to such practice.

Senator MORSE. Would I be unfair to the medical profession if I should suggest or at least raise the question as to whether it is true or not, that in the field of modern medicine, with great discoveries that have been made in recent years, the new techniques that have been developed in our medical schools, it is practically impossible for any modern-day doctor to qualify himself in all the techniques so as to give adequate medical attention to his patients?

Dr. WEINERMAN. Absolutely, Senator. The field is so complex today, and correctly so—I mean that we have progressed so far—that a doctor can only take a corner of medicine and become proficient in it. He cannot be efficient if he attempts to cover the entire field.

Senator MORSE. Would you say that as more and more new medical discoveries are made, it is going to become less and less possible for the average doctor to qualify himself to give what we will come to believe is adequate medical care to his patients without the use of specialists and joint conferences with other doctors and clinical attention?

Dr. WEINERMAN. I think that is absolutely necessary, sir.

Senator MORSE. Well, if that should come to pass, or if that is coming to pass, and if the doctor is going to see to it, as I think the ethics of his profession require him to see to it, that the best possible care is made available to his patients once he takes jurisdiction over the case, is it not true that the expense will be so great that millions of our citizens cannot afford to pay that expense?

Dr. WEINERMAN. Under the present system, sir?

Senator MORSE. Well, as this increased scientific knowledge on the part of the medical profession develops, which will call for what I have suggested to be clinical treatment and the attention of specialists—and specialists, highly so, are expensive—is it not true that the average citizen will be unable to pay for the medical care that he ought to have if he were to have what I have phrased as "adequate medical attention"?

Dr. WEINERMAN. Under the present pay-as-you-go system, sir, that will be absolutely true.

Mr. BOLTE. I think that has become true already, sir.

Senator MORSE. Well, let us talk in terms of trends anyway, because we have to think in terms of where we are going.

It is a bit paradoxical, then, would you say, to find the opposition that we are finding among the medical fraternity to an attempt on the part of a society through its Government to give to its citizens adequate care, find opposition to that, when the doctors themselves—and it is to their everlasting credit—through new scientific discoveries, are enlarging the sphere of medical knowledge so as to make it more and more difficult for them to give adequate medical care themselves because of their limited knowledge, as individuals, of their own profession, and making it more and more difficult for them to give adequate medical care to the patient concerned because of his inability to pay for the specialized service that would be required?

Dr. WEINERMAN. It is inconceivable, Senator.

Senator MORSE. A bit paradoxical?

Dr. WEINERMAN. Quite a bit.

Senator MORSE. Now, Mr. Bolte, do I understand that it is your position that this bill—S. 1606—in its present form, should be passed by the Congress of the United States without any change whatsoever?

Mr. BOLTE. One point I did suggest, Senator, I think before you came in, was that there might be provision made more specifically in the bill for the development of specialization in various fields within the Veterans' Administration.

There is actually nothing in the bill which would usurp any of those functions from the Veterans' Administration, but we think it might be wise to state explicitly that there should be encouragement in the development of new researches and techniques, and so on, to take care of the service disabilities of veterans.

Senator MORSE. But, first, to limit our discussion to the general principle?

Mr. BOLTE. We generally approve the bill as it stands.

Senator MORSE. But am I to understand that if any of us proposes amendments which do not defeat the major objective of this bill, which I understand from its sponsors to be the providing of adequate medical care to the people of the United States, that you would not object to such amendments so long as the objectives are protected?

Mr. BOLTE. Certainly not, sir.

Dr. WEINERMAN. May I ask a question, sir? Would that question that you have just asked imply possible changes in the concept of Nation-wide health insurance? I think we might have some reservations about changes in that.

Senator MORSE. Well, if you should consider such amendment as impairing the objectives of the bill, I take your answer to be that you would oppose any amendment that impaired the basic objective of the bill.

Dr. WEINERMAN. Just the basic objectives. We believe there is room for specific improvements.

Senator MORSE. Frankly, what I am trying to show on this record—I do not want this record to close with any implication in it, if it is a false implication, that Mr. Bolte says to the Congress, "It is this bill or nothing."

Mr. BOLTE. I would not want to give that impression at all.

The CHAIRMAN. Right there I want to interpose this statement: That when the bill was filed by the sponsors it was expressly stated that we did not consider the bill perfect and the final answer, and we expect, of course, that the bill will be studied by this committee and that some improvements will be made to it.

That is the situation with every bill that has ever been filed in the Congress since I have been here. I know of no perfect bill that ever went through Congress. I am sure that the bill can be improved upon as a result of our study, but the basic concept of the bill, will, I think, continue to be recognized as absolutely correct.

Mr. BOLTE. I assume, sir, that your committee as a result of these hearings would, quite probably, do some redrafting.

Senator MORSE. In other words, you recognize that in hammering out any legislative pattern in the Congress of the United States, there emerges a compromise pattern. That is the way democracy works in the halls of Congress; fortunately so.

FREE CHOICE OF DOCTOR

Well now, in this instance let me say that the Senator from Missouri again, as I have found to be his custom, is raising very important points that deserve the careful consideration of a committee such as this on the legislation that comes before us. I think he has raised some very vital points here this morning that the members of this committee are going to have to consider very carefully, and out of which discussion, I think some compromises will flow.

Let me mention one. My thinking on it has not crystallized at all. You remember that you were cross-examined by the Senator in regard to the provisions of the bill that pertain to a limit upon the maximum number of patients that a doctor under the plan may handle. That concerns me, too.

I am not ready to phrase the amendment. But I take it for granted that any amendment which would permit of flexibility as to the number of patients that a doctor can handle in accordance with special abilities—some doctors can handle more than others—certainly would not defeat the basic objective of the bill.

Mr. BOLTE. I should not think so, Senator.

Senator MORSE. I think some very serious consideration should be given by the proponents of this bill to the matter introduced by the Senator from Missouri.

This matter of choice which the Senator refers to, I think, is a pretty important one. May I put this question to you on that matter: A great deal of emphasis is being made here that part of the medical profession, an overwhelming majority of individual doctors that are opposed to the bill, believe that it is going to do something to the medical profession as a part of our private property economy. Do you think it is unfair to say that at the present time the choice which the average American citizen is free to exercise in selecting his doctor largely depends on his economic ability to pay for that choice?

Mr. BOLTE. I think it is absolutely essential to say that, Senator. It seems to me that the passage of this bill would actually provide so much more choice than the average citizen now has that there is simply no comparison.

I know people, personally, who do not have any choice of doctors at all when they get sick. They take what they can get in the charity ward. They do not have any choice whatsoever. I think this bill provides for a broadening of choice.

Would you like to comment on that, Doctor?

Dr. WEINERMAN. I do not want to interrupt the Senator's trend, but I would like to add something as to this question of free choice, because it is very important.

As a doctor, I was very interested to see the keen interest of all the Senators on this question of choice. I think it is only fair when we consider the problem of free choice in this bill to relate it not only to what is true today, as Mr. Bolte just did—in which case I think we all agree there is much more free choice in the bill than there is today—but we must also equate it to the countersuggestions that have been made. The most common one that I have heard is that we should substitute for this bill a system of voluntary health insurance supplemented by welfare medicine for those that cannot afford to pay the costs of voluntary insurance.

Now, I think, under that kind of a system there would be much less free choice than there would be under this kind, and perhaps even than there is now. Because the voluntary plans are similarly restricted to the doctors that choose to join them, and they have much smaller groups of physicians than there would be under this plan.

In addition to that, I believe it is safe to say that a majority of the American people cannot today afford the premiums of voluntary medical plans. Not only cannot they afford their premiums, but they get very limited coverage under them. Therefore they have to go outside the plans to buy other medical care. If they get pneumonia, for instance, the average medical plan does not cover that. So they pay money in the plan and outside of the plan, and that amount of money is too high, I believe, for a majority of Americans.

Therefore, under this suggested alternative, they would be the recipients of welfare medicine.

Now, I do not think many Americans want that. Under that system, Senator, there would be no free choice of physicians at all. And if the suggesters of this plan are afraid of State medicine—and that is a frightening term, the way it is used—just consider what would happen under their suggestion, where between 50 and 70 percent of all Americans would have to rely upon State-administered welfare medicine. The A. M. A. should much prefer the private-enterprise system under this bill, where the doctor treats his patient and gets his fee for service from the fund. And the patient can choose his own doctor.

Senator MORSE. In connection with this choice issue, Doctor, do you think that it is unfair for me to suggest that not only does the economic status of the patient determine to a large degree in this country what doctor he is going to get to treat him, but that the doctor himself, in giving such treatment as he does give, is influenced somewhat to varying degrees—depending upon the individuals, but to varying degrees—by the economic status of the patient, once he accepts him as a patient?

Dr. WEINERMAN. Do you mean, sir, that he is limited in the amount of treatment he can give him because of what he can afford?

Senator MORSE. Yes.

Dr. WEINERMAN. Yes; I think that is right.

Senator MORSE. Or put it this way: Here is Patient X. He has a pretty serious disorder. The doctor can select, we will say, one of three possible treatments. The more expensive one is in the best of standing with the profession and gives the best prognosis as far as cure is concerned. Is it not true that very frequently doctors at least think it necessary for them to not select that treatment because of the economic factor of the ability of the patient to pay?

Dr. WEINERMAN. Oh, I am certain it is, sir.

Senator MORSE. And I mean to detract not one bit from the great charity work that our medical profession does.

Dr. WEINERMAN. I think that is an example, Senator, of their feelings for the patient. Sometimes they hesitate to do things that would cut into their budget too much.

Senator MORSE. But the point I want to make is that I think the medical profession is deserving of great credit for the free service that it is rendering; but that free service, that charity service, in

giving treatment to our fellow citizens, in the last analysis is a matter of the exercise of free choice on the part of the doctors, is it not?

Dr. WEINERMAN. You mean to choose whether he will give the free service or not?

Senator MORSE. Yes.

Dr. WEINERMAN. Right.

Senator MORSE. And as to what the service will be, they exercise their choice?

Dr. WEINERMAN. Or the amount of it.

Senator MORSE. Whether it is the best service or some service, adequate or inadequate? But is that freedom of choice? And against that, we have to balance the public's interest in adequate service in the field of health for all of our citizens, do we not?

Dr. WEINERMAN. That is the public's responsibility, I think, sir.

Senator MORSE. But that is part of the controversy, at least?

Dr. WEINERMAN. Yes, sir.

Senator MORSE. Because we are right down here in this issue to the discussion of some basic political philosophy too: How far should a representative government go in protecting the health of its citizens? That cannot be escaped in the discussion of this bill, do you think?

Dr. WEINERMAN. No, sir.

Senator MORSE. We are now on this free choice matter. After all, the extending of charity treatment by the medical profession, fine as it has been, has not been adequate to give adequate medical care to large numbers of American citizens that have not had the funds with which to pay for it; do you agree?

Dr. WEINERMAN. I agree. May I add, sir, that as veterans, we are not looking forward to charity medicine. We would rather prepay our own way.

Senator MORSE. I will come back to the veterans' problem in a minute. I am talking now about the population as a whole. In spite of all the good work the medical profession has done by way of giving freely of its service to so-called charity cases, the fact is that that exercise of free choice on the part of the medical profession has not been sufficient to give adequate health protection and treatment to large numbers of our people.

Dr. WEINERMAN. I would agree to that on personal experience, sir.

Senator MORSE. It has been my observation that when cases have been pointed out to the medical profession, it has never failed to give its attention.

I know of no case where it has not given attention. I am a member of various clubs and lodges and service organizations. We have had our so-called crippled children's program and dental program and health program, where we call the attention of the medical profession of our city and county to outstanding cases, and they always respond. But we know where we pick out one case, there are many, many cases that we do not even know about and nobody knows about, which go unattended. If, as of tomorrow, the medical profession said, "We will handle all of the cases," it would not be very long before they would be wanting a lot of financial assistance to do it, do you not think so?

Dr. WEINERMAN. And administrative assistance, too.

Senator MORSE. If this service is to be rendered, it has to be paid for.

Dr. WEINERMAN. I think it is worth our paying for.

Senator MORSE. You agree, then, that one of the basic questions we have to decide as representatives of the people is whether or not that service should be rendered?

Dr. WEINERMAN. That is the basic question, sir.

Senator MORSE. And those of us that agree that it ought to be rendered, then, as the next step must direct our attention to how shall it be rendered?

Dr. WEINERMAN. I think that is very fair, sir. We are here to say it should be so rendered, and I think it is the duty of Congress to put it in the proper form.

Senator MORSE. And if it is to be rendered by the medical profession, then the doctors are going to have to be paid to render it?

Dr. WEINERMAN. And they should be paid adequately.

Senator MORSE. It is only fair that they should be paid well?

Dr. WEINERMAN. They should be paid well.

Senator MORSE. Now, either you or Mr. Bolte spoke in your testimony about the fact that there are certain parts of the President's health program that the medical profession enthusiastically supports?

Dr. WEINERMAN. A majority of it, I believe, sir.

THE MEDICAL PROFESSION FAVORS GOVERNMENT SUBSIDIES

Senator MORSE. Would it be fair for me to say that they support those parts which call for the building of hospitals, the providing of facilities at public expense for the practice of medicine?

Dr. WEINERMAN. Yes, sir.

Senator MORSE. And that part of the program which would clearly benefit the doctor economically, and at the same time make it possible for him because of better facilities to give better service in line with the principles of that great profession, finds support among the medical profession?

Dr. WEINERMAN. Yes, sir.

Pardon me, sir, may I make one brief statement? We feel that without this bill, many rural areas will not be able to use the hospitals provided under S. 191, and I think you mentioned, sir, the hospital plan in the President's statement. We do not see how hospitals can either be erected or maintained in rural areas unless they have the purchasing power afforded by this bill.

Senator MORSE. Well, would you say that it is true that on the basis of, certainly, present fees which the medical profession finds it necessary to charge—and I do not happen to be one, although there are extreme cases, who believe that the profession as a profession is over-charging the patients—

Dr. WEINERMAN. I do not think so, sir.

Senator MORSE. But on the basis of the present fees charged, the medical profession in this country cannot give, in light of increasing new discoveries of medical science, adequate medical care to our people without a tremendous investment on the part of the Government in the facilities that are necessary to use in practicing medicine.

Dr. WEINERMAN. I absolutely agree, sir.

Senator MORSE. And therefore the medical profession itself, in the exercise of its private property economy rights, functions on the basis

of the taxpayer's dollar too, to the extent that that dollar is invested in the facility which makes it possible for the doctor to earn his living through the facilities that the public, local, State, and national, through its Government agencies, provides him?

Dr. WEINERMAN. Yes, sir.

Senator MORSE. Therefore we have to weigh here this argument of some doctors that any form—and that may not be an accurate statement; it may only reflect my ignorance; but at least I have yet to have them show me any health program publicly supported on some such principles as this bill that they do favor. But to get back to my question: Then, the medical profession itself, when it opposes the use of such a plan as this one, opposes it and at the same time says to the taxpayers of this country: "But, to give such service as we do give—and we don't give it to all the people—but to give it to all the people—but to give such services as we do give under the fee system, you must provide us with these new and more modern facilities, so that we can practice our profession."

Are they not in that position, in perfect fairness to them?

Mr. BOLTE. I think the point is very well made, Senator.

The CHAIRMAN. Under the Hill-Burton bill, no community could qualify for these facilities unless they could prove that they were financially able to support them.

Mr. BOLTE. And the fact is, sir, that many communities would not be able to prove that at all without the operation of this bill.

The CHAIRMAN. So that the communities which were most in need of the kind of care which we are proposing here would be unable to receive it?

Dr. WEINERMAN. Without this bill?

Senator MORSE. Yes. Now, the point that I want to stress, which I happen to think is important, although my colleagues may not: Here we have to tussle, I think, with this very difficult question of how far should a democratic government go in spending tax money for the private benefit of any group within its citizens. I think it is justified whenever it can be shown that that group serves within its field the interests of all of our people.

What I am trying to point out here, to see if you will agree, is that, after all, the medical profession in this country, if we took away from them today all the facilities that have been bought and paid for by the taxpayers of this country, could not begin to give us the service that it is now giving. And if it is going to give us an enlarged service, which I think more and more as the years go by the people are going to demand, it is going to require greater and greater expenditure of tax dollars to provide the equipment and the hospitals and services through which it can practice, as private practitioners, medicine.

Do you agree with me?

Mr. BOLTE. Yes, sir. I just want to comment on that, Senator. It seems to me you have hit the fundamental philosophic point, if you like, of the political arena today, and I think its bearing on this cannot be overemphasized.

Because it seems to me that the most important natural resource any country has is the people who live in it; and in all our provisions for the other things that we do in this country, for the national defense and everything else, we overlook the one fundamental fact that, first

and most important, we must provide for the health of the people who make up the country and make up its greatest wealth.

Senator MORSE. I think that point is well made. There are one or two other questions. May I ask you gentlemen whether you agree with this: That your experience as veterans has emphasized to you the importance of a better Nation-wide health program as a matter of national security?

Mr. BOLTE. It is absolutely fundamental, sir.

Dr. WEINERMAN. Yes, sir; certainly.

Senator MORSE. We must, of course, take into account all of the modifications that will have to be made when we take up the question of military service rejections. Some of them are congenital. Some of them could not be helped by the medical profession at all. But boiling them all down, we still had too many young men—too many young men who did not meet the minimum health standards which we in our civilization of which we are wont to boast, have not had.

Mr. BOLTE. And it was a shocking experience to all of us, Senator, I think.

Senator MORSE. Now, on this subsidy matter, on the basis of the questions I have already asked, the facilities already provided the medical profession and the patients of this country constitute a form of subsidy; is that not true?

Dr. WEINERMAN. Yes, sir; I think a great percentage of the hospitals that already exist are governmentally owned.

Senator MORSE. Do you see any great difference between some subsidy in the payment of medical fees for protection of American health and the payment of American tax dollars that are now being paid for the protection of American health, and money that goes right into the pockets of veterinarians for the protection of the country's livestock?

Mr. BOLTE. I think what we hope for under this bill, Senator, is that we will come to the point where we will take care of all our people as well as we take care of our livestock.

Senator MORSE. Or try to. It is surely as important to eliminate contagious diseases by way of Federal support, if necessary, among the poor people of the country, as it is to eliminate Bang's disease among the poor farmers of the country because their herds are likely to spread it to the rich farmers too.

Mr. BOLTE. I should say it is at least as important; yes, sir.

Senator MORSE. Which again gets us back to this basic problem of what is the obligation in a constantly evolving, but we hope progressively evolving, society, a democratic society, with representative government, to protect with tax dollars the health of all of our people: That is the thing that I have to wrestle with all the time.

Because at least I think—I suppose there are those who doubt it—I am as strong a proponent of private property economy as anybody in the Senate. But I recognize that too little government is just as dangerous for public welfare as too much government.

Hence, I say to my friends, although there are certain parts of this bill that I am going to discuss by way of proposed amendments later on: There is no getting away from the fact that we have to move in the direction of adequate health treatment of all of our people.

One more, and I am through: We have had a discussion here this morning and questions and answers, about the views of the American Medical Association, whether or not they are honest views.

I share the opinion of the Senator from Missouri that they are honest views on social and economic questions. But my question will show the one modification that I would make and the question is this: Do you agree with me, Doctor, that the members of the American Medical Association that testify in opposition to this bill are special pleaders, in the sense that they are testifying from a particular economic point of view?

Dr. WEINERMAN. Senator, that is fairly difficult to answer. The ones that testify may have a more selfish point of view than the great mass of doctors whom they purport to represent.

I am just not quite sure how to answer that.

Senator MORSE. Then let me rephrase my question: We are quite accustomed on Senate committees to have labor representatives before us on labor bills. You can be perfectly sure, just take judicial notice, that when somebody comes in representing labor, they are going to represent labor's point of view. They are special pleaders in that sense.

Dr. WEINERMAN. Yes, sir.

Senator MORSE. Just as every attorney in the courtroom is a special pleader for his side of the case; and the job of the judge is to take the special pleading aspects into account but to give a just decision on the basis of all the facts and all the evidence in the case. That is the test of a legal mind.

It is quite an art. Strive as we all do to reach it, it is a difficult art to master.

But the point I want to make is that when the American Medical Association representatives come in here, they come in here as the special pleaders of a cause in which they sincerely and honestly believe.

Dr. WEINERMAN. I agree completely with that, sir.

Senator MORSE. And they have an economic interest in that cause; or they think they do. Is that not true?

Dr. WEINERMAN. To that, Senator, I would say that the great mass of lower-income doctors can probably look forward to greater financial security under the bill. It is undoubtedly true that a few at the top may not then be so prosperous. I think it is also true that the administrative top people may find some of their functions lost under the bill, people that are not in practice but are full time administrators of medical societies.

POLITICS IS ESSENTIAL IN DEMOCRACY

Senator MORSE. This is the last question: Both sides in every controversial issue use their own slogans and their own persuasive appeals, and that goes for the proponents of this bill as well as its opponents.

Dr. WEINERMAN. Yes, sir.

Senator MORSE. But the opponents are using, and I think very effectively, judging from my mail, the slogan "political medicine." Would you agree with me that in democracy, in any democracy, politics is in its high sense represented by rule of the majority but at the same time the protection of the legitimate rights of the minority within our constitutional guaranties, but that politics is to be desired and not deprecated in the administration of a democracy?

Dr. WEINERMAN. With that definition of the term; yes, sir.

Senator MORSE. And that if we are really going to promote the greatest good for the greatest number within a private-property economy, we must make political approaches through government to it?

Dr. WEINERMAN. Certainly, sir.

Senator MORSE. We, as your representatives, are politicians of course, but that does not mean, even contrary to cartoon conceptions, that we seek only banal and undesirable objectives.

We can even have high motives, too.

Dr. WEINERMAN. I think the framers of this bill did, sir.

Senator MORSE. And under our form of government you cannot tackle a problem such as adequate health programs for all the American people except through our political forms.

I know of no other way of doing it in a democracy. Do you?

Dr. WEINERMAN. No, sir.

Senator MORSE. That is, if the State itself is to make certain that the objective of providing adequate health is provided the people. I know of no other way of doing it.

Dr. WEINERMAN. And then the doctors will provide it?

Senator MORSE. And then the doctors will provide it; yes.

Dr. WEINERMAN. I would just like to say, sir, that microbes and germs do not recognize local and State lines; and this is a national problem.

Senator MORSE. I will simply close by this observation: That I think this is a great debate that is going to be confronting us, because it has many ramifications on how to strike this balance between fulfilling what I think is a necessary objective of a democratic form of Government, and at the same time protect the legitimate private property rights of the medical profession; that is the balance we must strike in the final solution of this bill.

I think it can be ironed out so that it can be struck. I tell my doctor friends that it never will be struck, because of the obstacles inherent in the situation, if we simply say to the American Medical Association: "We turn it over to you and place upon you the professional responsibility of providing adequate medical attention to 130,000,000 American people."

It never has, and physically it never will, without the friendly cooperation of the Government. I want to see a bill drafted and amended so that the two groups can work together. That is not going to be done, in my judgment, to the satisfactory of the medical profession, if the American Medical Association overemphasizes the special pleading aspects of its case.

PURPOSE OF RESTRICTION ON NUMBER OF PATIENTS PER DOCTOR

Senator PEPPER. Mr. Chairman, I want to ask two or three questions, with the Chairman's permission, and then I have to go. Mr. Bolte and Doctor, I want to direct your attention to section 210 on page 57, which reads as follows:

The Surgeon General may, after consultation with the advisory council and with the approval of the Administrator, determine for any calendar year or part thereof that every individual entitled to general medical, general dental, or home-nursing benefit may be required by the physician, dentist, or nurse furnishing such benefit to pay a fee with respect to the first service or with respect to

each service in a period of sickness or course of treatment. Such determination shall be made only after good and sufficient evidence indicates that such determination is necessary and desirable to prevent or reduce abuses of entitlement to any such benefit, and shall fix the maximum size of such fee at an amount estimated to be sufficient to prevent or reduce abuses and not such as to interpose a substantial financial restraint against proper and needed receipt of medical, dental, or home-nursing benefit.

Now, that is obviously provided to prevent abuses, is it not?

Dr. WEINERMAN. Yes, sir.

Senator PEPPER. A certain number of people, thinking that they could get free medical care for which they would not have to pay any additional sum, no matter how frequently they went, might tend to abuse that privilege. So the bill gives the Surgeon General authority after consultation with the advisory council in case he finds it necessary to prevent abuses, to impose the requirement that the people cover; they may have to pay a sum of money as the first fee.

Now, the able Senator from Missouri has made quite a point of the fact that the right of free choice was denied to the patients because there was this language in the bill, on page 50, subsection (j) :

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

Now, what do you suppose the purpose of that provision in the bill is?

Dr. WEINERMAN. Senator, I think the purpose of that section is to perpetuate an already existing standard of quality in the medical profession. We have been trained as physicians, that each of our patients requires a certain amount of time and a certain, at least minimum, amount of careful attention. I think this is a wise provision, with many safeguards that will enable the administrators of this program to see to it that in the rare instances where a doctor may choose too many patients, the patient will be protected.

The CHAIRMAN. Right there, I would like to point out that a very prominent doctor testifying here the other day pointed out that in private practice the physician himself was able to take care of the situation where too many patients are coming to him, by jacking up his fees, and in that way he limits or prevents the abuse of having too many patients.

Dr. WEINERMAN. Yes, sir; and that produces a limitation on the freedom of choice, certainly.

Senator PEPPER. Now, I happen to be a lawyer by profession, gentlemen, and occasionally we have lawyers that have to be disbarred, and sometimes we have lawyers that engage in sharp practice.

Sometimes, no doubt, they engage in unfair practice with respect to their clients.

Now, is it unthinkable that there might be a few doctors among all this great army of doctors who might, for the benefit of the additional fees, try to undertake to serve more patients than they could give, as the bill says, a high standard of care to?

Dr. WEINERMAN. I think one of the main contributions of the American Medical Association to the country has been its very vigilant safeguarding of quality, and its exposing and even disbarring, if I may use that term, of certain physicians who have malpracticed.

Senator PEPPER. Now, the Senator from Missouri has spoken about the good moral quality and the high purposes, and so on, of the American Medical Association, but this bill would not be limited to practice just by members of the American Medical Association, would it?

Dr. WEINERMAN. No, sir.

Senator PEPPER. Any doctor that is a qualified doctor under State laws would have the right, as the bill specifically gives him, to take patients, if patients select him under this bill, would he not?

Dr. WEINERMAN. Yes, sir.

Senator PEPPER. So there might be a great many doctors who are not in the American Medical Association?

Dr. WEINERMAN. Yes, sir; but in all fairness, I believe the great majority of practicing physicians are in the American Medical Association.

Senator PEPPER. It is no disparagement to say that there may be a few of its members who would yield to the pecuniary opportunity of taking care of more patients in order to make more money than they can really give care to the patients. It is just a matter of balance of interest. There may be a few fellows that might take advantage of the patients and in order to make more money, take on more patients than they could accommodate. You have to balance that possible detriment to the public as against the technical denial of choice, if the Surgeon General should exercise the authority that this section (j) gives to him, do you not?

Dr. WEINERMAN. Yes, sir.

Senator PEPPER. And it is all right, if you want to find out how many cases of abuse there are, but that is pointed out by some of the critics of this legislation as the effort of an authoritarian state—as some of these gentlemen are now beginning to call a government that does anything to help the people—that this is designed by people who have the point of view of the authoritarian state to deny the individual the right to a free choice of doctors.

You do not think that is a fair way to describe that provision in the bill?

Mr. BOLTE. That is just what I said earlier to the Senator: That this is in effect putting into law what already exists in common practice.

Dr. WEINERMAN. Senator, might I say that with regard to this section (j), of which you are talking, the millions of Americans, literally millions, that for the first time in their existence will have access to any physician in their community, far outweigh the hypothetical few that may come late to their favorite doctor and have to go to another.

Now, I recognize the justice of the criticism that very occasionally, under this bill, a few people may not get the doctor of their first choice, but we are considering the common good, and when you weigh that, sir, against the millions that will have medical care for the first time, would you oppose the whole program because of the rare discomfort to any individual? I think it is a very false construction of this section, to imply that it harms the patient.

Senator PEPPER. Good. Now, the next question, Doctor: You were in the Army of the United States?

Dr. WEINERMAN. Yes, sir.

Senator PEPPER. You were a doctor in the Army?

Dr. WEINERMAN. Yes, sir.

Senator PEPPER. You practiced the profession of medicine in the Army; and was your commanding officer a surgeon?

Dr. WEINERMAN. My immediate commanding officer was. My ultimate commanding officer was a line officer.

Senator PEPPER. Well, there was the Surgeon General of the Army, whom you served?

Dr. WEINERMAN. Oh, yes; the whole channel.

Senator PEPPER. And the Chief of Staff of the Army was not a doctor, was he; General Marshall?

Dr. WEINERMAN. No, sir.

Senator PEPPER. You were part of that Army, were you not?

Dr. WEINERMAN. That is right.

Senator PEPPER. And he was not a doctor, and he ran the Army?

Dr. WEINERMAN. He ran the Army.

Senator PEPPER. And as far as you know, you are not proposing if we ever have a war to put a doctor in charge as Chief of Staff, because there are going to be some doctors in the Army, and you want to be sure there is a doctor going to run the Army?

Dr. WEINERMAN. No, sir.

Senator PEPPER. You served under the Secretary of War; did you not?

Dr. WEINERMAN. I guess I did, sir.

Senator PEPPER. Well, the Secretary of War was a judge before he became Secretary of War; that is, Secretary Patterson was. And his predecessor was a lawyer. Yet you as a doctor functioned in that Army all right without Secretary Stimson or Secretary Patterson being a doctor; did you not?

Dr. WEINERMAN. Yes, sir; he never interfered with our medical practice.

Senator PEPPER. And yet there is a medical profession in the Army that functions pretty well, in your opinion, in spite of the fact that the Secretary of War or the Chief of Staff were not doctors?

Dr. WEINERMAN. May I say, Senator Pepper, that it has been very, very frequently pointed out that civilian doctors were the ones that gave the medical service in the Army. That is completely correct. It has also been very frequently pointed out that as soon as this bill is passed, the whole quality of medical care is going to deteriorate, as claimed in this advertisement, and all the doctors are going to give bad medicine.

Senator DONNELL. Does it say that in this advertisement?

Dr. WEINERMAN. I think it does, sir. I would like to submit that the civilian doctors who made up the Army Corps did not request to go into the Army. They were brought into it like any other American citizen. And even under far more stringent regulations than anything like this bill would ever call for, they gave good medical service.

I therefore cannot see the basis for the argument that by the passing of national health insurance all of a sudden the quality of medical care will become worse than it was before.

Senator PEPPER. Now, you were in the Medical Corps?

Dr. WEINERMAN. I was with a combat surgical team.

Senator PEPPER. That was headed up by the Chief of the Medical Division in the Army, somehow?

Dr. WEINERMAN. Yes, sir.

Senator PEPPER. He was a doctor, just as the Surgeon General is a doctor. There is no suggesting that the Surgeon General should not be a doctor in this bill; is there?

Dr. WEINERMAN. No, sir.

Senator PEPPER. There is no permission in this bill for a surgeon general to be other than a doctor; is there?

Dr. WEINERMAN. I believe he must be, sir.

Senator PEPPER. He certainly is presumed to be, and I believe it is legally required. But that does not mean that the Federal Security Administrator that administers this whole insurance program has to be a doctor, does it?

Dr. WEINERMAN. I believe, sir, the Federal Security Administrator has many functions under him. I am not certain of this, but I think he has the Social Security Board and the Office of Education and the Vocational Rehabilitation Agency, and that he is merely the broad administrator. I do not think he would have any of the detailed "say" about the workings out of such a health plan.

Senator PEPPER. Although that is an independent agency, there may come a time when the Federal Security will be put under a cabinet officer.

Mr. BOLTE. I believe it is required, sir, at least in practice, that the cabinet officer for the Army not to be a military man.

Senator PEPPER. I was just going to say: Is it not a part of our system of government that although the Secretary of War runs the Army, which is vast in technical divisions, and is vast in technical requirements, a civilian? And the man that runs the Navy, the Secretary of the Navy, was head of Dillon Read & Co., Mr. Jim Forrestal, and an able Secretary? But it is a part of our system that all these technical services in the Army and Navy are performed under the general direction of civilian Secretaries of War, Secretaries of the Navy, and generally under the direction of a civilian Commander in Chief who runs them all?

Mr. BOLTE. I think, sir, it is an essential element of that maintenance of control in the Government by the people which Senator Morse underscored.

THE ISSUE MUST BE DECIDED BY THE PEOPLE

Senator PEPPER. Now, one other question: As a matter of fact, some people look at this bill as a measure upon which the medical profession should have almost the final say. Let us see whether or not that should be true. Essentially what this bill contemplates is that the people's representatives duly elected are called upon to require the people of this country—that means 132,000,000 people, or the number of that that might be employed and come under the coverage of the act, doctors and civilians—to pay a sum of money into an insurance fund, which in turn will be used for providing medical services and facilities to those people. Is that not essentially what this bill is?

Mr. BOLTE. I think that was the point, sir, I made before you came in: That this is basically the people's problem.

Senator PEPPER. Now, the people of the United States do not have to ask the doctors as to whether their Congress shall impose upon them the requirement to pay a tax to provide a common fund with which they may buy something they want to buy, do they?

Mr. BOLTE. Not at all, sir.

Senator PEPPER. So the number of doctors who will be taxed is a part of the population, but an infinitesimal part of the whole population that will be covered by this tax bill, this bill which will ultimately lead to a tax bill; is that not true? They are a very small part.

The only place the doctors come into this bill, to get down to it, is in the question as to whether or not they are willing to perform medical services for the fees that the ones who administer this insurance fund find it possible to give them, taking into consideration the quantity of money that is in it.

Is that not substantially all they have to do with this thing?

Mr. BOLTE. Yes, sir.

Senator PEPPER. It does not contemplate that anybody is going to tell them how to practice medicine, does it, or any of their professional standards?

Mr. BOLTE. Not at all.

Senator PEPPER. Now, the bill does say if you are going to collect the fee as a specialist, you have to qualify by common knowledge as a specialist? You would not see anything wrong with that, would you? You do not pay special fees to a fellow who is only a common practitioner?

Mr. BOLTE. That is the way it is now, sir.

Senator PEPPER. And he has to show public authority then, that he is a specialist?

The fact that he has to indicate as a matter of free choice whether he wants to perform medical services for insured people and accept fees that the fund will authorize: That is about all the doctor has to do with this thing except to go on and practice medicine as he normally does. Do you call that socialized medicine?

Mr. BOLTE. I could not conceivably.

Senator PEPPER. Do you call that breaking down the system of American democracy? Do you call that breaking down our system of private property and free enterprise, and so on?

Mr. BOLTE. It is fantastic.

The CHAIRMAN. I was just going to ask one question.

Senator DONNELL. I hope Senator Pepper and Senator Morse do not leave, because I have enjoyed a very eloquent address here. Senator Pepper's address was beautifully phrased and presented, as it always is.

The CHAIRMAN. Under this bill, instead of witnessing any deterioration of professional ability or character of service, will it not mean a vast improvement to the great majority of the medical profession?

Dr. WEINERMAN. Well, Senator, when we talk about quality of medical care, we should really talk about it and not just use the word. Quality of medical care means having the doctor give the patient not only the best service that he knows how to give, but all the service that the patient needs at the time the patient is sick.

Now, today, as has been pointed out by Senator Morse and others, the doctor is able to give his patient, if the patient comes to him at

all, only such services as the patient can pay for, or as the doctor is willing to give free. There is a very substantial limitation. Under the bill, such financial barriers are broken down, and the quality of service becomes exactly the quality of medicine that the individual doctor is capable of.

If he is a good doctor, he will give good service.

The CHAIRMAN. And under this bill, the intention is to see to it that the profession does not deteriorate with respect to quality of service and ability.

Dr. WEINERMAN. I think there are very many safeguards on that.

The CHAIRMAN. Under section 205, that you find on page 47, the Administrator of this bill is required to—

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

- (4) aid in the prevention of disease, disability, and premature death; and
- (5) insure the provision of adequate service with the greatest economy consistent with high standards of quality.

Senator PEPPER. I want to apologize to my able friend from Missouri that I am going to miss his brilliant continuation of this inquiry, but I want to leave my interest to my good friend, Mr. Morris Fishbein, who is somewhat acquainted with this subject, in case something else may come up.

(Senator Pepper leaves at this point.)

The CHAIRMAN. You may proceed.

Senator DONNELL. Mr. Chairman, just a few observations and questions also. In the first place, before starting the questioning, I appreciate the point of view of the chairman, of course, and of the Senator from Florida and the Senator from Oregon, and I think it is a fine contribution that each of you gentlemen has made to the discussion of this measure, to point out, through effective questioning, which I appreciate is not quite the type of questioning that would be sustained by a judge in court as against objections on the ground of pleading. But nevertheless, I myself have asked the same kind of questions, and I think that this is a forum in which we may not only question the witnesses but to some extent indicate views and trends.

I might say, before asking these further questions of these gentlemen, that I do not desire to have my question understood as making determinative of whether or not this bill shall be adopted, the decision of the question as to whether this bill properly protects the private property rights of the doctors.

I do not regard that as the fundamental question at all. I appreciate, Mr. Chairman, that the doctors have expended years of time and quantities of money in the acquisition of education, and I think they are entitled to consideration of that standpoint too. But as I see it, there is a much broader question here than the mere preservation of the property rights, and I am sure my close friend from the State of Washington likewise regards that as subordinate to the larger questions of national public policy.

We have here, as I see it, questions of initiative, private initiative, the preservation of the system of private initiative, that is involved at least to some extent in this case. So I do not want it to be understood that I am standing upon the proposition that whether this bill should be supported or not is to be determined by its effect upon the private property rights of doctors.

Now, I would like to ask the doctor here one or two questions along that line. Senator Morse made the point that these gentlemen of the American Medical Association are in a sense special pleaders. I do not know the thought in the Senator's mind nor in the doctor's mind here this morning. But the point I desire to address myself to in questioning the doctor, to clear up any impression in my own mind that might be contrary to what he intends, is: Are you of the opinion, Doctor, that these members of the American Medical Association by and large who are opposing compulsory health insurance are doing so because they think it is going to hurt them financially? Is that their reason for doing it?

Dr. WEINERMAN. No, sir; I do not think that is their reason.

Senator DONNELL. You do not think they are here in the sense of coming here and advocating something simply because of its effect on their own pocketbooks, do you?

Dr. WEINERMAN. Senator, I think a few doctors probably feel that they would be hurt. I think the mass of doctors do not feel that, and their opposition to the bill stems from what they are given to read.

Senator DONNELL. Doctor, I do not know whether you have read this part of the testimony. I imagine you have, because obviously you have carefully studied at least parts of the testimony. It was testified here, as I recall, some days ago by one of the witnesses that this bill in all probability will very greatly benefit the doctors, at least on the whole, and will give them a generally more stable and substantial assurance of livelihood than under this present plan we now have.

Dr. WEINERMAN. Yes, sir; but those doctors are not the ones that have been speaking and writing about the bill.

Senator DONNELL. Very well. The point I am making is, though, that you are not claiming here that the American Medical Association's witnesses who have appeared here have been actuated by their own selfish personal financial interest in their testimony. I am correct in my understanding of your view on that, am I not?

Dr. WEINERMAN. When I agreed with Senator Morse I did not think that either of us thought that.

Senator DONNELL. I want it perfectly clear that you are not claiming that is their motive. You disagree with them on their economic motives, but you give them just as much credit for their intent to give us an unbiased, unselfish opinion as you do with respect to yourself.

Dr. WEINERMAN. Whom do you mean by "them"?

Senator DONNELL. Those members of the American Medical Association who appeared here and testified.

Dr. WEINERMAN. I do not know what their opinions are, sir. I believe that the mass of doctors are noble in their views.

Senator DONNELL. Now, some mention was made, Mr. Chairman, by Senator Pepper, speaking of the technical denial of freedom of choice under subdivision (j) of section 205. I may say, in passing,

that the term "technical", like terms of "socialized medicine" and "national health," and so forth, is perhaps one that may be unconsciously used by the user in a somewhat argumentative sense. The fact is, Doctor, that it does say in subdivision (j) of section 205 that the Surgeon General may prescribe these maximum limits to the number of potential beneficiaries.

That is in there in words, is it not?

Dr. WEINERMAN. The phrase is there, sir, yes, sir.

Senator DONNELL. All right. Now, whether it is technical or not remains a subject for argument, but that is the language. That is what I want to make clear. Now, you mentioned, Doctor, that this advertisement of the Medical Society of the State of Pennsylvania contains some pretty strong language here about what is going to happen, deterioration in service, and so on, and you even went so far as to use this language: "Give bad medicine."

You did not mean seriously that this advertisement said the doctors were going to give bad medicine after this plan was instituted?

Dr. WEINERMAN. I have not memorized it, sir.

Senator DONNELL. Well, let me ask you first if this is not what you referred to. This is one of the results which they prophesied: That—it will stifle initiative on the part of the doctors by making them subservient to bureaucratic control, thus lowering the quality and effectiveness of your medical care.

Now, that is what you had in mind, is it not?

Dr. WEINERMAN. Yes, sir; that is a statement that has no basis in fact.

Senator DONNELL. But that is what you had in mind in what you said here and what you said a little while ago about the contents of this advertisement?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. It does not say here certainly in express language that the resulting effect of this bill is going to be that the doctors will give bad medicine. It does not say that in express language?

Dr. WEINERMAN. It says, "Deterioration in quality."

Senator DONNELL. Yes, sir, it says:

It will stifle initiative on the part of the doctors by making them subservient to bureaucratic control, thus lowering the quality and effectiveness of your medical care.

Dr. WEINERMAN. The point I made, sir, was that in the Army, where restrictions are much more severe than they ever could be under a national health program such as this, there was no such stifling and deterioration.

Everybody has testified to the fact that the civilian doctors in the Army did a very fine job. That was my point.

Senator DONNELL. They were civilian doctors who have been operating under the American system in our country?

Dr. WEINERMAN. That is correct, sir.

I think this too will be the American system if you pass it.

Senator DONNELL. That is a subject upon which I respectfully suggest there may be some little question?

Dr. WEINERMAN. Certainly.

Senator DONNELL. At any rate, the American Medical Association and this association that passed upon this matter 8 days ago this

morning, did not agree with your view on that subject. That is correct, is it not?

Dr. WEINERMAN. The majority of them did not.

Senator DONNELL. The great majority out of every hundred of them, in the meeting held in New York 8 days ago, did not agree with your view?

Dr. WEINERMAN. That is correct, sir.

Senator DONNELL. Now, doctor, this was more the testimony of Senator Pepper, if I may refer to his questioning as that, than your own, but he was making quite a point about the fact that General Marshall is not a doctor, and so forth.

Now, are you familiar with the book issued by Sir William Beveridge in England, entitled "Social Insurance and Allied Services"?

Dr. WEINERMAN. I knew the Beveridge plan. I do not know that book, sir.

Senator DONNELL. You know who Sir William Beveridge is and of his connection with this plan?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. Did you know of the fact that Sir William Beveridge very strongly advocates a separation of the medical administration from the financial part of it? Did you know that?

Dr. WEINERMAN. No; I did not.

Senator DONNELL. I might call your attention to the fact that on page 48 of this volume appears this language, as to changes, as I understand, which he advocates in the existing system in England:

Change 5. Separation of medical treatment from the administration of cash benefits and setting up of a comprehensive medical service for every citizen, covering all treatment and every form of disability under the supervision of the health departments.

Then I call your attention also to page 158 and 159, in which this language is used:

Whether or not payment towards the cost of health service is included in the social insurance contribution, the service itself should (*a*) be organized, not by the ministry concerned with social insurance, but by departments responsible for the health of the people and for positive and preventive as well as curative measures.

You recognize the high standing of Sir William Beveridge among those who have studied these problems of social insurance, do you not?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. Now, the point was mentioned, Doctor, by my good friend, Senator Morse, as to the noble conception of politics, in which I thoroughly concur with him; and yet it is true, it is not that the same argument is used—and I mention this not with any sense of disparagement as to what he says, because I agree with him thoroughly as to the nobility of the politician in its highest sense—and yet the same argument is used, is it not, by those who do favor state socialism, the theory that you have to have various functions operated by political means, in the highest sense. I mean, because the private-enterprises system falls down. That is the argument as to socialism, is it not?

Dr. WEINERMAN. I cannot answer that, sir. I have not heard it.

Senator DONNELL. Have you ever studied socialism?

Dr. WEINERMAN. I took the normal college courses in such subjects.

Senator DONNELL. You know that that is substantially stated as one of the theses of socialism, that private enterprise cannot carry out as effectively certain great broad plans as can be properly administered governmental administration of those plans? That is the thesis of socialism, or at least one of the theses, is it not?

Mr. BOLTE. May I interpose, sir? You would agree that the post-office system is socialistic by definition, then?

Senator DONNELL. I am not talking about the post-office system. There are created, in the Constitution of the United States, functions with respect to post offices and post roads. I am of the opinion it is a very fine system. But the point I am making in my questioning of the doctor is that from his courses he must understand that one of the theses of socialism is that private enterprise cannot carry out certain functions as well as governmental administration of these same projects. That is the theory of socialism, is it not, Doctor?

Dr. WEINERMAN. Senator, I would hesitate to answer whether that is the basic theory of socialism.

I would say that that has nothing to do with S. 1606, and that is the only subject I have been qualified to talk on.

Senator DONNELL. Well, in this advertisement you quoted from here, that of the Medical Society of Pennsylvania, you may not agree with this, but it does say this in here, referring to the plan of S. 1606:

It may mean the employment of 300,000 local panel clerks and inspectors.

I do not know whether you have made any computations as to whether that is correct or not. Do you have any opinion on that?

Dr. WEINERMAN. I have definitely, Senator. I think that statement can be construed probably in the same light as all the other statements in that advertisement.

Senator DONNELL. What light is that?

Dr. WEINERMAN. That No. 2, concerning cost, is false, and the one about other countries is false, the one about the deterioration of quality is false, and the statement that participation in the medical services is compulsory is also false.

Senator DONNELL. The Medical Society in Pennsylvania generally is composed of physicians of high standard, is it not?

Dr. WEINERMAN. I just said that the references in the statement are not factually correct.

Senator DONNELL. I am asking you whether the Medical Society of the State of Pennsylvania is generally composed, in your opinion, of honorable, upright men.

Dr. WEINERMAN. Why certainly, Senator.

Senator DONNELL. And this opinion may be right or it might be wrong. There was a gentleman here the other day—I might say for the information of the doctor—and the gentleman testified that this will require 1,500,000 persons to administer it. That may be right or is may be wrong. Another gentleman suggested the idea that the decimal point had been misplaced; meaning, I suppose, 150,000. But let me ask you this: This will not operate itself without administrative officials all over the United States, will it?

Dr. WEINERMAN. Many of which already exist, sir.

Senator DONNELL. I am saying it will not operate without that; that is correct, is it not?

Dr. WEINERMAN. Of course, it is correct.

ASSIGNMENT OF SPECIALISTS

Senator DONNELL. Now, for instance, on the matter of the services of a specialist: This I want to approach from two or three angles, if I may.

It is provided in subdivision (d) of section 205 that—

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.

Then it proceeds,

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.

Now, you do not have in mind that all those medical officers would be located here in Washington, do you, Doctor? They would be scattered throughout the United States at convenient points, would they not?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. And for a person living in the little town of Sedalia, Mo.—not so little, either; they would probably object strenuously to that; but a town of 20,000 population, we will say—normally there would have to be some medical officer there to pass upon this very question of whether or not specialists and consultant services should be allotted to a given patient.

You would agree with that, would you not?

Dr. WEINERMAN. May I comment on that?

Senator DONNELL. I would like for you to tell me first if you agree.

Dr. WEINERMAN. I certainly would; but if I may amplify my remark, I believe that section can be misconstrued. I think it is a very wise protection for the patient. Today the only way a patient gets a consultant or a specialist is when his doctor suggests it. That is the way it is also spelled out in the bill. There may be very, very rare circumstances wherein a doctor for one reason or other might not wish to lose his patient by referring him on to a consultant. In that case, this bill, wisely for the patient, provides the mechanism by which the patient can, if he thinks he really needs a specialist, get one despite the very, very rare instance that his private doctor may not want him to have one.

I do not think at all that means that there has to be an administrative officer in every town and hamlet. I think our public health and other activities today show us that one such administrative officer for many counties even is very ample.

And we already have many of them.

Senator DONNELL. Well, Doctor, do you not think it would be somewhat disconcerting to a patient who thought he should have a specialist to perform a quick operation on him, to be required to go many counties away from his own and have that administrative officer, who has all of these counties under his jurisdiction, come down and pass upon his case, when perhaps there might be numerous other applicants ahead of him in other counties asking for the administration from that administrative officer?

Dr. WEINERMAN. Well, Senator, on that question I cannot con-

ceive of a doctor who has a patient that needs an immediate operation, who would not refer him to a surgeon.

Senator DONNELL. Well now, Doctor, that may be true, but I observe from this section that I have just quoted from that while the services of a specialist or consultant shall ordinarily be available only upon the advice of the general or family practitioner, it is contemplated, as you have indicated, that there may be circumstances under which the individual himself has some rights in the matter as distinguished from what his family doctor may say; and that individual, you think, very wisely is given the privilege under this act of having a medical administrative officer appointed by the Surgeon General to pass upon that question.

Now, may I just give you one county in Missouri, for instance, the county in which I was born, having a population of I think about 30,000, up in northwest Missouri, Nodaway County, Mo: Would you not think that there would have to be at least one medical administrative officer in a county of 30,000 population who would be able to pass promptly upon the request of an individual from any one of 15 or 20 towns in that county for a special consultant or specialist's service? Would it not be advisable to have one man, at any rate, in that county?

Dr. WEINERMAN. Well, sir, I believe under the bill it is already anticipated that for every approximately 30,000 persons there shall be a public health officer.

Senator DONNELL. Then you would agree, would you not, that it is necessary to have a medical administrative officer in that county? You would say that that would certainly be reasonable, would you not?

Dr. WEINERMAN. I would like to see a public health officer in every such county, sir.

Senator DONNELL. Very well. There are 114 counties in our State. Not all of them have that large a population. Some have more and some less. We have two great cities, St. Louis and Kansas City; and others that consider themselves great—they are, in their respective communities. Certainly those respective communities would have to have, as for illustration, St. Louis and Kansas City, many more than one medical administrative officer to pass upon all the questions that would arise within it.

That is correct, is it not?

Dr. WEINERMAN. Well, no, sir; I do not think so. The public health officers that we are all striving to have in every county of the country would have many, many functions besides the occasional one of passing upon such a case as this.

You are predicated that upon the fact that a patient may need a consultant in a hurry. If he does not, then there is no problem. I say that there is no doctor in the country, sir, that would not advise the consultation of a surgeon when the case is an emergency.

Senator DONNELL. Well, Doctor, I am not sure that just the hurry-up cases are the only ones in which this would be needed. It seems to me that it might well be that in a given community out a hundred miles from St. Louis there might be somebody as to whom the medical administrative officer should have some personal knowledge over a period perhaps of weeks, to determine whether that person needed

a consultant; rather than pass upon it as a matter of instantaneous opinion. But be that as it may, we do agree, do we not, that this bill does not pass any restrictions save only as might be embraced in the appropriation measure, with respect to the number of medical administrative officers to be appointed by the Surgeon General?

Dr. WEINERMAN. I think that is left to the discretion of Congress.

Senator DONNELL. And Congress has not exercised that discretion in S. 1606, has it?

Dr. WEINERMAN. Not as yet. I hope it will, sir.

Senator DONNELL. You think there should be some limitation on that, do you, in S. 1606, as to the number of officers that should be engaged; or do you think that should be left to the Surgeon General?

Dr. WEINERMAN. I think it should be left to the discretion of those who administer the program.

Senator DONNELL. Very well. Do you favor the idea of the Surgeon General being under the Federal Security Administrator, thus combining both the financial phase of it and the medical phase in a manner which Sir William Beveridge argues is inadvisable? Do you agree with the plan of the bill rather than the plan suggested here by Sir William Beveridge in that respect?

Dr. WEINERMAN. I have not studied that, sir. I just would say, in respect to your question, that I am in no position to propose a change in our administrative structure. It has worked well with the vast public-health program that we have now.

I am sure the Surgeon General is not going down to your county in Missouri and tell the public health representative there what to do. I do not think it would happen under this bill, either.

Senator DONNELL. The Surgeon General has not as yet operated a compulsory medical insurance feature over the United States.

Dr. WEINERMAN. Well, compulsory as to the matter of paying the small fees; there is nothing compulsory about the medical service.

Senator DONNELL. I say the Surgeon General does not operate under S. 1606 yet, because it has not been passed.

Dr. WEINERMAN. The Surgeon General does operate a compulsory health service which has been in effect for many, many years. That refers to the merchant marine. I may be wrong about the extent of it.

Senator DONNELL. Is it in existence at all at this time?

Dr. WEINERMAN. My knowledge is personal. To my knowledge, it is. I am perfectly willing to agree that I may be wrong.

Senator DONNELL. Well, even if it did operate in the merchant marine, it was not a Nation-wide compulsory Federal health insurance.

Dr. WEINERMAN. Certainly not. That is what this is all about.

Senator DONNELL. Doctor, I want to ask you one other question: Senator Morse brought out the point, a point in which I think there is much merit, about the benefit of the specialized knowledge in this situation, and the fact that today we do not trust entirely to the all-comprehensive services of a family physician as we did when I was a boy.

Now, this, however, this section of the statute, does recognize; that is, S. 1606, does recognize, as I see it, that the family practitioner does play a very, very important part. For it says:

The services of a specialist or consultant shall ordinarily be available only upon the advice of the general or family practitioner or the specialist or consultant attending the individual.

Do you favor that particular sentence in the bill? Do you think that is a wise provision?

Dr. WEINERMAN. Sir, I do. I think that is exactly what the most modern concept of group practice is. Our concept of group practice today is that the patient shall come to a general practitioner, who investigates to his over-all need, and then either treats him accordingly, or refers him to the specialist, who is particularly apt in the necessary department.

Now, under the bill, we would have in effect a group practice covering the entire community. The patient could go to his private doctor. If he needed, let us say, X-ray care, he could be referred to the X-ray man for no additional cost, and we would have the finest type of group practice in the widest possible sense.

I think the bill is very good in that respect.

Senator MORSE. If the Senator will permit me to say so, and I think the record will show it, I at least did not mean to imply that the family practitioner is not qualified to recognize when the patient needs care that he, the family practitioner, is not qualified to give. The family practitioner certainly knows that.

The only point I wanted to stress by my leading questions—and they were leading; the Senator is quite right—is that with modern medicine developing as it is, we need more rather than less in the clinical program of treatment.

Dr. WEINERMAN. When one goes to the general practitioner today, and he decides that the patient needs X-ray treatment, what is the patient going to do if he cannot afford the very substantial fees for X-ray treatment? He either goes without them or goes into debt or gets charity medicine. And then a free choice no longer exists.

Senator DONNELL. I am sure Senator Morse means exactly what he has amplified here. I did not question that at all. I realize his emphasis on the importance of specialization does not imply there is no place for the family physician.

You agree, do you not?

Dr. WEINERMAN. Oh, very definitely.

Senator DONNELL. Now, this may be an old-fashioned question, and maybe unscientific and wrong, but I would like to ask it anyhow: Is there any advantage in some cases in a patient having the opportunity to go to a doctor that he chooses himself and has a lot of confidence in and likes, and in whom he has a certain feeling of assurance and confidence when he comes to him? Is there any psychological and curative advantage in some instances to a patient in being able to go to a man that he has known a good many years and has confidence in and maybe cheered up by the doctor's personality? Is there any value in that?

Dr. WEINERMAN. Very great value, sir.

Senator DONNELL. Take, for instance, the case which I cited, which you may feel is improbable but it may not be:

Suppose that in my home town when the registration times comes under S. 1606, I am away. I am away some of the time down here, you know. Let us say I do not get in in time to sign up for the doctor that I have always had for a good many years and liked and had confidence in. I get in late, and though it is true that if you permit this combination service maybe I could hire him inde-

pendently, but I could not get the benefit of his services; as I understand it, if he had already got up to the maximum that the Surgeon General said he could have. I think that is right. Maybe I am wrong on that. But, assuming I am right on that, for purposes of argument, we will say that I get in there 10 days too late to register with him, and there are 50 other people on the waiting list that want to get in too. So I have to go to some other man down the line that I do not have the confidence in and do not have the personal contact with: Is it not true that it might react somewhat unfavorably on me in my illness to have that experience?

Dr. WEINERMAN. May I say, first—

Senator DONNELL. I wish you would answer my question first.

Dr. WEINERMAN. Sir, I can only answer in my own way.

Senator DONNELL. You can answer and then explain your answer.

Dr. WEINERMAN. The answer to that question is "yes." My continuing remark is this, sir: That this bill proposes to bring good medical care to as many people in the country as possible.

If, under this bill, in your town, this town of Sedalia, Mo.—

Senator DONNELL. I live in Webster Groves.

Dr. WEINERMAN. I stand corrected. In Webster Groves, Mo.: If thousands of citizens there can go to the doctors that they never before were able to go to, I think that is far more important than the fact that you, being busy in Washington, will have to go to a doctor of your secondary choice. And when we are weighing the advantages of this bill, sir, that is what we should take into consideration; that the great majority of your constituent citizens there will have an open door to medical care.

I grant the fact that in a very rare instance someone may have to go to a second-choice doctor. But that is vastly less important than the fact that many of them can now go to a doctor when before they could not.

DOCTOR-PATIENT RELATIONSHIP

Senator DONNELL. I may say, with respect to that, which is very leading and very argumentative on my part, as are many of my questions—Senator Morse and I are both responsible for that condition to some extent—to my mind there are many persons in the city of Webster Groves who might find themselves in a situation similar to mine. That is to say, the doctor that I want to go to has a very large practice and has decided that he can take me as one of his patients. And I think that situation I have mentioned is true of a great many other people. I would not be surprised if there were a great many people in that little city that might find they would have to change because they did not get in to sign up on the day they had to sign up, and they would have to take someone else.

Just assume for the purpose of argument that I am right on that. As to those who are unfortunate enough not to get on the particular doctor's list, it is possible, is it not, that those persons might be injuriously affected in the treatment of their cases by having to take a man that they really did not want? That is true, is it not?

Mr. BOLTE. Senator, may I interpose?

Senator DONNELL. I would prefer that the witness answer first, if you do not mind.

Dr. WEINERMAN. Sir, I am not a lawyer, but I do know some of the principles of logic, I think, and I cannot agree or disagree with a conclusion when I do not agree with the premise. Your premise was, sir, that there would be a great number of patients who could not get the doctor that they always had and liked.

Senator DONNELL. Let me amend that by disposing of the number question. I want to find out about the effect on the individuals, just taking it down to one man who fails to get the doctor that he wants: is it apt to or possible that it may have an injurious effect on him in the treatment of his case?

Dr. WEINERMAN. Under this bill, I do not think that would be the case.

The CHAIRMAN. Right there, let me ask a question: Is it not intended that there should be some flexibility in the administration of this bill, and if a doctor has already been assigned the full limit that he is to care for, is there anything to prevent that doctor from taking another case if the Administrator permits it in that community?

Dr. WEINERMAN. No; I think that is quite possible, sir.

The CHAIRMAN. And is it not quite possible for the doctor himself, under the bill, to decline to handle some of the cases that he has already taken? He is permitted, is he not, to refuse to treat patients that he does not want to treat?

Dr. WEINERMAN. That is a very good point. I had never thought of that, sir.

I would like to answer Senator Donnell with that position in mind; that if your doctor was anxious to have you under his care, he has the right to drop one of his other patients and take you.

Senator DONNELL. That would be a little hard on the fellow he dropped.

The CHAIRMAN. Not necessarily, if the fellow be dropped had no particular choice.

Senator DONNELL. He has shown that he did have the choice by selecting this doctor, and the doctor may not know in each instance just which one had the greatest desire for him or what the motives were for the choice.

Dr. WEINERMAN. I think there is one other point, Senator, that under this bill, the purchasing power, medically speaking, which would be in the hands of all citizens, would attract to Webster Groves, let us say, the additional physicians that they need, so that everybody can get medical care. Today there may be a scramble, and some are left out.

The CHAIRMAN. In a great many communities there is no freedom of choice at all, because there is only one doctor, and they have to accept the services of that doctor or go without.

Dr. WEINERMAN. I think Congress is well cognizant of the fact that in 81 counties in the country there is no doctor at all, and freedom of choice is no argument there.

Senator DONNELL. I just call to your attention for the record—I appreciate that you have not examined this book, but I think this is a reputable book—"Medical Insurance Practice," which I referred to this morning, published with the approval of the National Defense Trust, whatever that may be in England, issued by the British

Medical Association, where, at page 187, it says this, bearing on this question of elasticity:

A practitioner carrying on practice otherwise than in partnership is not permitted to have more than 2,500 insured persons on his list—

and so forth.

The point I make is not as to the number, but the point is as to the fact that there it appears there is no elasticity after you get up to a particular point.

Now, I would like to mention this, and I appreciate we cannot go into all of these ramifications or we would be here until the time we hope we will adjourn, some time in July, but at any rate, let me mention one or two other illustrations on this question of choice.

Mr. Bolte, you wanted to make a remark a little while ago, however. Do you have in mind what that matter was?

Mr. BOLTE. I just wanted to throw in a little human remark, Senator, to the effect that I am sure your doctor would not take you off of his list, you being a man of standing and distinction in the community.

Senator DONNELL. Well, regardless of that, and whether that is correct or not, the fact is that he would have to take somebody off his list, and maybe somebody that does not happen to be in public office, and it is just as injurious for that man as it would be for another man.

Now, one or two other things: For instance, under this bill, S. 1606, a certain time is fixed, as I recall it, within which the doctors come into the plan and their names are displayed to the public in some appropriate way under rules and regulations. Then the public has a certain time within which to decide to make preferences known as to which doctor's list they are going on.

Dr. WEINERMAN. Sir, may I add that that is only, I believe, under the capitation system.

Senator DONNELL. Yes, it is.

Dr. WEINERMAN. May I point out, also, that in America today, a very, very small proportion of the doctors will elect capitation. And the fee for service that prevails—the system that prevails today is the fee for service system. Whether that is good or not, I am sure that is the one that is going to be elected.

Therefore, this business of choosing your panel and limitations, and so forth, is only true in a very, very narrow sense.

Senator DONNELL. I do not know. I am not able to prophesy on that, Doctor. I notice that is very carefully worked out here. Obviously the framers of this bill were of the opinion that it was of importance, or they would not have worked it out.

Now, suppose that in the particular community where the doctors have decided to have the per capita basis of payment, everybody comes in and makes his choice and everybody gets the person he wants, and then you come in there in the next week or 10 days, or 3 months from then, and you want to get one somebody's list. You take whatever is left, do you not, under this bill? You do not have any freedom of choice except to take from those listed somebody whose panels have not been filled.

That is correct, is it not?

Dr. WEINERMAN. Sir, I probably would not go to that community.

Senator DONNELL. You would stay away because of that situation?

Dr. WEINERMAN. There are thousands of communities where doctors are badly needed.

Senator DONNELL. I am not talking about you as a physician. Take Mr. Bolte over there, who is a patient. He comes into that community after the doctors' panels are all filled, or we will say half of the doctors' panels are filled. He is going to be remitted back, is he not, under this bill, to get on the panel of somebody whose panel is not filled?

Dr. WEINERMAN. I think, as the chairman has pointed out, the system is certainly elastic enough to let anybody get on the list. You pointed out that in the instance you mentioned in Britain, they construed the limit so liberally that it was 2,500 persons. That is quite large. I am sure that is not a figure we would use here, even if we applied that.

Senator DONNELL. You know the reason for that in England, do you not?

Dr. WEINERMAN. Probably it is because they do not have enough physicians.

Senator DONNELL. And also because in order to give the doctor a sufficient income in England, they had to give considerable coverage.

Dr. WEINERMAN. I am glad that is not true in this country.

Senator DONNELL. In this country, the point I am making is that if Mr. Bolte should arrive in that community 6 months after the five leading physicians' panels had been filled, he is going to have to go on a panel that is not filled.

Dr. WEINERMAN. This is on the supposition: (1) That the doctors choose capitation; (2) that they are all filled up?

Senator DONNELL. No; not all filled up. I take the situation where five of them are filled, we will say, and five are not filled. He has to go on the five that are not filled.

Dr. WEINERMAN. In the rare instance where all the doctors in the community will choose capitation—and frankly, sir, I cannot think of such an instance as being possible—then Mr. Bolte would only have freedom of choice of half the doctors in the community for the remaining 6 months in the year. At the end of that time, if it works that way, and I do not know that it is going to work strictly on a yearly basis, he can again choose his doctor.

Senator DONNELL. There is nothing in this bill that says there shall be a reshuffling of this every year, is there?

Dr. WEINERMAN. There is nothing in the bill that says anything like that, I think, sir.

Senator DONNELL. You would not favor that, where a man would have to make a hurried trip down to the enrollment room at the end of every year, would you?

Dr. WEINERMAN. I do not think we are talking on a proper basis here. Everybody will go to the doctor he wants to go to, by and large. There is not going to be very much of a panel system if we use fee-for-service. So it is going to be exactly the way it is today, except for the fact that every doctor has his bills paid. The doctor sits in his office, and the patients come to see him.

Senator DONNELL. Take the case under this bill, where they have elected this per capita basis, which is provided for in law, is it not?

Dr. WEINERMAN. Yes; but we must admit, then, we are talking about a rare instance.

Senator DONNELL. I cannot say that, because I do not know, but the law does permit the per capita basis, does it not?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. And in England that is all they have, is it not?

Dr. WEINERMAN. I do not know, sir. I do not believe that is all they have.

Senator DONNELL. That is correct in my understanding. All they have in England is the per capita basis.

Dr. WEINERMAN. I am not sure. I would not want to go on record.

The CHAIRMAN. We only have the system that he is talking about there when the doctors elect to have it, per capita.

Dr. WEINERMAN. Oh, yes; it is up to the doctors to elect capitation, and from what I know of both the American Medical Association's thinking on how doctors should be paid, and from my own acquaintances, I would think that very few doctors would choose capitation.

Senator DONNELL. Well, Doctor, whether that be correct or whether it is not correct, the law does permit the choice of that client.

Dr. WEINERMAN. That gives the freedom to the doctor, sir.

Senator DONNELL. Yes; and then the patients have to follow the rules laid down in here.

Now, let me mention just one or two other points. I will try not to prolong this unduly.

The CHAIRMAN. Before you ask the next question, may I ask a question?

In the community, under the present system, where there are 35 or 40 doctors, with a population of 40,000, the patients are divided up among the 35 or 40 doctors. Now, under this bill, would not the same sort of a situation generally prevail?

Dr. WEINERMAN. I think it will prevail almost exactly, sir.

The CHAIRMAN. Just as it is today; they all cannot get the doctor that has the big reputation and has the most advertising. They cannot select him. It has to be divided up fairly among the 35 or 40 that practice.

Dr. WEINERMAN. Yes, sir. I do not think we have given enough attention to the fact that in the bill in this clause that we are discussing, as I recall it, it says that the Surgeon General "may" do all these things. It is just a wise proviso where necessary. But there is nothing that says that he shall or will do it if it is not necessary.

Senator DONNELL. The power is there, is it not, under the bill?

Dr. WEINERMAN. As a professional man, sir, I would say very wisely there.

THE ADVISORY COUNCIL

The CHAIRMAN. And under the operation of the Advisory Board.

Dr. WEINERMAN. That is known to occur at every stage of this.

Senator DONNELL. You would not contend that the Advisory Board has the power to require him to do what it may advise?

Dr. WEINERMAN. Senator, I am aware of the fact that the Advisory Board has not been given specific administrative power, which is wise, since they are not an elected or responsible body but in effect they have a great deal of power. They report to Congress, and they report to the public. They must be consulted. The bill says that in practically every page, at every professional step.

But much more important than those two things is the fact that when the Surgeon General reports to you gentlemen he must not only indicate what the Advisory Council has advised but what he did about it. And if that is not the source of power in the Advisory Council, I cannot see how he could give them any more without giving them the legal administrative duties that under our system of government they have no right to.

Senator DONNELL. They do not, however, have any legal power to require him to put any recommendation into effect, do they?

Dr. WEINERMAN. They have every power except the legal power.

Senator DONNELL. They had no legal power. That is what I am getting at. That is correct, is it not?

Dr. WEINERMAN. Well, they have power, sir.

Senator DONNELL. Well, I say they have no power to require him to do it. You understand that, do you not?

Dr. WEINERMAN. Yes; I think they do have the power to require him to do it, the power of their reports to Congress and to the public, and the power of their professional prestige in the community.

Senator DONNELL. I may mention, Doctor, in that connection, in this bill the Surgeon General is required to make a report to Congress as to what the Advisory Council has recommended, and the Surgeon General does so with his comments. You remember that, do you not?

Dr. WEINERMAN. Yes, sir.

Senator DONNELL. With his comments. Yes; here it is here, section 203, page 41, line 21, commencing with line 16, and following:

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

Now, there may be a provision in here, but I do not recall it, where the Advisory Council itself makes a report to Congress. I may be in error in that. If I am, I stand corrected. But the report to which I refer is one of the Surgeon General, and I take it that with the Surgeon General giving his comments on the matter—and I do not say this with any thought of unfairness, for he thinks he is doing right in doing what he is, but his comments are very apt to be extremely persuasive upon Congress as to the validity of the conclusions at which he arrived, regardless of what those may be.

Mr. BOLTE. Of course, sir, the Advisory Council does not operate in a hermetically sealed chamber. If the Surgeon General should keep the reports quiet, a very good opportunity would be presented to bring pressure to bear on the Surgeon General.

Senator DONNELL. I have never been very strong on this idea of bringing pressure to bear on public officials. I do not think it is advisable, in the first place. I think it is an unwise idea.

Mr. BOLTE. You would be opposed to the Advisory Council?

Senator DONNELL. No; I am very strongly in favor of it if we should have this bill, but as far as bringing pressure to bear, I really do not think that is right.

Mr. BOLTE. You say, in the first place, Senator, that the Surgeon General can put a muzzle on the Advisory Council?

Senator DONNELL. I did not say that at all.

Mr. BOLTE. Well, now you say no pressure should be brought on him.

Senator DONNELL. I think we are using "pressure" in a somewhat different sense. I cannot think that you would agree that the Advisory Council should undertake to bring some force of some kind on the Surgeon General, to do something that he thinks is unwise.

At any rate, my judgment here is that the language speaks for itself; that the Advisory Council makes recommendations which are in turn presented to Congress with the recommendations of the Surgeon-General.

Now, one or two other questions. One point that I would like to mention, Doctor: Under this bill, the choice of the doctor, where this per capita system is selected in a given community, that choice is, in the average case, made when the chooser is a well person, at least not down sick. I am correct in that, am I not?

Dr. WEINERMAN. Yes.

Senator DONNELL. Now, suppose a man makes a choice of that kind on April 1. He thinks that William Smith is the man he wants, Dr. William Smith. He goes on his list. Then this man becomes ill, we will say, on December 1. He has in the meantime heard some bad things about Dr. Smith and some mighty good things about Dr. Jones, and he wants to get over on to Dr. Jones' panel. He can withdraw, as I understand, from Dr. Smith, but he finds that Dr. Jones, at the time that he needs him, when he is sick, is the man that he would have confidence in, but his panel is already filled. So even though he chose, when he was well, the man that he thought he ought to have, he is precluded from getting the man he wants when he is sick and needs him.

That is a correct statement, is it not?

Dr. WEINERMAN. That is a correctly stated circumstance, but one of the most extreme under this bill that I can think of, sir. I do not see how it can be used as an argument against the desirability of the bill, when thousands of people in that community will have far greater access to doctors as we have demonstrated.

Senator DONNELL. Then may I give you one other point in further illustration. This town I live in of Webster Groves is a pretty good town. I live in Webster Groves, and I want to have a man over in Kirkwood, near me there, who lives 3 or 4 miles from where I do. He can come over in his automobile in 5 or 6 minutes and not violate any speed laws—or better make it 10 minutes. I am out of his area, but the doctors in Webster Groves, we will say, have elected to accept the per capita plan.

As I understand this statute, I cannot go to Kirkwood and select him, unless I pay for him myself. I cannot get the benefit of this plan by selecting a man in Kirkwood, because I do not live in his area.

Dr. WEINERMAN. As I understand it, Senator, I think you can. I may be wrong.

Let me say in addition that there have been a great many proposals that this sort of thing be done on a State level, in which case if you lived on a State line and the biggest medical center in your area was 2 miles away from you but in another State, you would be completely excluded from it.

Under the provisions of this national bill, I think you can use the Nation's resources wherever they happen to be.

Senator DONNELL. I do not recall the provisions to which you refer. I think it distinctly said, at the bottom of page 46:

The Surgeon General shall publish and otherwise make known in each local area to individuals entitled to benefit under this title the names of medical and dental practitioners and groups of practitioners who have agreed to furnish services as benefits under this title and to make such lists of names readily available to individuals entitled to benefits under this title.

Dr. WEINERMAN. Sir, there is nothing that says that you cannot go to the other area, though, if you wish.

Senator DONNELL. I think, Doctor, that I would say that the construction of the bill, to my mind, at any rate, is very clear as having in mind the setting apart of given areas. It is necessary to do that, I would think, for administrative purposes, under the plan laid out here. We would have to have some kind of an area. You could not have a man living in Boston selecting somebody in Albany, N. Y., to treat him.

Dr. WEINERMAN. I would not advise it, but I still say there is nothing in the bill that says it cannot be done.

Senator DONNELL. If it is, you would say it is unwise to have it in the bill, would you not?

Dr. WEINERMAN. I am not prepared to make a statement on that, sir.

DETERMINATION OF SPECIALISTS

Senator DONNELL. Now, one other thing, here, Doctor, on pages 45 and 46, down at the bottom of page 45, it says:

Services which shall be deemed to be specialist or consultant services, for the purposes of special rates of payment under this title, shall be those so designated by the Surgeon General, and the practitioners from among those included in subsection (a) of this section who shall be qualified as specialists or consultants and entitled to the special rates of compensation provided for specialists or consultants shall be those so designated by the Surgeon General as qualified to furnish such specialist or consultant services and only with respect to the particular class or classes of specialist or consultant services he shall determine for each such specialist or consultant, in accordance with general standards previously prescribed by him after consultation with the Advisory Council.

Now, all that is in there. That gives the Surgeon General, then, the power to determine who shall be considered specialists or consultants as stated in what I have read. That is correct, is it not?

Dr. WEINERMAN. Well, Senator, I was going to refer to this section myself. I would like to answer that question.

Senator DONNELL. I would like to have you answer it.

Dr. WEINERMAN. In the first place, sir, the AMA is very wisely attempting now to standardize the procedure for specialists so that only those men who qualify according to very well set up boards can claim that they can give consultant services.

Senator DONNELL. Could I throw in one remark here, which I know you will think is unfair, but I am going to throw it in, if you do not mind: You say they are wise in doing that. You do give some credit there; do you not?

Dr. WEINERMAN. Sir, I have mentioned repeatedly the wisdom of the AMA in medical matters.

Senator DONNELL. But I wanted to emphasize that while you so thoroughly disagree with them on these economic and social thoughts that have been mentioned here, you concede in the illustration you are going to give right now that they do show wisdom there, do you not?

Dr. WEINERMAN. They show wisdom in many scientific matters.

The CHAIRMAN. Right there, I want to say that we all agree to that, and it seems to me that the medical profession can be of great assistance to us in working out some of these problems that you are quarreling about today. It seems to me that if they accept the proposition that we should have some kind of a health-insurance system in this country that will bring medical care to people who are now denied it, that they could help us work out the provisions of the bill so as to make it operate correctly and with fairness to everybody concerned.

Senator DONNELL. Might I just interpolate this remark, and that is: Is it not possible that in part, at any rate, the opposition of the AMA, the American Medical Association, is based on scientific basis; that is, upon its conception of whether or not proper advancement in medical science and treatment will be encouraged by a bill of this kind, or whether, as the testimony has been from some of their representatives, there will result a deterioration in actual scientific medical service? I just mention that for the record at this point.

The CHAIRMAN. I think in taking that attitude they are laboring under a delusion. It does not seem to me that that position can be maintained.

Dr. WEINERMAN. In regard to this section on consultants, as I said, the American Medical Association is striving mightily to set up good rigorous standards for consultant service, and they look forward to the day, I am sure, when anyone who claims to be a consultant or a specialist will have had to pass the requirements for it. Under this bill, it is just that sort of thing that is set up. No one can get paid the specialist rates unless he qualifies for the specialist's standards. And I refer you to page 43 in the bill, sir, where it refers to the duties of the Advisory Council. On point No. 2 there, it is pointed out that one of the chief functions of the Advisory Council is the designation of specialists and consultants.

Then, over on page 45, in the section you just read to me, it says that these standards which must be adhered to if the physician who claims to be a consultant will get paid consultant rates, are set up "in accordance with general standards previously prescribed by him after consultation with the Advisory Council."

In other words, the Surgeon General cannot say to an individual doctor, "You do," or "You do not qualify," but the standards are set up in advance, and each practitioner must qualify or not qualify, so there is no personal determination involved.

The final word there, sir, is that any patient who thinks his family doctor can give him the specialty services that he wants, can still go to him. The only difference is that that doctor will not get paid the specialist's rates unless he qualifies as a specialist, and the doctors on the advisory board and the Surgeon General will set up those standards in advance.

Senator DONNELL. Will he be paid at all?

Dr. WEINERMAN. Oh yes, sir, he will be paid as a general practitioner.

Senator DONNELL. He will be paid as a general practitioner. Now, I call your attention to this: You mentioned, "In accordance with general standards previously prescribed." You do not contend, though, that this will be automatic; that a man will walk up and say he is a specialist and these general standards will work that way?

Dr. WEINERMAN. It works as it does now before the specialty boards. The applicant takes his examinations, oral or written, and the board passes upon him, and he either is designated as a specialist or he is not.

Senator DONNELL. Now, these standards, as you and I have read, are previously described by the Surgeon General "after consultation with the Advisory Council." You regard that consultation as of some value and importance, do you not?

Dr. WEINERMAN. I refer you back, sir, to page 43, where it was listed as the No. 2 function of the Advisory Council.

Senator DONNELL. May I call your attention, also on page 42, in connection with the Advisory Council, which is to advise with the Surgeon General in laying down the standards to determine whether or not a man is a consultant or a specialist for the purpose of payment—that that Advisory Council is not confined at all, as you realize, to medical or other professional representatives, but includes, second, public representatives "in such proportions as are likely to provide fair representation to the principal interested groups that furnish and receive personal health services," and so forth.

We have had before us representatives of labor, and we had a gentleman one day representing the colored physicians, who, as I recall it, advocated, as did the representatives of labor, that this Council include representatives from the colored race on the one hand, so advocated by the colored physicians, and from labor on the other hand, as advocated by the representatives of labor.

The point I am making is that this body, after consultation with which these standards are to be laid down, determining what shall constitute a specialist or a consultant, which as I see it is very largely a professional, technical, medical, or surgical question, that that body which consults may not at all have on it even a majority of members who are medical or other professional representatives, but may have quite a diversity of citizenship.

I am not arguing against the diversity of representation, on the whole, but the point I am making is that there is no adequate guarantee, first, that just automatically John Smith will come up and either be entitled or not be entitled to be selected.

Dr. WEINERMAN. No; he has to take an examination.

Senator DONNELL. Somebody will have to decide whether he is or not.

The second is that the body which is to be consulted with by the Surgeon General is a body which is not solely a professional body, which ordinarily would pass upon matters of who is a specialist and who is a consultant, and then, third and finally, that under this act all these matters as indicated on pages 35 and 36 are "under the supervision and direction of the Federal Security Administrator," who is, in the present instance, neither a doctor, or does not have to be a doctor, and possibly ought not to be a doctor.

Mr. BOLTE. Senator, do you not think, as a matter of common sense, that the Advisory Council would appoint a committee of professional men to draft up the requirements for specialists' and consultants' ratings, and that that committee would then bring in a report which would be adopted by the Advisory Council to test these men?

Senator DONNELL. I understand, Mr. Bolte, that every member of that Advisory Council would be entitled to vote, and I cannot quite conceive that one member is going to delegate to others the ultimate decision as to how his vote should be cast.

Mr. BOLTE. But, Senator, could you conceive of a situation where a labor representative, presented with a report such as we have been discussing, would object: "No, you have to pay more attention to coronary thrombosis"?

Senator DONNELL. I think that no person has the right to delegate the right to cast a vote. I think finally each man will exercise his own independent judgment as to how the vote will be cast on the council. It might work out fine, but the point I am getting at is that in a law here, which is going to be Nation-wide operated, covering a vast multitude of subjects, with a personnel of medical administrative officers appointed by the Surgeon General, with standards laid down here after consultation with a group of people, the majority of whom may not be professional at all, that we may find that, notwithstanding the hopes and desires and motives of the framers of this bill, there may be very serious and dangerous administrative problems and decisions.

Dr. WEINERMAN. May I point out the place at the bottom of page 44 where it specifies that the Advisory Council shall establish special advisory subcommittees, and it specifically refers to technical committees, to advise upon professional and technical subjects.

All of us, I think, will agree that the doctors will be constituted a subcommittee to set up specialist standards. I am sure neither the Congress nor the American people would allow of any other situation.

If one must oppose the bill, sir, I do not think it should be opposed on the basis that people are going to be designated in America as specialists by other than doctor members of the Advisory Council.

Senator DONNELL. All I know is what the statute itself says: That the choice is made by the Surgeon General after consultation with the Advisory Council, but at all times under the direction and supervision of a man who is not a doctor at all—the Federal Security Administrator.

The CHAIRMAN. If that is not the way to provide for it, would it not be a very simple matter to propose an amendment here that would protect the manner in which these specialists would be appointed?

Senator DONNELL. Mr. Chairman, I think when you come to amendments you have to go back, of course, to the whole philosophy of the bill—whether or not it is a wise bill, whether it does have these political dangers which these gentlemen do not think it does have, whether it does have this tendency to have the Government interfering too much in matters that personal initiative and private enterprise should develop.

I am not so sure that a person who doubts the fundamental soundness of the bill would very appropriately prepare an amendment.

Now, I think that amendments can be prepared. I think that improvements can be made. Possibly that will be done by someone on the committee.

The CHAIRMAN. We had somewhat similar problems in connection with the enactment of the workmen's compensation laws. Those laws were bitterly opposed by the medical profession. At the time they were called revolutionary and socialistic, yet they finally worked them out, and they have been in operation in this country for some time now, and the American people certainly would never want to give that system of workmen's compensation up.

I think here in this country we have to have some way of bringing medical care to the great masses of our people. This seems to me to be a sound way of doing it, and we ought to be able to work it out in some form in which it is not going to work any injustice on the people or on the medical profession.

Senator DONNELL. I have no doubt as to the sincerity and utmost of good motives of the chairman in this matter. I know he sincerely believes in this bill or he would not have joined in the introduction of it.

The CHAIRMAN. It is not a question of my good motives entirely, either, because we have some of the ablest men in the medical profession that are backing it and think that it is a wise manner in which we may meet this problem.

Senator DONNELL. Of course, I might say that we likewise have the fact that the greatest body in point of numbers, at any rate, of the American medical profession, having over 125,000 members, is opposed to it.

The CHAIRMAN. But I doubt if the vast majority of the members of the American Medical Association have given any study whatever to this bill. They are busily occupied in their professions. They have not had time to study it. And the only information they have received in regard to it is the information which has been furnished them by the physicians committee, the National Physicians Committee, which has furnished them with information which is not correct.

Dr. WEINERMAN. Mr. Chairman, in that regard, I wonder if I may quote one sentence from this periodical, the Pennsylvania Medical Journal, page 752, in the April 1946 issue. I quote from a conference of State medical society secretaries:

Only 3,000 of the 125,000—

these are **AMA** members—

are considered leaders of their profession in the sense that they are informed and willing to do anything more than pay their annual dues toward the achievement of the highest purposes of the association or its constituent and component societies; namely, to enlighten and direct public opinion in regard to the great problems of public health and hygiene.

In other words, the **AMA** are saying themselves there are only about 3,000 of their 120,000 physicians who are taking an active part in the opposition to S. 1606.

I think you, yourself, sir, have shown that there are about 3,000 taking an active part on the other side through the Physicians' Forum and other organizations.

Senator MORSE. The chairman really covered the question that I wanted to ask this witness for the record, but I want to put it in question form: Doctor, you are aware of the fact that we have various forms of workmen's compensation laws throughout the country?

Dr. WEINERMAN. Yes, sir.

Senator MORSE. And that those laws have various types of compulsory features?

Dr. WEINERMAN. Yes, sir.

Senator MORSE. And under them has been developed what the medical profession has named "industrial medicine."

Dr. WEINERMAN. Yes, sir.

Senator MORSE. Is it true that when those laws were first proposed, there was strong opposition to them from the medical profession?

Dr. WEINERMAN. The opposition was as strong as it is to this.

Senator MORSE. Is it also true that those laws bore the label "socialistic"?

Dr. WEINERMAN. And communistic, and everything else.

Senator MORSE. Would you agree with me that they have, generally speaking, demonstrated their essential worth and been promotive of better health and health protection among the workers of this country?

Dr. WEINERMAN. Very definitely, sir.

Senator MORSE. That is all I have to say, Mr. Chairman, with this one friendly suggestion to the chairman; that is, that in the interests of the good health of the Senate and in accordance with sound preventive medicine, that henceforth we adjourn not later than 12:30?

The CHAIRMAN. I never like to control the Senators on this committee.

I believe the questioning this morning has been very valuable, and I want to compliment all the Senators who have participated.

Senator DONNELL. Pardon me. This is just one more word: I observe in what the Doctor read a moment ago as having been said at the 1946 conference of State society editors, it simply says that the following statement was made; I do not know whether it was an official declaration of the society.

The CHAIRMAN. We will recess now and we shall meet at 2:30 this afternoon.

(Whereupon, at 1:45 p. m., a recess was taken until 2:30 p. m., this same day.)

AFTERNOON SESSION

(The committee reconvened at 2:30 p. m., pursuant to recess.)

The CHAIRMAN. Well, the hearing will come to order.

I understand that Mrs. Charles W. Sewell is anxious to catch a train and would like to put her testimony in first this afternoon. Will that be satisfactory?

Mrs. SEWELL. Certainly.

STATEMENT OF MRS. CHARLES W. SEWELL, ADMINISTRATIVE DIRECTOR, ASSOCIATED WOMEN OF THE AMERICAN FARM BUREAU FEDERATION

Mrs. SEWELL. Mr. Chairman and members of the committee: I am coming to you as a farm woman, an Indiana farm woman, engaged at the present time as the administrative director of the Associated Women of the American Farm Bureau Federation.

In the American Farm Bureau Federation, the Associated Women are an entity and an affiliate and our membership is deemed as on behalf of the wives or members of the family of an American Farm Bureau member.

I am not going to discuss the technical features of the bill.

I am going to try to bring to you a picture as we see it, over the 12 years of the existence of the Associated Women, and working a great part of that time in very close cooperation with the American Farm Bureau Federation.

In the great drama of American life, the farm woman has rarely been accorded speaking parts. Indeed, with her reserve and self-effacement she has been in danger of being pushed off the stage or regarded as part of the scenery or of a rather unimportant background.

RESOLUTION ON HEALTH

I deem it a distinct privilege and honor today to be afforded an opportunity to represent the million farm women who comprise the Associated Women of the American Farm Bureau Federation, and to present to you some of their thinking about health problems in rural America.

In the 1945 annual convention, the following resolution was adopted, and I quote:

One of rural America's most urgent problems is to provide a program to bring about better facilities in rural areas for hospitals, medical care and improved health. It will take the combined efforts of the medical profession and rural people to solve the problem.

The solution must provide for comprehensive health education, for well-trained doctors, dentists, nurses, technicians and laboratory scientists, as well as the establishment of public health centers, hospitals and clinics accessible to all sections of rural America.

The care of our former service men and women, of the mentally sick and the indigent and the control of communicable disease is a public obligation and should be supported from public taxation. In some communities, after careful surveys it may be found advisable to use Federal grants-in-aid to assist groups to erect and equip hospitals. These must be controlled by the local people themselves.

We believe in the extension of voluntary group prepayment services on some type of an insurance plan that provides greater flexibility and would be more likely to succeed over a wide area than rigid uniform plans on a compulsory basis. We believe that a plan which will provide for prevention as well as curative measures and the right of the free choice of doctors would be zealously guarded.

Adequate medical care and hospital service at reasonable cost has been one of the most emphasized items on the program of the Associated Women since its inception. Our national convention programs have included many addresses by eminent speakers whose efforts to accomplish some of the desired goals are well known.

In 1937 the subject for the annual public speaking contest conducted by the Associated Women was Better Health for Rural America. In some 25 States farm women studied the problems of the health matters of rural people and debated such significant questions as: "How shall the sick be helped" and "How shall the doctor be paid?"

In the prize-winning essay submitted that year, the speaker cleverly referred to the old poem entitled "Which Shall It Be?" and then continued with the story of a father and mother taking a survey of their children as they lie asleep, trying to decide which one they would give away for a sum of money, and the question was asked: "Would you care to make a survey of the children of your home or your community and see which one you would be willing to lose, in either rural or urban America, for the sake of saving money?"

The needs of rural people for adequate health protection and high standard of medical care are in no way different today than from those of dwellers of other groups and professions. Time has shown that no longer are people who reside upon the farms and in the farming communities necessarily more healthful or less immune to contagious diseases than are our city cousins.

Cultivation and civilization had always gone hand in hand, and as quickly as the caravan from the eastern coast or the broad waters of the Pacific took from the wagon the clumsy plow and began the cultivation of the soil, in the vicinity nearby a settlement sprang up, and in a little while a town was established to serve the needs of the country people. The doctor, the teacher, the preacher, and the lawyer were component parts of that little community and each rendered a high degree of service and became the acknowledged leader of the people whom they served.

The place of the country practitioner in the hearts and homes of his clientele has received much attention in accounts of both fact and fiction. One of the most beautiful memories of my own childhood is that of the friendship of our entire family with the country doctor.

DIFFICULTIES OF INSURANCE PLANS IN RURAL AREAS

In the larger towns and cities of the United States much has been accomplished by the organization of public-health services, municipal hospitals, free clinics, and welfare agencies. The accessibility of the hospital makes it a generally accepted place for the care of the sick. Insurance plans providing for prepayment of the unpredictable emergency arising from illness have been evolved and are working with remarkable precision and satisfaction in many cities throughout the Nation. Here again, farm people encounter varying obstacles in setting up similar plans to meet their health needs.

Perhaps the first of these would be the scattered population; the disproportion of organized farm families to those found in unorganized groups. The low income of large numbers of rural population is another tremendous handicap. A third is the irregular income, since great numbers of farm people do not have a source of revenue except from the sale of products two or three times in any given year. The amount received at these times must be made to serve all of the countless needs of the farm family until the next sale of some other crop or livestock can be made.

No longer that we find in many rural communities the genial country doctor with his kindly care and great contribution to the whole countryside, for the young doctor has sought the city where he may associate himself with a group of contemporaries in a well-ordered clinic; can serve patients who have a more satisfactory and regular income; and there is an opportunity for him to become a specialist in the one line of the medical service which most appeals to him rather than attempting to be all things to all men.

The physician who does remain, many times, is the elderly man who, because of the multiplicity of duties and small income has not been able to avail himself of research and study which will keep him abreast of the latest developments in medicine and surgery. His isolation prevents the valuable consultation, and the type of his service becomes

very much less proficient through no fault of his own. But the fact remains, that rural America still needs this unselfish friend.

In a few instances, members of our organization who are residents of a territory not too far removed from some of the larger metropolitan centers, have been able to work out satisfactory arrangements for hospital insurance. That is true in Senator Donnell's State, I am sure, and in Ohio and Indiana farm bureaus, plans for inclusion of medical and surgical care have been developed through their own insurance companies.

From 1900 to 1940 the death rate in the United States fell from 17.2 per 1,000 to 10.8 per 1,000. Notable improvement was made by public-health programs with respect to diseases that respond to better sanitation procedures. The death rate from typhoid and similar fevers was reduced by 97 percent; from diarrhea and arthritis, 92 percent; diphtheria by immunization, 97 percent. One dollar out of every five which we spent for health is raised by taxation and the Government's role in matters of prevention, sanitation, food inspection, and sewage disposal has been most encouraging. Here is perhaps the greatest contribution that can be rendered by the Federal and State governmental agencies.

In the past the American Farm Bureau Federation has favored the objectives of legislation providing that the Federal Government should reasonably extend its public-health program with respect to maternal and child health, rural hospitals, public-health services, and medical care for those unable to provide such care for themselves.

OPOSITION TO COMPULSORY NATIONAL INSURANCE

We believe such legislation should safeguard the rights of the States to develop their own programs to meet their own local needs, and that the Federal Government is not justified in assuming the burden of supporting health and medical facilities that the States can and should bear, but only to the extent necessary to bring about equalization among the several States.

We have endorsed in principle the proposals of the Hill-Burton bill, now before Congress, designed to establish commissions to study health needs and to set up hospitals in rural communities, and which is one of great interest to us. It is to be hoped that if such arrangements are completed, the utmost care will be taken to place the hospitals in communities of greatest need, and not only the problem of building, but that of maintenance and location receive careful consideration.

In 1938 strictly rural areas had only one-third as many physicians in proportion to population as did urban communities. Here we feel there is a great need of trained personnel.

We are greatly interested in proposals designed to provide compulsory Federal hospital and health insurance. Our chief concern is to get more adequate medical care and hospitalization for our farm folk. We are wondering if the personnel set up to administer such a health program would know no more about the subject than those placed in positions of authority in other Government bureaus dealing with agriculture.

We wonder if it would require as many trips to the county seat to secure stamps for medical care as it has done to get gasoline, tires, farm

machinery, and rubber boots, in order to carry on agricultural production.

We wonder if the stork could delay his visit while necessary red tape was cut, or if we might receive a directive such as the sheepmen were presented, advising them, in the face of shortage of herders for the critical lambing season, to postpone the lambing until more favorable weather.

We have repeatedly expressed our opposition to compulsory insurance plan by resolution.

In answer to the statements that we are not moving rapidly enough with such a program we point to the growth of Blue Cross plans among our membership. Like the Chinese scholar who taught the famous Chinese marching song to groups of soldiers, 10 at a time, and then in 20 minutes had an army of 10,000 singing "Many hearts with one mind, Brave the enemy's gunfire—March On—March On," a song that was heard round the world, we believe it can be done through voluntary effort and a broad educational program.

In no case do we wish to sacrifice standards of medical care. Rather do we hope to see still higher standards developed and rural people given every advantage of high type medical care and hospitalization afforded other groups of citizenry. If a member of this distinguished group, or one of their family, suddenly needs the services of a doctor or surgeon, you seek for one of the highest qualifications. You want a man devoted to the service of humanity; one who has spent time and money to prepare for his profession; a man willing to work long, hard hours to alleviate pain and suffering; not a cog in the wheel of governmental machinery, or one who is working by the clock, perhaps compelled to refuse to administer to your needs because it is after hours.

ENDORSEMENT OF VOLUNTARY INSURANCE

The principle of insurance through mutual benefit associations, for hospitals and medical care, appear to us to be the most plausible solution to some of these vexing questions. As rapidly as possible, workable plans already in existence should be extended until they reach the remotest parts of rural America. However, we are not blind to the frailties of humanity and rural people are not greatly different from those of any other group. A program of education for this type of insurance must be carried forward until health and hospital insurance provisions become just as well known and as genuinely accepted as fire, or automobile, or life insurance.

Experience with cooperative associations in practically all of our State federations, in both purchasing and marketing organizations, show us the very great need of the preparation of our membership to be loyal under conditions of adversity. There will be at least for a long period ahead through competitive practices and usage already established, need for emphasis upon people remaining true to their obligation.

Farm folk are by nature conservative; and like to pay their own way. They believe firmly in the American ideals of self-help, hard work, and free enterprise.

In no other country in the world, as in America, have such standards for the average citizen been reached. We are convinced "that in

many heads there is wise counsel" and that through discussion and debate, we can set in motion plans that will speed our health program by voluntary effort.

In short, I am trying to tell you that the American farmer wants adequate medical care and hospitalization at reasonable cost; he wants the medical profession, both as individuals and as an organization, to acquaint themselves with the needs of rural America, and our attempts to formulate programs that will help to fill them. Only with adequate farm income can we hope to realize adequate medical care. The parity principle must be extended to medical care. For example, an appendectomy at \$150 when corn is \$1 per bushel is vastly changed when corn drops to 30 cents per bushel.

We believe such problems will be best attacked at the local level in conferences arranged between organized groups of farm people, the hospital associations, public health officials, and county medical societies, all working together at that local level, in friendly discussion. Here each will be fully aware of the exact conditions in that particular area. There will be no need for lost motion or loss of precious time between such groups; no expensive record keeping; and no yards of wasteful red tape to untangle or unwind.

Any program for better rural health must be an integrated one. There must be an appreciation of what better farm housing, more farm to market roads, rural electrification, and improved facilities in farm homes for the care of the sick can do to assist in keeping well people well and bringing those who are ill back to health.

Since the crisis occasioned by the war has clearly demonstrated our urgent need for more qualified doctors and nurses, we strongly recommend that larger numbers of young men and women be specifically prepared for service in rural areas. There must be better distribution of doctors and hospitals.

This will take time, and it will require more than the waving of a wand to obtain all the answers to the "\$64 question." The passage of any bill, however meritorious, cannot produce doctors or erect hospitals, both of which are so sorely needed at the present time. We do not believe you can legislate health any more than you did prohibition. One hundred thirty or forty million Americans constitute that many individuals with American ideals and ideas of independence, and their inherent rights to do as they please, no matter what phase of life is considered.

Perhaps we should not attempt to change this, for this is the American way.

The greatest organizer that the world has ever known, Jesus of Nazareth, from a handful of followers, only 12, 1 of whom proved unfaithful, built his organization by the demonstration method. He lived His gospel—then preached it. His program ministered to all human needs. He sought to help the people where they are, as they are.

Farm people understand the demonstration method. In some 26 of our State organizations, demonstration health programs are under way.

And I should like to file with the committee material along this line.

(The material referred to is as follows:)

A CHILD IS BORN IN MISSISSIPPI

(By Wilma Bobo Sledge)

Dedicated to all the children of Mississippi with the fervent hope that by the time they are grown, married, and ready to rear families the Farm Bureau health program will have become a reality and every needed hospital and medical facility will be within their physical and financial reach.

Once upon a time there was a baby who wanted to get himself born. He looked and looked for a place to get born in and finally he decided he wanted to get born in Mississippi.

Now this little baby had a very special reason for wanting to get born in Mississippi, else he would never have been brave enough to run the risk. He was a smart little fellow, so he went to St. Peter who keeps all the statistics and the angel shook his head, and said, "Tsk! Tsk. You would choose Mississippi! Don't you know that Mississippi is the third most dangerous State in America to get born in? More babies don't live to get born there than most any other State." But this little baby just blinked his big, blue eyes at the angel and smiled his cute little smile 'til the angel had to smile back and say, "All right—but I warned you."

Now the reason that this baby wanted to get born in Mississippi was because he had selected the mommy and the daddy that he wanted to have and they lived in Mississippi.

When mommy and daddy found out that the baby wanted to be born, mommy said, "I must see a doctor right away so he can help me get baby born safely." So she went to the phone to ask the doctor to come out to see her.

"Madam!" said the doctor, "Don't you know I can't come to your house! Do you realize there are only 915 of us active doctors in Mississippi to wait on over 2,000,000 people? How do you expect me to wait on 2,000 people if I have to come to your house and see you!" "Besides," he moaned, "I'm an old man. * * * My eyes are bad, and my ears are bad, and my feet hurt me. I'm over 65 years old and I should be retired instead of working day and night bringing babies into the world. Come see me Wednesday," he said, and hung up the phone.

So next Wednesday mommy went to the clinic and she waited and waited and waited for five whole hours, but she got so tired, nervous, and restless that she left and never did get to see the doctor.

Then daddy got mad, and he said, "I'm going to get you to a hospital." So he went to the hospital and he went to the superintendent and said, "I want a room for our baby to get born in," and the superintendent looked at him like she felt sorry for him and she said, "I'm sorry, but every room in our hospital is booked up. You'd better try another place." So daddy went home and got a list of all the hospitals in Mississippi and he and mommy studied the list. Then they looked at each other. Mommy looked a little scared and daddy looked awfully serious. You see, they found that there were only 103 hospitals in Mississippi and only 4,426 beds in all the hospitals, which means there is only one hospital bed for each 493 people in Mississippi! Just imagine that many people stacked into one bed if all the people got sick at once. That surely wouldn't be a good place for a baby to be born in 'cause it would look like this.

Then mommy said, "Maybe if we got a trained nurse she could come home with us and get the baby born!" So they hunted and hunted and hunted for a nurse but they are as scarce in Mississippi as are doctors and so they couldn't get a nurse.

Now daddy was a farmer and he didn't have much money to spend even to get a baby born, for he only averaged \$692 net income last year on his Mississippi farm.

So mommy kept looking scareder and scareder and daddy kept getting madder and madder and madder 'cause it looked like the stork would have to bring the baby instead of him coming in a doctor's bag.

And daddy got to studying and he thought and he studied and he talked.

Now daddy belongs to something called the Farm Bureau Federation. It isn't really a bureau like this bureau. It is a group of farm men and women working together to get the things they need to make themselves more useful citizens. Federation means that they aren't just in Mississippi, but in most all the States in the Union, and that they join hands and work together to secure the things which farm people justly deserve.

Daddy decided that 45,000 farmers in Mississippi could do something about getting a health program in Mississippi. Sure enough, they got to thinking and talking and their health committee studied plans and this is what they decided to do:

The Mississippi Farm Bureau decided to ask the Mississippi Legislature for \$5,000,000 to build hospitals. Daddy said that was a lot of money, but that the State has over \$25,000,000 in its piggy bank and can afford to help build hospitals in Mississippi with 20 percent of this money.

Somebody would need to have charge of all that money so they decided to ask Governor Bailey to find some men and some women (one out of each three to be a farmer) who would be a commission on hospital care. These people would stay busy 'cause they would need to make something called a "survey" to find out just which of the 31 counties without hospitals need them most, and where it would be best to build new hospitals or make old ones bigger, and what kind of hospitals they should be. Then daddy found out that Uncle Sam might give Mississippi some money to spend on building hospitals and the commission could handle that as well as the \$5,000,000 which the State would spend. Then, the committee said that people would not want to take money for a hospital in their town or county without putting up some money themselves, so the commission would need to work with the local units in building nonprofit hospitals.

The Farm Bureau said they didn't want the commission to get "bossy" and wield a big stick so they said the hospitals should be locally controlled, tho the commission would help count the money.

The Farm Bureau says that if we can put their full program across there will be enough hospital beds in Mississippi for everybody who wants to go to the hospital.

Then the Farm Bureau said, "Hospital facilities will do more than anything else to bring doctors to Mississippi, but it would be fine if we had a big school for doctors so that we can educate them and put them in our hospitals. Then every baby would know that he would arrive in a doctor's bag instead of getting air sick riding on a stork's bill."

A lot of people over the State for all interested in building a medical school and they wanted to take a lot of the State's money and spend it all on a big school with one great big hospital.

The Farm Bureau said, "No! Hospitals scattered over all of Mississippi will do the people more good. Let's build them, and work out a plan for the school and hospital that will give the same results but will not cost so much money." They think that \$1 out of each \$4 of the proposed \$5,000,000 is enough to build the hospital for the school if all the hospital beds already in Jackson can be utilized.

Daddy and mommy both said not to forget to plan for the nurses, too, so the Farm Bureau asks that nurses be trained and that along with the graduate nurses here should be many more practical nurses, also.

Mommy and daddy got to thinking: It is hard enough for a white baby to get born and reared in Mississippi—What about the Negro? What can he expect? A midwife would be almost all the help he could hope for. So the Farm Bureau remembered the Negroes, too, and promised to ask the legislature for money for Negro doctors to be trained outside the State.

Daddy remembered how much money it costs to have a baby, or to be sick in a hospital, so he said, "Can't we have something that will help Farm Bureau members meet their bills?" The Farm Bureau decided we need something called health insurance. * * * They said it would be a prepayment plan, but not compulsory.

When mommy and daddy heard that the Farm Bureau was trying to get hospital beds, doctors, nurses, and a way for Farm Bureau members to pay for their services, mommy stopped looking scared and looked happy and daddy stopped looking mad and looked happy too.

Daddy and mommy hope that more hospitals and more doctors and more nurses are all ready by the time baby arrives.

Do you want this health program enough to:

1. Discuss it with your neighbor?
2. Have a program about it at your club?
3. Write a letter to the paper saying you want more hospitals, doctors, and nurses?
4. Write to and talk with your legislator about more hospitals, doctors, and nurses?

MISSISSIPPI FARM BUREAU FEDERATION HEALTH PROGRAM**BANISH WORRY OVER UNEXPECTED HOSPITAL OR SURGICAL BILLS**

Your own hospital or surgical plan another farm-bureau service.

Hospitalization and surgical care through farm-bureau facilities for just a few cents a day.

The cost will be low

<i>Hospital only, per month</i>	<i>Hospital and surgical plan, per month</i>
-------------------------------------	--

Individual -----	\$1.00	\$2.00
Individual and one dependent-----	1.25	2.50
Individual and all dependents-----	1.50	3.00

A \$1 enrollment fee is required if only the hospital plan is desired.

A \$2 enrollment fee is required if the combination plan is desired.

Eligibility

You are eligible for this protection if you are a farm-bureau member and under 65 years of age. Dependents are eligible if they are between the ages of 3 months and 18 years inclusive.

Dependents receive the same hospitalization benefits except that the daily room rate is \$1 less per day and the surgical allowance for dependents is 80 percent of the surgical schedule.

You asked for it—here it is.

The farm-bureau plan for hospital and surgical care will be an organization owned and operated by farm-bureau members. The plan will be so arranged that members may have either hospital service alone or a combination of both surgical and hospital service. The plan will reimburse you for expenditures paid to hospitals or to your doctor according to the following partial list of benefits:

Tonsilectomy-----	\$25	Hernia-----	\$75
Appendectomy-----	100	Goiter-----	150
Breast operation-----	125	Removal of kidney-----	150

Liberal benefits will be paid for hundreds of different types of ailments requiring hospital services or surgical attention.

1. Hospital room, any hospital, 30 days, \$5 per day. Hospital need not be member of any particular association.

2. Nursing service.

3. Operating room often as required.

4. Anaesthesia.

5. Routine laboratory.

6. Routine medicines, surgical dressings.

7. X-ray for accidental injury.

8. Ambulance service.

9. Nurse's fees in event nurse needed in home.

10. Maternity benefits after contract in force 10 months.

11. Optional maternity benefits (allowances for maternity in event you elect to be confined for childbirth outside of hospital).

12. Optional tonsilectomy benefits (if you elect to have tonsilectomy performed in a clinic or office of a physician instead of in a hospital).

13. Free choice of hospital or doctor and full benefits paid regardless of hospital you choose.

14. Doctor bills paid for hundreds of different types of surgical operations.

NEBRASKA FARM BUREAU FEDERATION

Farmer owned—farmer controlled

AN ANNOUNCEMENT TO OUR FARM BUREAU MEMBERS ON HOSPITAL EXPENSE INSURANCE

It is the duty of every county farm bureau to constantly strive for a fuller and better life for its membership. To attain a better life it is necessary that the purchasing power of our people be constantly increased. It is as important to get more for our dollars as it is to get more dollars. It is with this thought in

mind that your county farm bureau, in cooperation with the Farm Bureau Mutual Automobile Insurance Co., offers a plan of hospital expense insurance.

We heartily recommend this plan to our membership as a real opportunity for broad protection on a cooperative basis, and we suggest that every member carefully consider the scope and purpose of the plan as outlined in the following pages.

APPLICATION FOR INSURANCE

In order to obtain this insurance it will be necessary for you and a sufficient number of other members in your county farm bureau to voice their desire for this protection. May we suggest as a medium for this expression advisory council meetings, local membership meetings, county membership meetings, etc.

For any further information on hospital expense insurance, contact your county farm bureau.

FARM BUREAU MUTUAL AUTOMOBILE INSURANCE CO.

State office: 200 Loomis Street, Burlington, Vt. Home office: Columbus, Ohio

ELIGIBILITY

Who are eligible?

Each certified voting member of the county farm bureau and adult residing in the same household is eligible for the insurance benefits provided by a group policy issued to his or her county farm bureau.

Each member must make separate application for insurance. Any member can apply for dependent coverage, provided in no instance it would be a duplication of coverage.

Who are members?

For the purpose of this insurance a member is defined as any male or unmarried or widowed female, 18 years of age or over, who is a certified voting member of the county farm bureau or who resides in the same household with such voting member.

Who are dependents?

The term "dependent," as used herein, refers to the wife and any one or all of an insured member's unmarried children between the ages of 3 months and 18 years.

When the insurance is effective

Any person who is a member of the county farm bureau prior to the effective date of the master policy, and who makes written application for the insurance prior to or within 31 days following the effective date of the master policy, shall be insured as of the date of the master policy or the date of his written application, whichever date is the later.

Any person who first becomes a member of the county farm bureau after the effective date of the master policy, and who makes written application for the insurance within 31 days of the date he first becomes a member, shall be insured as of a date one calendar month following the date he signed his application card.

If on the date the insurance becomes effective the member or insured dependent is disabled by injury, disease, or congenital condition, or is already confined in a hospital, any benefits that would otherwise become effective for the member or dependent shall not become effective until the member or dependent has completely recovered from such disability or confinement. In no event shall the insurance of any member become effective unless and until the member is regularly performing the duties of his occupation.

Note: The effective date of the master policy will be that date specified in the county farm bureau application for a group policy, the issuance of which is contingent upon 50 percent of the certified voting members of the county farm bureau making application for the insurance on the insurance company's forms.

GROUP INSURANCE BENEFITS

A. Hospital confinement benefits before age 65

1. Each member and dependent shall be insured for a daily benefit of \$5, such benefit to be payable for a maximum period of 31 days during any one disability,

provided the member has been confined in a legally constituted and operated hospital for a period of at least 18 consecutive hours (only 6 hours are required if the member or dependent receives emergency care following an injury or undergoes a surgical operation).

2. In addition to the benefit described above, each member and dependent will be reimbursed for actual charges incurred by him for (a) use of operating room, (b) the administration of an anesthetic, (c) ordinary laboratory service including X-ray fees, and (d) medicines or supplies, except that in no event shall the total reimbursement during any one period of hospital confinement exceed \$25. Such reimbursement does not include medical fees, charges for nursing, or any other charge or expense not specifically mentioned in the preceding sentence.

3. Successive periods of hospital confinement of a member or dependent not separated by at least 3 months of active work at his or her active occupation shall be considered as one period of hospital confinement unless subsequent hospital confinement is due to causes entirely unrelated to the causes of the previous confinement.

B. Surgical expense benefits before age 65

Each member and dependent shall be reimbursed for the actual fee incurred by him (up to the maximum amount specified in the schedule of operations as set forth in this folder) for an operation performed by a legally qualified surgeon.

MATERNITY BENEFITS FOR DEPENDENTS

After the female dependent has been continuously insured for more than 9 months, the company will, subject to the provisions and limitations, pay the same benefits for a claim resulting from pregnancy or resulting childbirth, abortion, or miscarriage as provided under the section entitled "Hospital Confinement Benefits Before Age 65" except that the daily benefits shall be paid for not more than the maximum number of 10 days instead of 31 days for any one period of such confinement.

Also after the female dependent has been continuously insured for more than 9 months, the company will, subject to the provisions and limitations, reimburse the member on behalf of the female dependent for the fee incurred because of an operation or obstetrical procedure performed by a legally qualified physician except that such reimbursement shall not exceed the following amounts:

Delivery of child or children.....	\$50
Caesarean section, including delivery.....	100
Abdominal operation for extra-uterine pregnancy.....	100
Miscarriage	25

EXTENSION OF BENEFITS

If, within the period of 3 months immediately following termination of a member's insurance, such member or an insured dependent is confined in a hospital or undergoes a surgical operation which would result in a valid claim were the insurance in force on the date the confinement commenced or the operation was performed, the company will recognize such confinement or operation as a basis for a claim, provided due proof is furnished that (a) the insured was totally disabled when the insurance terminated and remained continuously so disabled until the date of the confinement or operation, and (b) the hospital confinement or the operation was due to the injury, disease, or condition causing such continuous total disability. In the case of a female dependent, hospital confinement commencing, or a surgical operation performed, within 9 months after termination of her insurance, shall also be considered as the basis for a claim, provided due proof is furnished that such confinement or operation (a) is due directly to pregnancy or resulting childbirth, abortion or miscarriage, and (b) would result in a valid claim were the insurance in force on the date such confinement commenced or the operation was performed.

No premium shall be charged for the foregoing benefits after the termination of the member's insurance.

BENEFITS AFTER AGE 65

If an insured member or dependent is confined to a hospital or undergoes an operation after attaining age 65, the member shall be entitled to only 75 percent of the same benefits which were payable for a similar claim previously; likewise, if an insured member or dependent is confined to a hospital or undergoes an operation after attaining age 70, benefits shall be further reduced and the member shall be entitled to only 50 percent of the same benefits which were payable for a similar claim before age 65.

LIMITATIONS

No payment shall be made if the hospital confinement or operation for which claim is made—

(1) is not recommended and approved by a legally qualified physician or surgeon; or

(2) is due to sickness resulting from occupational disease, or to accidental bodily injuries arising out of and in the course of the insured's employment, which is covered by a workmen's compensation law, plan, or agreement, or which is secured without cost under laws enacted by the legislature of any State or the Congress of the United States; or

(3) is due to injuries sustained or sickness contracted while in the military, naval, or air service of any country, or while performing police duty as a member of any military or naval organization; or

(4) is due to injury willfully or intentionally self-inflicted while sane or insane; or

(5) occurs outside of the United States and Canada; or

(6) involves plastic surgery because of conditions existing before the effective date of the member's insurance, or is the result of congenital deformities; or

(7) is the result of pregnancy, resulting childbirth, abortion, or miscarriage, except as is provided for dependents after a waiting period of 9 months, under the provision "Maternity Benefits for Dependents."

If two or more operative procedures are performed in the same operative field at the same time, reimbursement shall be made only for that one operation for which the largest amount is payable. If two or more operations are performed during any one period of disability, or at different times, as the result of the same cause or related causes, the total reimbursement for all such operations shall not exceed \$150.

NO AGE LIMIT

No member shall be refused insurance because of age. Attention is, however, called to the reduced schedule of benefits described fully under the section entitled "Benefits After Age 65."

CERTIFICATE OF INSURANCE

A certificate of insurance will be issued by the Farm Bureau Mutual Automobile Insurance Co. for delivery to each member insured under this plan.

INDIVIDUAL DETERMINATIONS

The hospital expense and surgical fees insurance of each member and his dependents shall automatically cease upon the occurrence of any one of the following events:

1. Termination of the policy; or

2. The cessation of premium payments on account of such member's insurance; or

3. The termination of bona fide membership in the county farm bureau group.

Any insured dependent who ceases to be a dependent, as defined herein, shall immediately cease to be insured. Any such dependent who can qualify as a member, as defined herein, may be insured without evidence of insurability and without any waiting period by paying a premium at the member rate and giving notice to the policyholder not later than 1 month after ceasing to be a dependent.

The insurance, if voluntarily discontinued by the member while eligible to remain insured, can be revived provided satisfactory evidence of insurability is furnished to the company for each insured at the member's own expense.

The monthly cost of the benefits described in this folder

Benefit	Monthly premium for members	Additional monthly premium for dependents		
		Wife only	Children only	Wife and children
Member's benefits:				
\$5 per day, 31-day maximum for any one disability	\$1.10			
\$25 for incidental hospital expense				
\$150 maximum surgical schedule				
Dependent's benefits:				
\$5 per day, 31-day maximum for any one disability		\$1.55		
\$25 for incidental hospital expense			\$0.90	
\$150 maximum surgical schedule				\$2.40

TOTAL MONTHLY PREMIUMS

For husband only	\$1.10
For husband and wife	2.65
For husband and children only	2.00
For husband and wife and dependent children regardless of number	3.50

Schedule of operations

	<i>Maximum amount of reimbursement</i>
Abdomen: Cutting into abdominal cavity for diagnosis or treatment of organs therein (unless otherwise specified in the schedule)	\$100
Abscesses: Abscesses requiring hospital residence (furuncles excepted) one or more	25
Amputation of:	
Thigh	75
Leg, entire foot, arm, forearm, or entire hand	50
Fingers or toes, each	10
Appendix, removal of	100
Blood transfusions, each	25
Breast:	
Amputation	100
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)	40
Initial induction of artificial pneumothorax	25
Dislocation, reduction of:	
Hip or knee joint (patella excepted)	35
Shoulder, elbow or ankle joint	25
Lower jaw	15
Collar bone or wrist	10
For dislocations requiring an open operation the maximum amount of reimbursement will be twice the amount shown.	
Excision, removal of:	
Shoulder or hip joint	100
Knee joint	75
Elbow, wrist, or ankle joint	50
Diseased portion of bone, including curettage (alveolar processes excepted)	50
Ear, nose, or throat:	
Mastoidectomy:	
One side	75
Both sides	100
Tonsillectomy, or tonsillectomy and adenoidectomy	25
Sinus operation by cutting (puncture of antrum excepted)	35
Submucous resection of nasal septum	35
Tracheotomy	35
Bronchoscopy for removal of foreign body or biopsy	35
Any other cutting operation (tapping excepted)	10

*Schedule of operations—Continued***Eye:**

	Maximum amount of reimburse- ment
Any cutting operation into the eyeball (through the cornea or sclera) -----	\$50
Removal of eyeball-----	35
Any other cutting operation on eyeball-----	20

Fracture, treatment of:

Thigh, leg, kneecap, upper arm, vertebra or vertebrae, or pelvis (coccyx excepted) -----	50
Lower jaw (alveolar process excepted), collar bone, shoulder blade, or forearm-----	25
Wrist, hand, ankle, or foot-----	15
Fingers or toes, one or more-----	10
Nose, rib, or ribs-----	10

The amounts shown above are for simple fractures. For compound fractures the maximum amount of reimbursement will be one and one-half times the amount shown above for the corresponding simple fracture.

For fractures requiring an open operation (including bone grafting or bone splicing), the maximum amount of reimbursement will be twice the amount shown above for the corresponding simple fracture.

Genito-urinary tract:

Removal of kidney-----	150
Cutting into or fixation of kidney-----	100
Removal of tumors or stones in kidney, ureter or bladder:	
By cutting operation-----	100
By crushing, cauterization, or endoscopic means-----	25
Stricture of urethra—open operation-----	50
Intraurethral cutting operation-----	25
Removal of entire prostate by open operation (complete procedure)	150
Removal of part of prostate:	
By endoscopic means-----	40
By other cutting operation-----	75
Varicocele, cutting operation on-----	25
Hydrocele, excision, or incision and treatment of sac (tapping excepted)-----	25
Orchidectomy or epididymectomy-----	35
Complete removal of uterus, tubes, and ovaries-----	150
Other operations on uterus and its appendages:	
Cutting operation with abdominal approach-----	100
Cutting operation without abdominal approach-----	50
Dilation and curettage (nonpuerperal)-----	25

Goiter:

Thyroidectomy (complete procedure, including ligation of thyroid arteries, to be treated as 1 operation)-----	150
Ligation of thyroid arteries not followed by thyroidectomy-----	

1 or more at 1 operation-----	50
2 or more stage operation (complete procedure to be treated as 1 operation)-----	75

Hernia, cutting operation for radical cure:

Single hernia-----	50
More than 1 hernia-----	75

Joint, incision into (tapping excepted)-----	25
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Ligaments, cutting operation-----	25
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Suturing of tendons:	
Single-----	25
Multiple-----	40

Obstetrical:

Payable for insured dependents only. For maximum amount of reimbursement, see provision herein, "Maternity Benefits for Dependents."	
Paracentesis (tapping of):	

Abdomen, chest, or bladder (other than catheterization)-----	10
Eardrum, hydrocele, joint or spine-----	10

Schedule of operations—Continued

	Maximum amount of reimburse- ment
Rectum, cutting operation or injection treatment for radical cure of hemorrhoids (complete procedure)	\$25
Cutting operation for prolapsed rectum or fistula in ano	25
Cutting operation for fissure	10
Skull, cutting into cranial cavity	150
Spine or spinal cord, operation with removal of portion of vertebra or vertebrae (except coccyx)	150
Removal of part of all of coccyx	50
Tumors, cutting operation for removal of malignant tumors, except of face, lip, or skin	100
Malignant tumors of face, lip, or skin	25
Benign tumors, 1 or more:	
a. Requiring hospital residence	25
b. Not requiring hospital residence	10
Varicose veins, cutting operation or injection treatment (complete procedure on all veins)	40

The company reserves the right to determine the amount of reimbursement, if any, to be paid for any cutting operation not specified in the above schedule.

HOSPITAL BILL PAID BY BLUE CROSS PLAN

How Farm Bureau members are appreciating Blue Cross hospitalization insurance is indicated in a letter from a good member at Centertown, Ky. He stated:

"I received your paid statement of hospital charges incurred by my daughter, paid by you under the Blue Cross plan. The bill of \$83.95 cost me only \$15.60, and I still have the right to hospitalization for the rest of the 12 months. The service was just the same good service we have always received at the Owensboro, Daviess County, Hospital. You can count on me renewing my membership."

The yearly rate for this insurance was increased to \$18 a family on April 1. This covers the husband and wife and all unmarried children up to 19 years of age.

Many Farm Bureau members have already taken out this insurance that pays all hospital bills except the doctor. A good number of them have already obtained benefits from the coverage.

Old members can get the insurance only when the county holds its annual membership drive. New members can obtain it any time within 30 days after joining.

HOOSIER FARM BUREAU LIFE INSURANCE CO.,
Indianapolis 4, Ind., April 17, 1946.

To the Members of the Medical Care Committee of Farm Bureau, and Indiana Society of American Medical Association:

On Sunday, April 7, 1946, a joint committee meeting composed of two groups was held at the Columbia Club at 2 p. m. Those present were Dr. F. S. Crockett, Drs. Scott, Combs, Smith, Cring, Burney, Ray Smith, Alice Womacks, Hassil Schenck, Anson Thomas, Morley Ringer, and Jack Rosenbrough.

Dr. Douglas, of Valparaiso, and Dr. Mays, of Madison, were unable to attend. These two were the other doctors on the AMA committee. Mrs. George Jaqua, of the Farm Bureau committee, was also unable to attend.

A very splendid and worth-while meeting was held with Dr. Crockett leading the discussion, and since it was found that the two committees have a very definite need for coordinating their activities, it was decided that many meetings of the joint committee would be held. It was discovered that the two general programs were certainly very similar, and for your information we are attaching copies of the program.

Dr. Burney reported to us on the survey which had been made by the board of health, and stated that in the near future many important figures would be available which would be of a great deal of assistance in guiding the future activities of these committees. It was decided that a sample county should be selected by the Farm Bureau committee and ratified by the AMA committee in

order that we might use it as a "guinea pig," so to speak, for the setting up of a health center which would contain the offices of the public health nurse, X-ray, urinalysis, blood count, a few beds perhaps, and minor surgery, these being general specifications and would, of course, be designed to fit the particular needs of the county as well as to fit the appropriations which would be made.

It was found that Dean Reed, of Purdue University, would in all probability cooperate with our committees in having a conference on rural health. The suggestion met with whole-hearted support and the committee was very enthusiastic about the possibility of having such a conference.

Subsequent to this meeting a letter has been written to Dean Reed and a committee meeting will be held within the next few weeks to consider the possibility of holding this conference sometime during August.

It was agreed that the prime objective of both committees was to furnish the most efficient hospital and medical service possible for rural peoples.

JACK J. ROSEN BROGH,
Chairman, Medical Care Committee of Farm Bureau.

PROPOSED PROGRAM FOR ACTION OF STATE RURAL HEALTH COMMITTEES

What should the State Committee on Rural Medical Service undertake?

Meet with interested farm groups—Farm Bureau—Grange—Farmers Union—and agree on objectives for common effort.

Three general types of activity may be considered:

1. Hill-Burton bill. See that sound judgment is exercised in placing of facilities and other details applying to rural areas.

(a) Insistence on and devising methods for maintenance of high professional standards in all facilities constructed so that more service will not mean service of lower quality.

(b) Deciding what constitutes the unit to be served by various types of facilities, number of people, distance the sick can be transported, desirability of a public ambulance service. The present available professional personnel and possibility of attracting more.

(c) Deciding what is meant by diagnostic center—health center and their relation to the hospital as they should apply in each State.

(d) Close affiliation with agencies of State government created to administer the Hill-Burton bill or like legislation.

2. Extending to country people the benefits of prepayment plans for catastrophic illness and hospitalization.

Special plans for marginal farmers who may be in part medically indigent, but should be encouraged to pull their pound.

3. Promotion of health education among farm people. Initiative here must reside in organized farm groups: Parent-teachers, 4-H clubs, home economics clubs, boys camps, extension departments of State agricultural schools, accident prevention and first aid, sponsoring proper kind of publicity in farm press, local papers and local radio.

4. Conference of rural and health leaders sponsored by State colleges of agriculture, Ohio University is a good example.

RESOLUTION OF MEDICAL CARE COMMITTEE

It is recognized by Indiana Farm Bureau that there can be no item of greater importance to its membership and to the State of Indiana and to the United States and to the entire world than the health condition of the peoples of the world. In view of this fact, the Indiana Farm Bureau has caused to be appointed a medical care committee in Indiana.

This committee recognizes the very small part which it can play in this immense field, consequently, it is recommended:

1. That the Indiana Farm Bureau and its entire membership wholeheartedly support this committee in its program designed in the interest of health in Indiana and with the health of rural peoples.

It is further recommended:

2. That the general program of the medical care committee be adopted as the health program for the Indiana Farm Bureau. This program is as follows:

(a) A public health nurse be established in every county.

(b) Information concerning the provisions of the Wagner-Murray-Dingell bill be disseminated throughout the State. The medical care committee opposes the bill.

(c) Assist in obtaining a survey of the medical and hospital facilities that are available in our State.

(d) Encourage the schooling of more doctors including veterinarians in whatever way possible.

(e) Encourage the hospitals to utilize the great reserve of volunteer help which has been amassed through the war.

(f) It is recognized that there is, or will be, available a great deal of medical and surgical equipment. It is recommended that the counties, or groups of counties, get together and attempt to purchase this equipment and equip hospitals within the counties.

**THE ASSOCIATED WOMEN OF THE AMERICAN FARM BUREAU FEDERATION,
Chicago 2, Ill., May 1, 1946.**

Hon. JAMES E. MURRAY,

Senator from Montana,

Senate Office Building, Washington, D. C.

DEAR SENATOR MURRAY: In furtherance to my appearance before your committee yesterday afternoon:

There is enclosed copy of the 1945 annual report of the American Farm Bureau Federation; also a copy showing list of members by States, as compiled at the close of our fiscal year, November 30, 1945.

From these States, voting delegates are chosen to formulate and adopt the resolutions which constitute our program of work and our legislative policy.

On the membership report, the States marked in red pencil are those in which programs for medical care and hospital insurance are being carried on.

Thank you for your courtesy of yesterday, and I wish to assure you that if we can cooperate further with you we would be happy to have you call on us.

Very truly yours,

Mrs. CHAS. W. SEWELL,
Administrative Director.

Monthly report on membership, Nov. 30, 1945

State	Number of members			Quotas		
	Total for 1944	Comparison as of Nov. 30—			Quota 1945	Percent as of Nov. 30—
		Fiscal year 1945	Fiscal year 1944	Change		
Alabama.....	50,101	52,608	50,101	2,507	51,000	103.2
Arizona.....	708	1,187	708	479	1,000	118.7
Arkansas.....	28,715	35,596	28,715	6,881	40,000	89.0
California.....	32,716	33,356	32,716	640	35,062	95.1
Colorado.....	1,166	1,683	1,166	517	4,500	37.4
Connecticut.....	8,780	9,700	8,780	920	9,000	107.8
Delaware.....	510	628	510	118	1,000	62.8
Florida.....	4,363	4,839	4,363	476	6,000	80.7
Georgia.....	20,671	31,277	20,671	10,606	27,000	115.8
Idaho.....	529	964	529	435	1,200	80.3
Illinois.....	103,483	111,932	103,483	8,449	108,000	103.6
Indiana.....	50,681	58,463	50,681	7,782	60,000	97.4
Iowa.....	78,414	90,051	78,414	11,637	85,000	105.9
Kansas.....	23,693	32,027	23,693	8,334	32,017	100.0
Kentucky.....	23,363	32,711	23,363	9,348	25,000	130.8
Louisiana.....	7,501	8,197	7,501	696	12,600	65.1
Maryland.....	8,509	10,515	8,509	2,006	9,500	110.7
Massachusetts.....	4,222	6,298	4,222	2,076	5,500	114.5
Michigan.....	29,030	38,120	29,030	9,090	37,000	103.0
Minnesota.....	46,209	51,717	46,209	5,508	50,000	103.4
Mississippi.....	35,900	44,558	35,900	8,658	44,000	101.3
Missouri.....	20,150	25,164	20,150	5,014	25,000	100.7
Montana.....	961	635	961	328	1,200	52.9
Nebraska.....	4,701	6,946	4,701	2,245	11,000	63.1
Nevada.....	1,275	1,335	1,275	60	1,300	102.7
New Hampshire.....	3,100	4,477	3,100	1,377	4,000	111.9
New Jersey.....	8,768	10,426	8,768	1,658	10,000	104.3
New Mexico.....	593	1,109	593	516	2,600	42.7

Monthly report on membership, Nov. 30, 1945—Continued

State	Number of members			Quotas			
	Total for 1944	Comparison as of Nov. 30—		Quota 1945	Percent as of Nov. 30—		
		Fiscal year 1945	Fiscal year 1944		Fiscal year 1945	Fiscal year 1944	
New York.....	65,866	76,500	65,866	10,634	75,000	102.0	109.8
North Carolina.....	30,010	32,506	30,010	2,496	32,500	100.0	200.1
North Dakota.....	1,276	2,880	1,276	1,604	6,509	44.2	42.5
Ohio.....	40,272	45,857	40,272	5,585	45,000	101.9	115.1
Oklahoma.....	3,535	5,035	3,535	1,500	4,500	111.9	101.0
Oregon.....	1,014	1,523	1,014	509	2,000	76.2	67.6
Puerto Rico.....	686	1,316	686	630	8,998	14.6	6.9
South Carolina.....	2,971	7,641	2,971	4,670	6,000	127.4	-----
South Dakota.....	510	534	510	24	2,000	26.7	25.5
Tennessee.....	22,261	27,020	22,261	4,759	25,000	108.1	123.7
Texas.....	7,843	10,722	7,843	2,879	12,000	89.4	65.4
Utah.....	3,909	4,347	3,909	438	4,000	108.7	130.3
Vermont.....	9,246	10,195	9,246	949	10,000	102.0	122.7
Virginia.....	14,706	19,189	14,706	4,483	17,500	109.7	98.0
Washington.....	2,192	3,117	2,192	925	4,000	77.9	109.6
West Virginia.....	10,702	11,721	10,702	1,019	15,817	74.1	107.0
Wisconsin.....	10,059	17,065	10,059	7,006	17,000	100.4	100.6
Wyoming.....	2,616	2,449	2,616	-187	3,005	81.5	116.3
Total.....	828,486	986,136	828,486	157,650	990,308	99.6	106.8
Midwest.....	408,478	480,756	408,478	72,278	478,526	100.5	106.8
South.....	252,626	313,215	252,626	60,589	312,098	100.4	105.0
Northeast.....	119,703	140,460	119,703	20,757	139,817	100.5	115.8
West.....	47,679	51,705	47,679	4,026	59,867	86.4	96.0
Total.....	828,486	986,136	828,486	157,650	990,308	99.6	106.8

**ANNUAL REPORT OF THE AMERICAN FARM BUREAU FEDERATION
FOR 1945****LOOKING AHEAD**

(By Edward A. O'Neal, President)

INSURANCE DEPARTMENT

The AFBF insurance department to provide advisory service to the States desiring it was set up February 15, 1945, with John T. Casey in charge. Farm bureaus had already formed their own insurance companies in New Hampshire, Ohio, Indiana, Kentucky, Illinois, Wisconsin, Iowa, and Kansas. Estimates for the end of 1945 indicate total figures for all companies as follows:

	Life	Casualty	Fire
Annual premium.....	\$8,350,000	\$17,500,000	\$4,000,000
Admitted assets.....	35,000,000	21,450,000	5,000,000
Insurance in force.....	435,000,000		

During 1945 several new companies have been organized—Alabama and Indiana—fire insurance; Iowa—a life company expecting \$30,000,000 of insurance by December 31; Oklahoma and North Dakota—casualty; Nebraska—hospital and medical service. Also in 1945 Florida, Texas, Mississippi, and Missouri have decided to form casualty companies and several southern farm bureaus will form a life insurance company to serve southern States desiring to participate.

Functions of insurance department

The director has provided advice and assistance in connection with the newly formed companies and, when requested, to those already formed. The director has also met and consulted with an AFBF committee on medical care and

rural health and with several similar state committees. A limited time was also devoted to national legislation on social security matters.

The insurance department also seeks to keep abreast of developments arising from a Supreme Court decision reversing long established precedent and holding insurance to be commerce and subject to Federal regulation. An act of Congress and revision or prospective revision of all State laws indicate new taxes, new rate and statistical requirements and mandatory operations and procedures likely to impose serious restrictions on Farm Bureau companies. Your director seeks to advise all companies and to represent those desiring representation.

There has been considerable travel, trips having been made to conferences of Farm Bureau presidents and secretaries of the West, Midwest, and Southern areas and to North Dakota (twice), Wisconsin, Iowa, Florida, Tennessee (three times), Mississippi, Alabama (twice), Arkansas, Texas (twice), Louisiana, Washington, D. C., and New York City and Missouri (three times). Trips to Massachusetts and Connecticut are planned before the end of 1945.

Conclusion

Farm Bureau leaders in those States having their own insurance companies generally believe such companies have helped to develop and maintain membership. The insurance department hopes to be a clearing house of information about these companies, to assist them wherever possible, to coordinate their practices to the extent desired and to counsel with other farm bureaus, on request, concerning all types of insurance, pension plans and prepaid hospital and medical plans.

Your director wishes to acknowledge the valued advice and assistance of Mr. Kirkpatrick, general counsel of AFBF.

* * * * *

Mrs. SEWELL. We firmly believe that any program must contain the elements designed to develop self-help.

Richard Evans says:

Civilization has grown by the debt each generation paid those who follow, since they cannot pay their debt to those who have gone before. Our churches, schools, and social institutions have never brought forth a substitution for a good home or a virtuous mother. To raise a society of people to artificial standards by coercion or regimentation is the direct sham, because there is no way of permanently lifting men higher than their own intelligence, desires, or their own industry and efforts will carry them. If we wish to save any people, we must teach them to help themselves.

On behalf of our organizations and myself, may I express our appreciation for the time and courtesy afforded us by this distinguished group to present our viewpoint.

The CHAIRMAN. Thank you, Mrs. Sewell.

Now, the organization that you are speaking for here is the American Farm Bureau Federation?

Mrs. SEWELL. That is right, and the Associated Women of the American Farm Bureau, the affiliated organization, Senator Murray.

The CHAIRMAN. What official position do you occupy?

Mrs. SEWELL. I am called an administrative director.

My duties are those of executive secretary of the women.

The CHAIRMAN. Of the women?

Mrs. SEWELL. Not for the men, but I am speaking on behalf of both groups.

The CHAIRMAN. Now, you say that there must be a better distribution of doctors and hospitals?

Mrs. SEWELL. Yes, sir.

The CHAIRMAN. In the rural sections of the country?

Mrs. SEWELL. That is right.

The CHAIRMAN. How do you propose that that should be accomplished?

Mrs. SEWELL. Well, I think the principles of the first part of the bill, which are, in essence, very much that of the Hill-Burton bill, through Federal grants-in-aid, will help to do that, Senator Murray, and equalize the opportunities there.

If we had the hospital service, most everybody seems to think we can get the doctors into a community much more quickly.

The CHAIRMAN. Well, you are familiar with the Hill-Burton bill?

Mrs. SEWELL. Yes; we have filed on that.

The CHAIRMAN. I see. Well, you know that under that bill it is necessary for the localities that would be seeking a hospital to be able to prove that they have the financial ability to support it?

Mrs. SEWELL. That is right, and to match the dollars.

In the little pamphlet which I have filed with you, on top of the pile, you will find a health program which is being carried out at the present time in Mississippi, instituted by the State farm bureau, and providing in one of the poorest and one of the lowest levels of health work the matching funds for that sort of cooperation between Federal and State Governments.

The CHAIRMAN. Of course, there are various rural communities where they are unable financially to support a hospital at the present time.

Mrs. SEWELL. That is probably true.

The CHAIRMAN. Yes.

Mrs. SEWELL. But I doubt very much whether it would be to the best interest of any community if we put in a hospital if we cannot maintain it after we get it there.

The CHAIRMAN. That is true, of course, but do you not think that where there is a need for hospital services and for the facilities that are offered to the medical profession for practicing medicine, do you not think that there should be hospitals in the community to serve the people there regardless of the financial condition of the people?

Mrs. SEWELL. That is probably true.

The CHAIRMAN. Yes.

Mrs. SEWELL. I do not think, though, we would want to say we ought to have a hospital in every county. Now, with modern transportation and all that, there should be some sort of public health center.

The CHAIRMAN. Yes.

Mrs. SEWELL. I like the idea of the small center, and going from that to the larger, and on, and you will find that the Indiana Farm Bureau is attempting to set up one of these demonstration counties in the very near future.

The CHAIRMAN. There should be, of course, hospitals and facilities established to meet the needs and requirements of the people.

Mrs. SEWELL. That is right; yes.

The CHAIRMAN. It does not necessarily follow they should have hospitals in every county, as you say, but they should be located in such a way that they could take care of the people that need hospitalization?

Mrs. SEWELL. That is right.

The CHAIRMAN. And provide the means and the facilities for the medical profession to practice good, modern medicine?

Mrs. SEWELL. Yes.

The CHAIRMAN. Now, under the Hill-Burton bill you would not be able to secure hospitals for some of these rural sections of the country,

because they have not got the ability to sustain it. There is no other way to get a hospital under the Hill-Burton bill except through the enactment of a law such as we are proposing here, which would make it possible for medical practitioners to be paid for their services, where the people are unable to pay for it themselves.

Mrs. SEWELL. Well, we have said we are willing for that to be done.

The CHAIRMAN. I beg your pardon?

Mrs. SEWELL. We have said by resolution if they are unable to pay for it themselves, that that is one of the functions of Government.

The CHAIRMAN. Instead of having it under a system of this kind, which provides compulsory insurance, you believe that it should be furnished on the basis of charity, that it should be provided for by the Government?

Mrs. SEWELL. Not necessarily, Senator Murray. I believe very firmly that the whole thing is education. I think there are a great many people unable to pay for medical care and hospital service, when that time comes, that are perhaps earning a pretty good wage now, but they are not being trained. You propose to train them by compulsion. I propose to train them by an educational program and the demonstration method.

The CHAIRMAN. How long have you been studying this problem of the need of medical care in the rural sections?

Mrs. SEWELL. Fourteen years.

The CHAIRMAN. Fourteen years?

Mrs. SEWELL. Fourteen years.

The CHAIRMAN. What have you done during those 14 years to bring about a better distribution of doctors and hospitals?

Mrs. SEWELL. We have tried very hard to accomplish an educational program of the need for prepayment of medical care and hospitalization program.

The CHAIRMAN. And yet, of course, you have tried very hard?

Mrs. SEWELL. Yes.

The CHAIRMAN. But yet the situation is such that great areas in the rural sections of the country are without adequate modern medical care and hospitalization?

Mrs. SEWELL. Of course, we cannot leave out the last 4 or 5 years of the war and put back the doctors.

The CHAIRMAN. Of course.

RAPID GROWTH OF THE BLUE CROSS

Mrs. SEWELL. And we could not have gone on with our hospital buildings. I think we might have had a different picture, and as I tried to point out in the prepared statement, the growth in the last 2 years—may I go back?—I believe it is 6 years ago that a representative of the American Hospital Association, speaking before our group, told us that the plans, such as the Blue Cross plan, could not be extended to rural areas, and some of the women asked why, and he said because there was no machinery to collect the funds or set up the groups as in the industrial centers or towns and cities; and the farm women themselves undertook that work, and I have there a map showing you the distribution of the hospital service work in the State of Minnesota.

I can point to the same thing in Missouri. That is where the women have undertaken that and it has gone, someone says, "like a prairie fire."

The CHAIRMAN. Like a prairie fire. So you think the Blue Cross plan is spreading over the rural areas of the Nation?

Mrs. SEWELL. I do.

The CHAIRMAN. How long has that been going on?

Mrs. SEWELL. About 5 years. I think the greatest growth has been made in the past 2.

The CHAIRMAN. It started 5 years ago?

Mrs. SEWELL. That is right.

The CHAIRMAN. Before that, this situation in the rural areas of the country existed where they were without adequate modern medical care?

Mrs. SEWELL. Surely.

The CHAIRMAN. Nothing was done by your organization prior to 5 years ago?

Mrs. SEWELL. The women have been working a lot longer than that.

The CHAIRMAN. Were you building hospitals?

Mrs. SEWELL. No; we were not building hospitals. Nobody pretends that we were. We are now—

The CHAIRMAN. Your organization was educational?

Mrs. SEWELL. We had been working in educational work. We are now working, through our organization, to get the hospitals being built in a number of States where they have passed legislation this year.

The CHAIRMAN. How many people are being served by the Blue Cross in the rural areas?

Mrs. SEWELL. Well, I could not tell you exactly, but we have 26 States. There are 26 States in which the program is being carried on, Senator Murray.

The CHAIRMAN. Is it not true that only about one-half or three-quarters of a million people are being provided service through the Blue Cross system in the rural areas?

Mrs. SEWELL. I suspect that is about right. I think 2,500,000 is claimed throughout the country.

Is that not the statement made before this committee?

The CHAIRMAN. The information I have is that somewhere between one-half and three-quarters of a million people of rural areas.

Mrs. SEWELL. I mean for the entire country.

The CHAIRMAN. For the entire Nation, something like 20,000,000. It can be done.

Mrs. SEWELL. By the voluntary method, I think, as you have expressed several times during the morning, there needs to be the compromising or getting together and bringing together of some of these ideas; but I do not believe we can do it in one fell swoop by passing a law that provides for compulsory insurance.

The CHAIRMAN. What service is rendered to the people under the Blue Cross system?

Mrs. SEWELL. We have schedules there that vary. There are three or four States that have medical care and surgical benefits, and obstetrical benefits. Some of them have 21, some of them 30 days of hospital.

The CHAIRMAN. In your State, what service does it render?

Mrs. SEWELL. Twenty-one days' hospitalization.

The CHAIRMAN. Twenty-one days' hospitalization.

Mrs. SEWELL. And the surgical benefits, and the obstetrical care.

The CHAIRMAN. You do not render home medical care or office medical care?

Mrs. SEWELL. No. That is in the program now, and several States are working on that.

The CHAIRMAN. So a person in the rural areas, where your Blue Cross system operates, if he becomes sick, he would not be entitled to any service under the Blue Cross system?

Mrs. SEWELL. Not unless they were members of the Blue Cross.

The CHAIRMAN. I mean to say, they would not be entitled to any home service or office care?

Mrs. SEWELL. In a few States, Senator Murray, they are extending medical care.

The CHAIRMAN. I am confining myself to your State.

Mrs. SEWELL. In my State, there is such a plan in formation.

The CHAIRMAN. In formation?

Mrs. SEWELL. Where we have a full medical care.

The CHAIRMAN. You mean in process of formation?

Mrs. SEWELL. Yes; in process of formation.

The CHAIRMAN. Now, did you consult with other people in connection with the testimony you were going to give here today?

Mrs. SEWELL. No; I did not, except my own people and by resolution.

The CHAIRMAN. The statement you gave here today is entirely your statement?

Mrs. SEWELL. It certainly is.

The CHAIRMAN. And was prepared by you personally?

Mrs. SEWELL. Indeed it was.

The CHAIRMAN. And it is based on information you have of your own knowledge?

Mrs. SEWELL. That is right, Senator Murray.

The CHAIRMAN. Have you copies of your statement?

Mrs. SEWELL. I gave the secretary one, and I am ready to leave this one with you.

The CHAIRMAN. That is all right. I thought you probably had some mimeographed copies.

Mrs. SEWELL. No; I did not.

The CHAIRMAN. You feel that the voluntary system will be sufficient, although at the present time there is only from one-half to three-quarters of a million people being served under the Blue Cross system in the rural areas of the country?

Mrs. SEWELL. It is not as quick as we would like to have it, but I believe it is the safest and the best way to do it, but I do think out of such debates as we have here we can begin to get the best way of getting this across. It has not been too long since particularly the rural people carried no life insurance. They did not carry automobile insurance. We had one State in the Union that had a compulsory automobile insurance law, and that has been completely outmoded. And it is being done by the growth of farmer-owned and controlled insurance companies, and that has extended from the automobile insurance to the life insurance, and now coming into the medical care.

The CHAIRMAN. But at the present time, though, notwithstanding the fact that you have been working on this problem in the farm areas for 5 years, your organization, you only have from a half to three-quarters of a million covered by the Blue Cross system?

Mrs. SEWELL. That is right.

The CHAIRMAN. The Blue Cross system does not give complete coverage?

Mrs. SEWELL. No.

The CHAIRMAN. That is to say, it gives coverage only for cases where they have to go to a hospital?

Mrs. SEWELL. That is right.

The CHAIRMAN. So that all of the cases that arise in the country, and where they do not need hospitalization but require the services of a doctor, either at the home or in the office, would not be covered by the present system you have?

Mrs. SEWELL. No. It would not, by the present system, no, sir.

The CHAIRMAN. And, of course, most of the cases in the country are cases of that character, where a person gets hurt on the farm or where they become ill?

Mrs. SEWELL. Of course, mostly that kind of case would be surgical or accidental, which would need hospitalization. A serious accident.

The CHAIRMAN. A serious accident. Yes. But I mean to say the average case on a farm is a case which can be cared for by the doctor in his office or at home?

Mrs. SEWELL. Yes. A great many of them.

The CHAIRMAN. That is not only true of the farmers but also in the cities.

Mrs. SEWELL. Yes.

The CHAIRMAN. That the great majority of medical care are cases rendered in the home or in the office.

Mrs. SEWELL. I still believe that we need a lot, as I have tried to say, of education and public health and preventive measures as well as curative things, and I think we would like to see a public health center in every county we have, and the extent that there are small hospitals, and then on to the larger chain of hospitals.

The CHAIRMAN. That is exactly what this bill is proposing.

Mrs. SEWELL. We can agree with a portion of the bill, Senator Murray.

The CHAIRMAN. The only part you disagree with is the part which provides for the compulsory insurance system?

Mrs. SEWELL. The part which provides for the compulsory insurance system.

The CHAIRMAN. If it were not for that, if it provided a voluntary system, you would be satisfied?

Mrs. SEWELL. I think we would, so far as it corresponds with our resolution.

Again, I could not go further than that, until after another annual meeting, when it would be brought to the delegates.

The CHAIRMAN. But you understand, under a voluntary system, people cannot be compelled to join.

Mrs. SEWELL. That is right.

The CHAIRMAN. And the experience under the voluntary system is that some people who feel that they are not expecting to be ill hesitate about joining?

Mrs. SEWELL. Surely.

The CHAIRMAN. So that the result is that the income from that kind of a system does not supply sufficient funds to take care of their people upon a basis of reasonable charges?

Mrs. SEWELL. I believe I understood you this morning to say that it would not be possible to take care of it by the money which would be collected under the pay-roll deduction or whatever it would have to be, and that it would be subsidized by the Government to make up the additional charges.

The CHAIRMAN. No.

Mrs. SEWELL. Did I not understand that from the testimony? I thought that statement was made.

The CHAIRMAN. No. Of course, in addition to the medical care, the bill, of course, contemplates a lot of other services besides that. There are two titles. Title I and title II.

Mrs. SEWELL. Yes. My point was not intended or thought that there was enough to be raised by the payment through the compulsory insurance to finance all this program.

The CHAIRMAN. How many members has your organization?

Mrs. SEWELL. One million members.

The CHAIRMAN. How many?

Mrs. SEWELL. One million members. That means families, Senator Murray.

The CHAIRMAN. One million families?

Mrs. SEWELL. That is farm families. That would be a farmer and his wife and three or four children.

The CHAIRMAN. In what States?

Mrs. SEWELL. All of them except Maine, Rhode Island, and Pennsylvania.

The CHAIRMAN. And the organization has chapters in various communities?

Mrs. SEWELL. We call them local units. We have township or local units, and county units, and then the counties in regions, and the State and national.

The CHAIRMAN. Has this subject been discussed in all of these units?

Mrs. SEWELL. Very largely. It is one of the most important and widely discussed matters before our membership today. I think it is one of the most popular of the programs we have.

The CHAIRMAN. Have you adopted resolutions in the various units?

Mrs. SEWELL. Yes. This resolution was made up of resolutions which were sent to us from the States.

The CHAIRMAN. I see. How many resolutions were sent to you from the States?

Mrs. SEWELL. I suppose very likely from the 45 States we had 32—I think 32 States were represented in the compilation of this one particular resolution.

The CHAIRMAN. Were they local unit resolutions or State resolutions?

Mrs. SEWELL. State resolutions.

The CHAIRMAN. All of the 32?

Mrs. SEWELL. I think there were 32 represented in this particular group in the adoption of the resolution for the American Farm

Bureau Federation. It has to be the representatives of the States. All States have to vote upon those resolutions.

The CHAIRMAN. Can you give us the names of the 32 States who sent in these resolutions?

Mrs. SEWELL. I think I can, if you will give me a moment. New Hampshire, Vermont—

The CHAIRMAN. I wish you would do this for me: Would you prepare a statement for me and file it with the committee, giving me the names of each of the States that have adopted these resolutions as State organizations?

Mrs. SEWELL. Yes. I would be glad to do that. I would be glad to furnish that.

The CHAIRMAN. Now, have you studied this bill, the bill which provides for the compulsory insurance system in full detail?

Mrs. SEWELL. I cannot say I have. I have read the bill and tried to study it and understand it. I am not sure I could tell you all the answers to the technical questions.

The CHAIRMAN. You do not wish to point out any defects in the various provisions of the bill?

Mrs. SEWELL. No.

The CHAIRMAN. Which undertakes to provide the insurance?

Mrs. SEWELL. I have attempted to bring you the thinking of our people on the health program for rural America.

The CHAIRMAN. You are supporting the theory that a voluntary system can supply everything that is necessary in the way of a national health program?

Mrs. SEWELL. That is my feeling.

The CHAIRMAN. Notwithstanding the fact that only 20 million people in the country at the present time belong to the Blue Cross system?

Mrs. SEWELL. That is right.

The CHAIRMAN. And that it does not have complete coverage?

Mrs. SEWELL. But if the growth is as rapid in the next 2 years as it has been in the past, our story will be very different in the next few years.

The CHAIRMAN. This agitation has grown up in the last 5 or 6 years?

Mrs. SEWELL. Certainly it has. It has not been attempted at all until the last 5 or 10 years.

The CHAIRMAN. But long prior to this, this situation existed in the country where the people were unable to get medical care because of the cost of modern medical care and because of—

Mrs. SEWELL. Inaccessibility, as much as anything else, because we have not had the doctors and the hospitals, and we have not got them yet.

The CHAIRMAN. And you never would have them unless you developed some system of health insurance?

Mrs. SEWELL. I think we need to call the attention of the people to these facts. Everybody is like Mark Twain and the weather. They have not done anything about it. It is not a new problem.

The CHAIRMAN. But under a voluntary system, a lot of people will continue to do nothing about it?

Mrs. SEWELL. I am not so sure.

The CHAIRMAN. You are not so sure?

Mrs. SEWELL. I would like to be sure we would not have black markets and things going wrong with this, just the same as some of these other well-intended programs. There are loopholes we can get around. I think we need to be taught, maybe in 5 or 10 years, and then we would be ready for the compulsory. That might be; but I would like to see the other way tried first.

The CHAIRMAN. In the meantime, a lot of people would be unable to get modern medical care. They would grow up sickly, in some parts of the country, as the reports have indicated from the Selective Service Administration, and people would suffer severely as the result of a system developed in this country in the near future.

If you have to wait for education, you will wait a long time, it seems to me.

Mrs. SEWELL. That is what you believe.

The CHAIRMAN. What?

Mrs. SEWELL. That is what you believe.

The CHAIRMAN. Do you not believe that yourself?

Mrs. SEWELL. I think it can be done much more quickly than we are thinking at this moment.

The CHAIRMAN. Much more quickly than we are thinking at this moment?

Mrs. SEWELL. I think we could do a lot more than we have.

The CHAIRMAN. You think it is going to be done by voluntary system?

Mrs. SEWELL. I do.

The CHAIRMAN. You are satisfied with that, notwithstanding the fact that evidence up to date is that voluntary systems do not give the coverage, do not provide for the home care, and you feel that, notwithstanding the fact that the voluntary system does not provide that full coverage, nevertheless, it would eventually be sufficient?

Mrs. SEWELL. I think it would be more desirable.

The CHAIRMAN. More desirable?

Mrs. SEWELL. Much more desirable and would meet with the general approval and acceptance of people much more quickly.

The CHAIRMAN. Well, other farm groups have appeared here and testified to the contrary.

How do you account for that? Other people representing farmers have come here and testified.

Mrs. SEWELL. Who are the other groups?

The CHAIRMAN. There was a man here the other day representing national farm unions.

Mrs. SEWELL. The National Farmers Union. It has about 400,000 members. Is that not right?

The CHAIRMAN. I do not know the membership.

Mr. SEWELL. I know about them, and they have differed from us on this program. I know that.

The CHAIRMAN. And he told about farm areas in this country where they are almost totally without medical care and hospitalization?

Mrs. SEWELL. I have heard their statement.

The CHAIRMAN. There are situations where a doctor is 25 or 50 miles away.

Mrs. SEWELL. Yes.

The CHAIRMAN. And that exists in my own home State, where in a whole county sometimes they are without a doctor.

Mrs. SEWELL. That is true.

The CHAIRMAN. And you think that a voluntary system—

Mrs. SEWELL. I do not think the passage of this bill would bring the doctor. I think you will have to have years getting doctors trained, getting them into the rural communities, an integrated program that will make it more desirable to live in the rural communities. Just the passage of law would not do it.

The CHAIRMAN. Would not we have an integrated program if we had a national health system?

Mrs. SEWELL. Not unless you had roads and schools, and rural electrification.

The CHAIRMAN. That is all going on.

Mrs. SEWELL. Will that be done under this bill?

The CHAIRMAN. That is all going on concurrently. The farmers are pretty prosperous right now, and the roads are being built.

Mrs. SEWELL. I have lived through a good many years as a farm person, and there have been more years that they were not than that they were.

The CHAIRMAN. Well, we have been listening to the farmers here in Washington, and coming to their rescue, and giving them assistance in the various farm programs developed in the country, and much good has come from those programs.

Mrs. SEWELL. I think it is a part of the whole national picture.

The CHAIRMAN. Well, the roads are being pretty well built up in the rural sections at the present time.

Mrs. SEWELL. There is still need for many more, and it goes hand in hand with your school, and your health program.

In my own life, it was easier to get my husband 85 miles to the State capital for treatment in a serious illness, than it was to get a doctor when my first child was born, over 10 miles of road. That actually happened.

The CHAIRMAN. And when you have a doctor brought from a great distance, it is very expensive?

Mrs. SEWELL. Yes.

The CHAIRMAN. And the road program will go on in every State of the Union, and the Federal Government is assisting them.

Mrs. SEWELL. And it is a Federal grant-in-aid, is it not?

The CHAIRMAN. That program is pretty well in hand.

Mrs. SEWELL. Yes, but it cannot be left out of the whole picture.

The CHAIRMAN. But the situation with reference to adequate medical care in the farm sections at the present moment is not very satisfactory.

Mrs. SEWELL. No, it is not.

The CHAIRMAN. And you recognize the fact that something must be done about it?

Mrs. SEWELL. We have recognized it and tried to do something about it ourselves. We have tried to do it ourselves.

The CHAIRMAN. And you think you can do it?

Mrs. SEWELL. We think we have made progress. We do not think we have done it all, but we think we have made progress, and it is a demonstration of what could be done.

The CHAIRMAN. Do you not think that is a very insignificant progress, where you only have half to three-quarters of a million people?

Mrs. SEWELL. We only have 1,000,000 members.

The CHAIRMAN. There are 140,000,000 in the country.

Mrs. SEWELL. We are not going to be responsible for the people in the city. We have addressed ourselves entirely to the rural problem.

The CHAIRMAN. Your organization is thinking about the members of the organization?

Mrs. SEWELL. To all rural people. You are counting the question of a million. I said we had 1,000,000 members. If we had 1,000,000 people served, we would be doing pretty well. It is not enough. I am quite confident of that. We want to do better.

The CHAIRMAN. And you think it is a long, drawn-out process, and there would be a lot of education in connection with it before we will get to the point where we will have adequate medical care in the rural sections?

Mrs. SEWELL. I do, Senator Murray. It cannot be done by wishful thinking. It will take some time.

The CHAIRMAN. I think it has been pretty well demonstrated. I do not think there is any doubt about it.

You are in favor of the Hill-Burton bill?

Mrs. SEWELL. Yes. We have appeared on behalf of the passage of that, and suggested some modifications and amendments.

The CHAIRMAN. Well, now, under the Hill-Burton bill, what has been done in any of the rural sections you have knowledge of with reference to securing a hospital?

Mrs. SEWELL. Well, you could not go further than to try to get the enabling legislation through your State to match the funds if and when the bill is passed. That is in process in a number of our States.

Mississippi is an outstanding example.

Missouri took action.

Minnesota has taken action.

South Carolina; Florida; Oklahoma.

Those States that I have knowledge of have already passed that through their current legislatures. Some of our legislatures will not meet until next year.

The CHAIRMAN. That is to enable them to take advantage of the Federal grant-in-aid?

Mrs. SEWELL. That is right.

The CHAIRMAN. Thank you very much.

Senator DONNELL. Mrs. Sewell, I do not think your address appears in the record.

Mrs. SEWELL. Otterbein, Ind.

Senator DONNELL. Just a very few questions.

You referred to the State of Missouri?

Mrs. SEWELL. Yes.

Senator DONNELL. The Missouri Farm Bureau Federation is a very active organization, is it not?

Mrs. SEWELL. Yes.

Senator DONNELL. And had its general meeting in Jefferson City, attended by people from all sections of the State—

Mrs. SEWELL. That is right.

Senator DONNELL. You were there once at the Governors Hotel?

Mrs. SEWELL. That is right.

Senator DONNELL. The room is a large banquet room, filled to capacity with people from all over the State?

Mrs. SEWELL. That is right.

Senator DONNELL. And Mr. R. W. Brown was the head, and then he died, and was succeeded by Mr. Slusher?

Mrs. SEWELL. Yes.

Senator DONNELL. On these State meetings, they are very productive of the dissemination of information and education?

Mrs. SEWELL. They are productive many ways: they bring together all the work that has been done by the people out over the State in the nature of reports, and the pooling of that information goes back to the people, and the inspiration and information is extended all over the State.

Senator DONNELL. And then the organizations, such as yours, have publications, do they not?

Mrs. SEWELL. Yes.

Senator DONNELL. Which they circulate and they are widely read?

Mrs. SEWELL. That is right.

Senator DONNELL. That is right. And Senator Murray referred to this as a long, drawn-out process of education. I appreciate any educational program takes a while, but, as a matter of fact, this process of voluntary health insurance has been going rapidly in the last 2 or 3 years.

Mrs. SEWELL. It has. The Missouri Farm Bureau women were the first to take this matter up and begin the organization in the little township units and into the counties, and then Mr. Chester G. Starr was made the director, and in the clipping service I have there, you will find a typical report which appears by the action of the Missouri Farm Bureau.

Senator DONNELL. Does the Missouri Farm Bureau itself affiliate with the Blue Cross system?

Mrs. SEWELL. It acts in conjunction with the Blue Cross, and there is a committee set up in the township which, in turn, works with the Blue Cross.

Senator DONNELL. The township is a subordinate unit smaller than a county?

Mrs. SEWELL. Yes.

Senator DONNELL. There may be 12 or 15 townships in a county sometimes.

Mrs. SEWELL. Yes.

Senator DONNELL. And it is organized pretty much to the "grass roots"?

Mrs. SEWELL. Yes.

Senator DONNELL. Out in our part of the country, have not the farmers developed mutual fire insurance companies?

Mrs. SEWELL. Yes.

Senator DONNELL. Hail insurance?

Mrs. SEWELL. Yes, and life insurance, and automobile insurance companies.

Senator DONNELL. There are a great many million dollars of insurance carried by the farmers in the central west in these various mutual or semimutual companies?

Mrs. SEWELL. I believe the life insurance company, operated by the Illinois Agricultural Association, is the largest such company in the United States.

Senator DONNELL. Do you know about what the total volume is in policies outstanding in dollars and cents in that life insurance company?

Mrs. SEWELL. I am sorry. But I would be glad to furnish that.

Senator DONNELL. What is the name of that company?

Mrs. SEWELL. The Country Life Insurance Co.

Senator DONNELL. Do you think you could collect information for us on that company and some of the other companies?

Mrs. SEWELL. I would be happy to do it.

Senator DONNELL. And give us an idea of the development of fire, life, hail, and similar types of insurance?

Mrs. SEWELL. I would be glad to do it. I think there is another company under consideration of about five southern States coming together and setting up such a service for their membership.

Senator DONNELL. Thank you, ma'am.

The CHAIRMAN. How is your organization supported?

Mrs. SEWELL. By voluntary dues, Senator Murray.

The CHAIRMAN. Voluntary dues?

Mrs. SEWELL. Voluntary dues. In Indiana, we pay \$5 a year. One dollar of that stays in my township. One dollar goes to my county—two dollars go to my county. Two dollars to the State, and 50 cents of that, in turn, is sent to the American Farm Bureau Federation.

The CHAIRMAN. Does your organization get any contributions from the outside?

Mrs. SEWELL. No, sir.

The CHAIRMAN. Is all of this educational material you have handed me here paid for by your organization?

Mrs. SEWELL. Yes. That is gotten out by the State federations.

The CHAIRMAN. State federations?

Mrs. SEWELL. Yes.

The CHAIRMAN. And that is paid for by the dues?

Mrs. SEWELL. Yes.

The CHAIRMAN. By the members of your organization?

Mrs. SEWELL. That is right.

The CHAIRMAN. They get no contributions from the outside, organizations of any kind?

Mrs. SEWELL. No; but if they operate one of these insurance companies, they would have those funds they might use, but that would be done by the membership itself.

The CHAIRMAN. What contribution does each State have to make to the national organization?

Mrs. SEWELL. Fifty cents per member on a per-capita basis.

The CHAIRMAN. Fifty cents per member. And that is the source of the funds used by the national organization?

Mrs. SEWELL. That is right.

The CHAIRMAN. In handling this literature?

Mrs. SEWELL. That is right.

The CHAIRMAN. That is all.

Senator DONNELL. Mrs. Sewell?

Mrs. SEWELL. Yes?

Senator DONNELL. How soon could you conveniently give to us that information about the development of fire, hail, automobile, and life insurance among the farmers?

Mrs. SEWELL. I will be in Chicago tomorrow morning. I will try to see that it goes out to you by mail tomorrow afternoon.

Senator DONNELL. That will be fine. Thank you, Mrs. Sewell.

The CHAIRMAN. That is all.

The next witness is William E. Tate.

Is William E. Tate here?

(No response.)

The CHAIRMAN. I guess we will have to let that go until some other time.

I guess that will end the meeting today.

We will meet tomorrow morning again at 10 o'clock in the same room, I believe.

(Whereupon, at 3:35 p. m. Tuesday, April 30, 1946, the committee recessed until Wednesday, May 1, 1946, at 10 a. m.)

NATIONAL HEALTH PROGRAM

WEDNESDAY, MAY 1, 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, Aiken, and Donnell.

The CHAIRMAN. The hearing will come to order, please.

The first witness this morning is the Honorable Lewis B. Schwellenbach, Secretary of Labor.

Mr. Secretary?

STATEMENT OF HON. LEWIS B. SCHWELLENBACH, SECRETARY OF LABOR

Secretary SCHWELLENBACH. I have a statement which I would like to read, first.

Mr. Chairman and members of the Committee, I appreciate very much this opportunity to give to the Committee on Education and Labor my views on S. 1606, the proposed National Health Act of 1945. This is highly important legislation and should receive favorable consideration by the Congress at the earliest possible time.

The Department of Labor is vitally interested in an intelligently planned program which will assure adequate and comprehensive medical care to the millions of wage earners of this country.

In the administration of maternal and child health and crippled children's services under title V of the Social Security Act and the emergency maternity and infant-care program, the Children's Bureau of the Department has had a record of 10 years of experience in this field which demonstrates both the urgent need of providing such care and the feasibility of Federal legislation for this purpose.

The proposed National Health Act offers a firm foundation for the attainment of the objectives of better and more adequate medical care for all the people. Good health is a national asset and we must not permit it to be jeopardized any longer through sheer failure to organize and make available to every American the scientific skills of modern medicine.

We have the technical resources and skill, and in the medical profession we have men devoted to the highest standards of practice awaiting the opportunity to render the best possible service, if we only make it possible for them to reach the people who so badly need them.

The President in his message to Congress requesting the adoption of national health legislation pointed out that—

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

EVIDENCE OF NEED

There is ample evidence to show that we have failed in this country to achieve those levels of health and physical well-being which we could attain through modern medical science.

An interdepartmental committee on medical care appointed by President Roosevelt as early as 1935 reported that it was

impressed with the evidence now available that one-third of the population which is in the lower income levels is receiving inadequate general medical service.

It is not only the lack of ability on the part of low-income groups to pay for medical care that is at the root of our failure, but also the maldistribution of the country's existing resources for health and medical services. The consequences of our failure to solve these economic and social aspects of medicine have been serious in terms of human life and depletion of health and vigor of millions of our working people and their families.

The extent of our needs is generally agreed upon. Although death rates have decreased, there is still much preventable sickness. We could, I believe, also reduce the length and severity of much non-preventable illness through adequate and timely care.

An estimate of the prevalence of disability for the entire population indicates that, on the average day of the year, more than 7,000,000 persons are disabled by sickness.

I want to say that the 7,000,000 figure is for the average for the year 1939, because I use the figures for 1942 and 1943 later, I think it would be unfair to not specifically call your attention to the fact that that figure is for prewar years.

For about half of these, the period of disability lasts for more than 6 months. In 1942, absenteeism caused by sickness or injury was responsible for a loss of some 500 million work-days.

It is estimated that wages lost in temporary or continued disability by workers who have been more or less regularly in the labor force aggregate not less than 3 to 4 billion dollars annually. Total costs of sickness and disability, including wage losses and costs to business are nearly three times the cost of medical care. It is estimated that in 1943 these costs amounted to substantially more than \$100 per capita of the population.

While we are all familiar with the great strides medical research and modern laboratory techniques have made in conquering diseases which have long been enemies of mankind, it comes as a shock to realize how persistent and widespread are the scourges of those diseases which continue to take a heavy toll in disability or death.

I am sure you all must have been impressed, as I have been, with testimony submitted by the Public Health Service to your committee; showing that cancer, rheumatic fever, heart disease, and pneumonia "are accountable for an ever-increasing number of deaths."

It is clear, I think, that there is ample basis for the conclusion reached by the Public Health Service that—

unless medical research reveals some new methods of attack—and probably even then—the only effective means of helping the victims of these diseases is to provide them with adequate medical care through full personal health services.

Perhaps the most striking evidence, not only of the need for more adequate medical care for our people but also of the waste which results from our failure to provide such care, is to be found in the fact that a large proportion of the defects and diseases of the men rejected in the selective service examinations could have been prevented with adequate medical care.

Many diseases remain to strike heavily at the health of our children. According to the National Commission on Children in Wartime appointed by the Chief of the Children's Bureau rheumatic fever, influenza, pneumonia, tuberculosis, and appendicitis cause 5,000 deaths each year among children 5 to 15 years of age. The work of the Children's Bureau in providing through State health agencies more and better care for children, has deservedly won commendation.

Dr. Martha Eliot, Associate Director of the Bureau, will discuss in detail the medical needs of children which are still to be met, and will describe to you the extended programs of medical care and health service which S. 1606 would make possible if certain changes agreed upon by the Federal Security Agency and the Department of Labor are made in the bill.

There is a widespread misapprehension, both among the public at large as well as among doctors, that sick people, whether in low-income groups or not, get taken care of somehow or other. It is frequently assumed that public clinics take care of all those who cannot afford to pay, and that fees for office visits are scaled in a rough sort of way to allow for variations in income.

Such complacence with the social effectiveness of medical service does not rest upon an accurate appreciation and understanding of the over-all picture. The true facts about lack of medical care are distorted because we hear so much about public clinics.

I agree that no one can pay too much tribute to doctors who give unspareingly of their free time. It is my belief, however, that seldom do doctors know about or get to see the vast number of sick people from low-income groups who do not get to the clinics and receive no other attention.

The poor and the low-paid wage earners suffer more, are sick longer, can afford less medical care and, in fact, receive much less medical care than they need. The simple fact is that the one-third of the people of this country who are in the lowest income groups have higher rates of sickness and disablement than prevail among groups with larger incomes, and they have less capacity to buy and pay for the services they need.

According to a recent study made by the Bureau of Labor Statistics of family income and spending (Bulletin No. 822), average—and I emphasize the word "average"—average annual expenditures for medical care according to income class were in 1941 as follows:

Under \$500-----	\$27	\$2,000 to \$3,000-----	\$120
\$500 to \$1,000-----	40	\$3,000 to \$5,000-----	152
\$1,000 to \$1,500-----	63	\$6,000 and over-----	310
\$1,500 to \$2,000-----	86		

Thus, the highest amount paid on the average for medical care by families receiving a yearly income of less than \$1,500, was \$63 per annum.

This figure is particularly significant since, according to the same survey, about 50 percent of the families of this country received incomes below \$1,500 in 1941.

Over 33 percent of the families received an aggregate income of less than \$1,000, and were able to spend on the average only \$27 to \$40 per year for medical care.

While incomes have increased since 1941, the costs of medical care have likewise increased. A study by the Bureau of Labor Statistics discloses that the cost for all medical services, plus medicines and drugs, from 1941 to December 1945, increased 15.1 percent; for medical services alone 17.4 percent; and for hospital services alone 27.8 percent. I call to your attention the fact that these statistics refer to family income and not to individual income.

Furthermore, while the percentage of annual income spent for medical care is, on the average, not much greater for low-income groups than for higher-income levels, aggregate expenditures per low-income family in dollar terms represents a far more serious inroad on the income of such a family.

In other words, where the elementary necessities of life, such as food and shelter, represent a large percentage of total expenditures, as they do for the low-income group, finding enough spare money to pay doctor bills, let alone hospital and special service fees, is a very difficult thing to do, and these expenditures are commonly put off as long as possible. This, of course, only increases the burden of high costs of medical care for the low-income family when visits to the doctor can be put off no longer.

The mere presentation of data showing average expenditures by families for medical care, however, fails to tell the most significant part of the story. The high cost of medical care for low-income families results from the fact that in individual cases the incidence of such costs cannot be foreseen or controlled. Illness strikes in an unpredictable and uncertain manner.

One person may go on for years without serious illness while his neighbor may suffer frequently. A long and costly illness may be ruinous even to a family of substantial means, particularly where it results in a loss of income to the head of the family. It may well result in the loss of lifetime savings, the evaporation of hopes of purchasing a home or farm, the end of educational opportunities, and even the breaking up of the family unit itself.

Families living on the margin of economic self-sufficiency cannot, even if they would, budget against expenditures which come unexpectedly and which fluctuate even to the point where they sometimes exceed annual income. This is true not only between various income groups but even within the same group.

Despite the vast advances of modern medicine, the fruits of those advances are far too commonly unavailable to those who are most desperately in need of them.

The proposed National Health Act of 1945 strikes at the core of the problem by eliminating the financial hazard resulting from the unpredictable incidence of illness and by making the results of scientific progress more evenly available to all the people.

There is a wide area of agreement on what our objectives should be, but disagreement on the methods for attainment of those objectives. It is sometimes argued that there is no need to attempt to tackle the problems of furnishing adequate and comprehensive medical care on a Nation-wide scale. I am thoroughly convinced that the magnitude of the problems involved in bringing medical care to the people calls for the mobilization of all the resources at our command.

I have also heard it said that the bill goes too far. It is contended that there should be some more gradual amelioration of the consequences of our failure to provide care; that more careful budgeting of payments by poor people or some plan of voluntary prepayment is the answer. Or it may be argued that the people who make up the low-income group are individualists in their thinking and object to interference with their own planning.

The American Medical Association apparently takes the position, with respect to the average person in the low-income group, that—despite the absence of a large financial reserve he gets by very well. Although the unpredictable illness may require budget payments, he pays debts incurred within a reasonable time.

These contentions, however, are not supported by the facts. It is just not true that people of low incomes faced with the overwhelming burden of prolonged and serious illness get along very well.

Laissez-faire is the traditional last resort of those who are dogmatically opposed to the assumption by the people of cooperative responsibility for the elimination of unnecessary hazards to employment at fair wages, to a secure old age, and to good health.

Every piece of constructive social legislation has had to fight its way against a barrage of propaganda which covers an attitude of complacency and indifference to the needs of the people. I am not disposed to enter a debate on that level. But I am convinced that the outstanding challenge to a democratic society today lies in the question whether it is capable of providing security for its people.

We have the opportunity now of demonstrating whether, within the framework of a democratic society, we can intelligently plan for the well-being of our people.

VOLUNTARY PLANS ARE INADEQUATE

The important question is whether anything short of public responsibility can meet our urgent needs. Limited types of arrangements to distribute the costs of medical care through commercial insurance, Blue Cross plans, group health, and so forth, have enrolled large numbers of middle-income families. But such plans cover only a fraction of the population and fall far short of meeting our needs.

As the Social Security Board has pointed out in its last annual report:

Privately initiated prepayment plans of medical-care insurance are performing valuable functions within their limited field. They are necessarily more costly than the arrangements that can be evolved with wider sharing of sickness risks and with the administrative economies feasible for large units. Their great shortcomings are that they give only limited protection, reach too small a share of the population, and fail to reach the groups in greatest need of insurance.

Because hospitalization plans are all comparatively new, they have grown rapidly in recent years and are still growing. New plans grow

rapidly at first, demonstrating a recognition by the community of the need for some type of prepayment plan. Growth tapers off when those who are financially able to pay have obtained membership. Under the best of circumstances, hospitalization plans will take many years to extend their limited form of protection to our American workers and their families. For those who want and need what modern medicine can furnish so that they may live vigorously and look forward to a long and useful life, the rate of growth of these plans is much too slow.

Moreover, where health needs are greatest, that is, in small communities in rural areas and among low-income groups, it is difficult and costly to initiate and administer private prepayment plans. Such plans have hitherto, and in the future will undoubtedly, continue to be confined to a great extent to large cities and middle and higher income families.

BENEFITS OF S. 1606

No one who has given serious thought to medical care problems in this country can, I am convinced, successfully challenge the basic conclusion that achieving adequate medical care for all the people requires that the costs be distributed over periods of time and over large groups of the population.

Through national health insurance, the costs of meeting the economic hazards whose consequences are lack of essential services and dependency are reduced from the maximum which each individual must be prepared to meet to the average cost of affording over-all protection. Care is guaranteed by the financial stake each individual acquires through his payment into the insurance fund. Adequacy of care will be assured by the expansion of facilities and the development of services and training which this bill, together with the Hill-Burton hospital bill, will make possible.

The redistribution of medical costs that the proposed National Health Act will achieve will accomplish the spread of ability to pay and will direct Federal funds into areas which have been unable to support doctors, hospitals and laboratory equipment. The program will eventually relieve doctors of the double burden of having to be both bill collectors and medical practitioners.

Furthermore, the bill will help to avoid the concentration of physicians in large urban centers where they are attracted by the possibility of stable income and will enable wage earners to support aggregate expenditures for medical care in a way to insure permanent stability of income to those who render medical care.

The proposed bill will provide assistance to practitioners in their use of opportunities for postgraduate study. Together with the Hill-Burton hospital bill, a concerted effort can be made to bring hospitals and health centers with the technical equipment of modern medicine and public health services to areas that need them most urgently.

Physicians trained in modern medical schools to utilize up-to-date diagnostic techniques and other facilities find it too difficult to practice in communities where these facilities are not easily available. Through a combined program using general revenue as well as pooled insurance funds, patients will be able to seek the care they need in hospitals, and medical practitioners will be enabled to make use of the best facilities that modern science has to offer, and will have both incentive and

opportunity to improve standards of medical service. The proposed bill will provide for the payment of care in hospital and other facilities made available to communities under the Hill-Burton hospital bill.

PROPOSED AMENDMENTS TO TITLE I

As I indicated at the beginning of my remarks, the Federal Security Agency and the Department of Labor have agreed that it would be desirable to include in S. 1606 certain amendments which are intended to broaden the coverage of maternity care and of medical care to children to include noninsured as well as insured, and to make the care adequate for all mothers and children, to remove certain ambiguities, and to provide for improved coordination in the administration of the provisions of title I, part B, and title II. These amendments have already been submitted to this committee. I regard their incorporation into the bill as indispensable.

In these times it is intolerable that we should allow the vitality of our people to be sapped by preventable ill health and disease.

I urge this committee to give early and favorable consideration to the proposed bill amended in the manner I have recommended.

The CHAIRMAN. Any questions, Senator?

Senator DONNELL. Yes, sir; I would like to ask the Secretary some questions.

Mr. Secretary, may I ask you, please, just what was the course of procedure adopted in the preparation of this statement?

Secretary SCHWELLENBACH. Well, the same procedure which is uniformly adopted in the Department of Labor. I do not dictate the statements myself.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. We had a meeting. I had meetings with various members of the staff when the bill first came up. I read it, and attempted to study it, and had my general ideas about it, and then referred the various parts to Miss Lenroot, head of the Children's Bureau, and Dr. Eliot, of the Bureau of Labor Statistics, to get certain figures. The actual preparation of the statement was done in the solicitor's office in the Department.

Senator DONNELL. Do you know who was the person who actually prepared the statement?

Secretary SCHWELLENBACH. I think Mr. Tyson actually prepared the statement.

Senator DONNELL. The reason I make that inquiry is in part this, Mr. Secretary: Of course, in appearing before our committee as the Secretary of Labor and a man of standing that you are professionally and in your official capacity, the expression of opinion by you carries great weight. We all realize that, and I would like to inquire somewhat in detail as to some of the statements made in here which you have adopted, as I understand it, in your statement.

Secretary SCHWELLENBACH. It is the statement, not only my own but the statement of the Department of Labor.

Senator DONNELL. Well, it is entitled here—

Secretary SCHWELLENBACH. I know that.

Senator DONNELL. Statement of Lewis B. Schwellenbach, Secretary of Labor, before the Senate committee.

Secretary SCHWELLBACH. I am just adding that it is the combined views of a lot of people in the Department.

Senator DONNELL. But you are making the statement as Secretary of Labor.

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. And I would like to inquire into some of the matters therein discussed.

Will you be kind enough to turn to page 12 of that statement, Mr. Secretary.

In the first full paragraph you referred to various amendments which have been submitted to the committee.

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. And you say: "I regard their incorporation into the bill as indispensable."

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. Could you tell us, please, what are the major amendments to which you refer, and which you regard as indispensable for incorporation into the bill.

Secretary SCHWELLENBACH. Have you seen the amendments?

Senator DONNELL. I do not think I have seen them at all. No, sir.

Secretary SCHWELLENBACH. What is the status of those?

The CHAIRMAN. Of the amendments?

Secretary SCHWELLENBACH. Yes.

The CHAIRMAN. They have been submitted to the committee, but they have not been gone over. You might introduce them in the record at this time.

(The amendments referred to are as follows:)

PROPOSED AMENDMENTS TO S. 1606

1. Page 13, line 24: Insert after the word "children" the words "(under 18 years of age)."

2. Page 14, line 1: Insert after the word "services" the following:

in the community, by providing supplementary personal health services needed by maternity cases or children entitled to personal health service benefits under title II of this Act, and any personal health services needed by maternity cases or children not entitled to such benefits.

Page 14, line 3: Insert after the word "demonstrations" the following: "research".

3. Page 14, delete lines 5 and 6 and substitute the following:

to be appropriated for the fiscal year ending June 30, 1947, the sum of \$50,000,000, and for each fiscal year thereafter a sum sufficient to carry

Page 17, delete lines 3 and 4 and substitute the following:

authorized to be appropriated for the fiscal year ending June 30, 1947, the sum of \$25,000,000,000, and for each fiscal year thereafter a sum sufficient

4. Page 14, line 18: Insert at end of line:

"Provided that, to the extent feasible, the plan shall be submitted by the same State health agency as that utilized by the Surgeon General in furnishing services under title II, sec. 203 (e)."

Page 14, line 17: Delete the word "the" before the word "State" and substitute the word "a".

Page 14, line 18: Delete the word "the" before the word "State" and substitute the word "a".

Page 38, line 4: Change period to comma and insert:

provided that, the Surgeon General shall, to the extent feasible, utilize the same State health agency as that submitting, and having approved, plans under title I, part B, sec. 121.

5. Page 16, line 1: Insert the word "community" before the word "services."

Page 16, line 4: Delete the word "and" at the end of the line and add subsection (9), as follows:

"(9) provide that as personal health services are furnished under the plan they shall be available to all maternity cases and to all children in the State or

locality who are not entitled to such services as benefits under title II of this act and who elect to receive such services under the plan."

6. Page 16: After new subsection (9) insert new subsection (10) to read as follows:

"(10) provide for granting to any mother or person acting in behalf of a child whose claim with respect to care or services under the plan is denied, or to any physician or other person, organization, or institution, participating or desiring to participate in furnishing services or facilities under the plan, an opportunity for a fair hearing before the State health agency."

Page 16, line 5: Change the numbering of old subsection (9) to subsection (11).

7. Page 24, line 3: Insert after the word "members" the following: "and, as necessary, technical advisory committees."

8. Page 25, after line 2, insert the following:

"(d) Under a state plan approved by the Chief of the Children's Bureau with respect to Sec. 121, personal health services may be provided through (1) payments to the persons or institutions furnishing such care, or (2) direct provision of such care, or (3) through arrangements by the State agency with the Surgeon General of the Public Health Service for services furnished under Title II of this Act, on the basis of equitable payments to the Personal Health Services Account established under Title II of this Act, or through any combination or modification thereof."

Page 25, line 3, change "(d)" to "(e)."

9. Page 37, line 3, insert the following at the end of the line:

including payments to State agencies for personal health services given in accordance with arrangements made by the Surgeon General with such State agencies under plans approved under title I.

10. Page 78, line 7, insert new section 301 as follows:

"Sec. 301. Whenever funds are paid to a single State agency under two or more parts of Title I, or under one or more of such parts and also under Title II, the State agency may commingle such funds and account therefor by such accounting, statistical, sampling, or other methods as may be found by the Federal administrative officer or officers authorizing such payments to the State agency to afford reasonable assurance that such funds are expended for the purposes of the respective parts or titles of this Act."

Page 78, line 7: Change numbering of "Sec. 301" to "Sec. 302."

KATHARINE F. LENROOT,
For the Secretary of Labor.

HARRY N. ROSENFIELD,
For the Federal Security Administrator.

MARCH 29, 1946.

Secretary SCHWELLENBACH. So far as the amendments are concerned, like all other amendments, they are not capable of understanding unless you have an explanation of them. These are the amendments.

Senator DONNELL. Yes, sir.

Secretary SCHWELLENBACH. For example, it says, page 13, line 24, insert after the word "children" in the words "under 18 years of age."

Dr. Eliot is here and will be the next witness.

Senator DONNELL. She will testify on that phase of it?

Secretary SCHWELLENBACH. Her particular task will be this testimony about the amendments.

Do you want me to read the report that I made?

Senator DONNELL. What I would really like to get at is this, Mr. Secretary: in your statement, that sentence appears: "I," and I take it that is the personal pronoun "I", Lewis B. Schwellenbach.

Senator SCHWELLENBACH. Yes.

Senator DONNELL. (reading):

regard their incorporation into the bill as indispensable.

Now, I would like to know, preferably by memory, if you could give it to us that way, which of those amendments proposed to this

bill, and which have been submitted to the committee, you regard as of especial importance.

Secretary SCHWELLENBACH. Well, we went over them all and I have a feeling that each one of them is of importance. I would not pick out any one.

Senator DONNELL. Mr. Secretary, I know you will not take offense to this line of questioning. You realize what I am getting at is to find out what is your own personal opinion.

May I just ask you this: Can you tell us, preferably by memory, what you regard as the most important of those amendments that have been proposed?

Secretary SCHWELLENBACH. I think, if you insist upon the question—

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. I think I would say amendment No. 3 is the most important.

Senator DONNELL. Amendment No. 3?

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. Now, I think the record might show that the Secretary, before making his response, examined the memorandum which is before him. I wonder if I might have a copy of that so that I might question the Secretary on that.

The CHAIRMAN. Yes, you may.

Senator DONNELL. Do you have a copy?

Secretary SCHWELLENBACH. This is a letter which I wrote to the committee. What I actually have here is a copy of the letter I sent to the House committee on the same bill.

Senator DONNELL. I see.

Secretary SCHWELLENBACH. But I wrote a letter to the committee.

Amendment No. 3 is the cost of maternity care and medical care of children under 18 years of age in noninsured families who elect to participate, and also the cost of supplementary health services for insured maternity patients and children to be met under title I, part B, administered by the Children's Bureau and State health agencies.

We have a program now. The Children's Bureau, for years, has been handling the program for the betterment of the condition of children, particularly health.

We want to be sure that the adoption of this bill would not deprive those who are now eligible under State plans of the same care that they are able to get under the State plans at the present time.

Senator DONNELL. Do you remember, Mr. Secretary, any amendment which was proposed by your Department or yourself to title II of this S. 1606? I am just inquiring whether you remember it.

Secretary SCHWELLENBACH. No; I do not remember.

Senator DONNELL. You do not remember. And are you able to remember any other amendment? Any other amendment proposed to title I, after reference to the memorandum here this morning?

Secretary SCHWELLENBACH. I am going over these amendments. There are nine of them, as you see.

Senator DONNELL. I have not seen them as yet. I am not questioning the statement, but I am not familiar with any of them, not having seen them before.

Secretary SCHWELLENBACH. The first one is the insertion of the words "under 18 years of age" to make certain that that is the age limit.

Senator DONNELL. Where is that to be inserted?

Secretary SCHWELLENBACH. Page 13, line 24, after the word "children."

Senator DONNELL. Line 24. What are those words?

Secretary SCHWELLENBACH. "Under 18 years of age."

The CHAIRMAN. Page 13 line what?

Secretary SCHWELLENBACH. Twenty-four.

Senator DONNELL. Who suggested that amendment, Mr. Secretary?

Secretary SCHWELLENBACH. The Children's Bureau.

Senator DONNELL. You did not personally consider that amendment, did you, and study that?

Secretary SCHWELLENBACH. No; there is no question about it. The Children's Bureau has a group of what I think are some of the finest and most competent experts in the country.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. And Miss Lenroot and Dr. Eliot came up, and we went over the provisions insofar as they referred to children, and they concluded that these amendments should be inserted in the bill.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. I discussed them with them. They explained them to me, and upon the basis of their recommendations, I say that I consider them very essential to the bill.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. I think that you will find in any department of Government that a situation where certain amendments should be made to a piece of legislation, amendments involving questions in which there are particularly skilled experts, trained by work and long experience, that the recommendations of these experts are accepted. There is no question about it. I will not dispute it with you. I did not prepare these amendments. I did not think of them. They were prepared by experts.

Senator DONNELL. The point I am getting at is what I regard as fundamental. This is not a criticism of you. If there is any criticism, I think it is of the entire system.

We have, in your presence here this morning, illustrated the prevalence of the practice of bringing in the heads of departments, who incorporate into their statements what purports to be their own personal opinion, as for illustration, "I regard their incorporation into the bill as indispensable."

Secretary SCHWELLENBACH. When Miss Lenroot and Dr. Eliot came in and told me these amendments were necessary, I accepted their views, and they became my views.

Senator DONNELL. I understand your statement on that, Mr. Secretary.

The point I make is this: that it appears to me what we really should have here, and this is not at all critical of you, what we should have is the personal opinion of the people who have studied these matters, rather than merely the use of the prestige of the name of the member

of the Cabinet of the President of the United States, who, naturally, could not possibly give detailed personal attention to all these details.

Secretary SCHWELLENBACH. May I say something off the record?

Senator DONNELL. You certainly may.

(Discussion off the record.)

The CHAIRMAN. May I ask a question, Mr. Secretary?

Senator DONNELL. Is this on the record?

The CHAIRMAN. Yes.

Senator DONNELL. I think we ought to have all this on the record if we are going to have some of it.

Secretary SCHWELLENBACH. Well, I just wanted to make that off the record.

The CHAIRMAN. As I understand you, Mr. Secretary, the heads of these departments that are under your jurisdiction took this subject up with you and went into it in detail?

Secretary SCHWELLENBACH. Yes.

The CHAIRMAN. And discussed the amendments, and showed the reason for the amendment, and as the result of your study of the amendments with them, you agreed that these amendments were proper to this bill?

Secretary SCHWELLENBACH. Plus my confidence in their ability and integrity and study and understanding of this particular subject; yes.

The CHAIRMAN. Yes. And after your careful consideration of their recommendations, you accepted them, and are willing to support them as necessary amendments to this bill?

Secretary SCHWELLENBACH. Yes; that is right.

Senator DONNELL. Now, Mr. Chairman, I want to make it perfectly clear that I intend no courtesy in the slightest to the Secretary. He was requested to come to this committee. He is here. He is courteous, as he always is, and we are glad to have him.

But the practice, nevertheless, to my mind, is decidedly improper, to bring in the heads of Departments who obviously cannot take the time to go into the details of these matters and then have prepared statements made up by somebody else which they read to the committee using the personal pronoun as their opinions, whereas what we should have, as I see it, would be the opinions of the persons who can personally study these matters, and that would serve us most usefully.

Secretary SCHWELLENBACH. Dr. Eliot is here.

Senator DONNELL. Yes, I know; and it is proper she should be, and I am not saying it is improper for the Secretary to be here.

Secretary SCHWELLENBACH. It is true that the statement was prepared, but I cut a lot of things out of the statement.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. Just because I do not write them does not mean I accept them as written. I frequently rewrite them. Many statements which I do not approve of are eliminated.

Senator DONNELL. Mr. Secretary, this statement right here that I asked you in substance and you answered it in substance, this statement, which consists of 12 sheets of paper, did you prepare any of it personally?

Secretary SCHWELLENBACH. Did I personally dictate any of it?

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. No, sir. I eliminated a number of parts from the original draft.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. I suggested certain changes.

Senator DONNELL. Yes. Now, there is a quotation in here from the American Medical Association which is at page 8.

You say, "apparently takes the position, with respect to the average person in the low-income group, that 'despite the absence of a large financial reserve he gets by very well,'" and so forth.

I dare say, Mr. Secretary, that you could not tell us here personally what the context is in which that is used by the American Medical Association, or what publication?

I am talking about you personally, what publication that appears in of the American Medical Association, could you?

Secretary SCHWELLENBACH. It was a statement by Dr. R. L. Senenich, chairman of the board of trustees, American Medical Association, printed in Health Insurance in America. It was a publication of the Chamber of Commerce of the United States.

Senator DONNELL. Did you see it in that publication, or was that information given to you by somebody else who prepared this portion of this statement?

Secretary SCHWELLENBACH. The information was secured by somebody else. That is true.

Senator DONNELL. You have not seen that publication or the statement by Dr. Senenich, yourself, have you?

Secretary SCHWELLENBACH. No; I have not.

The CHAIRMAN. It seems to me this is irrelevant. If the statement is not true, if it is an incorrect statement, of course, it would be proper for you to show that, Senator, but it seems to me that if the statement is made and is taken from some publication, the Secretary would be entitled to regard it as truthful and accurate. If it is not, why, it would be easy for someone to show that it is not.

Senator DONNELL. I am not raising a question as to the correctness of the quotation. I do not know the context, however, and neither does the Secretary, in which this is used.

The CHAIRMAN. What difference would it make, whether he saw the original statement at the time it was published, or whether he read it in some newspaper. If it is true, that is the important thing.

Senator DONNELL. Have you ever read it anywhere in any newspaper or anywhere else?

Secretary SCHWELLENBACH. I never read it.

Senator DONNELL. You never have read it.

The CHAIRMAN. Has it been called to your attention?

Secretary SCHWELLENBACH. It was printed in this particular publication "Health Insurance in America."

The CHAIRMAN. And it was called to your attention as an authoritative statement by the member of the Medical Association?

Secretary SCHWELLENBACH. Chairman of the board of trustees.

The CHAIRMAN. If we continue with a fine-tooth comb like this, we will go on all summer. It is either true or it is false, and it seems to me if the Secretary says that the matter was called to his attention, and he accepted it as correct, he would have a right to rely on it.

Senator DONNELL. Well, Mr. Chairman, with all due respect to the opinion of the chairman, the point I make is that the Secretary does

not himself know whether there is any word of this in this publication from which he quotes. He has not seen it. He has never seen it mentioned in a newspaper, even.

And yet he comes in here with a statement in which he tells what he has heard.

"I have also heard it said that 'the bill goes too far,'" giving a personal opinion on matters which obviously he could not form, certainly to the extent of making these matters as personal as this statement would appear.

That is not said critically of the Secretary, but it is said critically of this plan of bringing into these committee hearings the heads of Departments, who obviously cannot testify, and the main purpose, in my judgment, of the use of these gentlemen is in order to get the prestige of a Cabinet official, or of some outstanding official appearing.

I am not questioning that the American Medical Association said this. I am not questioning it came from this document that he says it did.

But I do say, as the Secretary himself said, that he never saw the document or a newspaper reference to it. I am correct on that; am I not?

Secretary SCHWELLENBACH. I just happen to have confidence in the people that work in my Department. When they tell me a certain statement is made I believe them. I have a lot more confidence in those people, apparently, than you have.

Senator DONNELL. That is not a question of confidence. I know Dr. Eliot. She was in my office in Jefferson City. She is a cousin of a neighbor of mine in Webster Groves, Mo., and I have confidence in her, and I have confidence in the Secretary, but the point I make is this: Let me ask this question, Mr. Secretary. You have served upon the Federal bench of this country?

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. If this statement were to be brought in to a Federal court and read by a witness in evidence, as against objection, there is a very large part of it that would be stricken out. You agree to that, do you not, and that the court would not permit the witness to state it because of his lack of personal knowledge?

You agree to that; do you not?

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. For instance, this statement that the American Medical Association says this, when the witness never saw it.

Secretary SCHWELLENBACH. On the ground that it is hearsay; yes.

Senator DONNELL. Hearsay, and would be stricken out.

Secretary SCHWELLENBACH. Yes.

I never understood that congressional committees were limited to the same rules of evidence that the courts are.

Senator DONNELL. I agree with the Secretary, but I do say this: that in weighing the degree of prestige to be given to this statement, coming from the Secretary of Labor, a member of the Cabinet of the President of the United States, we have a right to determine how much of it he personally knows, the basis of these statements, who prepared these statements, and matters of the type to which I have addressed myself.

The CHAIRMAN. Is not the same practice carried on every day on the floor of the United States Senate? Statements are made, sometimes quotations from newspapers.

Senator DONNELL. Yes.

The CHAIRMAN. And the Senate debates a problem or question, and if the statement is not correct, of course, other Senators have a right to call attention to the qualifications of the statement which should be made.

Senator DONNELL. Yes.

The CHAIRMAN. And that is the way they discuss and debate legislation every day, and every committee of the Senate follows the same practice.

If that statement is not a correct statement, it would be a very simple matter to dispose of.

Senator DONNELL. Mr. Chairman, I am not questioning that the American Medical Association used this language. I have just as much faith as the Secretary does in the persons who have given him this information, but I still maintain that it is a problem here, when the Secretary has, in pursuance to a request from this committee, courteously come before it, that we are entitled to inquire into the degree of personal knowledge he himself has.

I know that he does not object.

Secretary SCHWELLENBACH. No.

Senator DONNELL. He is pleasant and courteous and kind in the matter, as he always is. And I think the statement that goes out of here, goes into our records, goes into the press of the Nation, is the statement not of the gentleman in the Solicitor's Office, not the statement of Miss Eliot, not the statement of someone else, but the statement of the Secretary of Labor, and it carries a tremendous prestige, and we are entitled to inquire into the degree of personal knowledge, as I see it.

I want to ask you this, Mr. Secretary—

The CHAIRMAN. Before you go any further in the matter—

Senator DONNELL. Yes, sir.

The CHAIRMAN. It seems to me that the Secretary of Labor is here representing the Department of Labor, and he is expressing the views of the Department. He has to report to the President, and only through him can the Department operate.

He represents the Department, and he is here speaking for the Department, and naturally, on matters of this kind, he has to depend upon the personnel of his Department. He takes people who are qualified and expert on these problems. They come before him, discuss the matter, lay before him the questions and recommend certain amendments.

Now, it seems to me that is the only way a democratic government can operate. He comes in with the recommendations of his Department, and certainly I cannot see the wisdom of going into all this detail of cross-examining the Secretary with reference to each letter and each jot and tittle in this statement.

It represents his views, after full consideration with his Department, of what should be done.

Senator DONNELL. Mr. Secretary, I believe you stated that in your 6 years of service in the United States Senate, the practice did not prevail at that time of bringing the Cabinet officers into the com-

mittees, at least to the extent that the practice has subsequently developed? That is correct, is it not?

Secretary SCHWELLENBACH. That is right.

Senator DONNELL. Yes, sir.

Now, Mr. Secretary, the chairman has referred to experts in the Department. Who is the expert in your Department on health insurance?

Secretary SCHWELLENBACH. Well, insofar as the statement is made in reference to health insurance, it is secured through a study of various documents.

Except to the extent that the Children's Bureau assists in the administration of Maternal and Child Health and Crippled Children's Services, under title V of the Social Security Act, we do not have any relation with the Social Security.

Senator DONNELL. Your department does not have an expert on health insurance, does it?

Secretary SCHWELLENBACH. No.

Senator DONNELL. I am correct in that, am I not, that your Department, the Department of Labor, does not have an expert on health insurance. That is correct, is it not?

Secretary SCHWELLENBACH. Yes. I think that is right.

Senator DONNELL. You, however, have included, as you say, in the amendments which have been submitted to this committee, various amendments applicable to title II, which is the health-insurance provision of this act. Am I right in that?

Or are you able to tell us, Mr. Secretary, without reference to the documents, whether the Department has submitted any amendments relative to the health-insurance provisions of this act to the committee?

Secretary SCHWELLENBACH. Let me look and see now.

Senator DONNELL. Just take that down. The Secretary says: "Let me look and see now."

Secretary SCHWELLENBACH. I really have no objection to your method of cross examination. This is a difficult and long bill, as you know, as you have indicated. Amendment No. 9.

Senator DONNELL. Amendment No. 9.

Secretary SCHWELLENBACH. Page 37.

Senator DONNELL. Page 37.

What is that, Mr. Secretary?

Secretary SCHWELLENBACH. Line 3.

Senator DONNELL. Yes, sir.

Secretary SCHWELLENBACH. Insert the following at the end of the line—

including payments to State agencies for personal health services given in accordance with arrangements made by the Surgeon General with such State agencies under plans approved under title I.

While it goes to title II, it actually applies to title I.

Senator DONNELL. I see.

Secretary SCHWELLENBACH. Then, on page 78.

Senator DONNELL. 78. Yes, sir. That is the last page of the act.

Secretary SCHWELLENBACH (reading):

Whenever funds are paid to a single State agency under two or more parts of title I, or under one or more of such parts and also under title II, the State agency may commingle such funds and account therefor by such accounting,

statistical, sampling, or other methods as may be found by the Federal administrative officer or officers authorizing such payments to the State agency to afford reasonable assurance that such funds are expended for the purposes of the respective parts or titles of this act.

Senator DONNELL. Yes, sir.

Secretary SCHWELLENBACH. That, again, is a relationship between title I and title II.

Senator DONNELL. Yes, sir.

Secretary SCHWELLENBACH. You asked about experts.

Senator DONNELL. Yes, sir.

Secretary SCHWELLENBACH. The Children's Bureau has been the Bureau which has distributed the funds appropriated by Congress to State agencies for many years.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. And they do know about that. They know more about it than anybody in the country.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. And they felt that to make sure that there be the proper distribution of the funds resulting from their experience in the grants-in-aid to States under the act which authorizes them to allocate the funds to the States, where title I was involved and also title II, that those two amendments were necessary.

Those are the only amendments to title II.

Senator DONNELL. Those are the only amendments to title II; yes, sir.

Secretary SCHWELLENBACH. They do not relate to the question of health insurance, as such.

Senator DONNELL. They go as to the relationship between title I and title II, as you have indicated in your statement.

Secretary SCHWELLENBACH. Yes, sir.

Senator DONNELL. Mr. Secretary, is there anyone in the Department of Labor who has been directed to specialize along the line of study of compulsory health insurance in other nations? The experience that other nations have had in compulsory health insurance? Anyone in your Department who has been instructed by you or at your direction to make a study of the experience of compulsory health insurance in other nations?

Secretary SCHWELLENBACH. Unless the Bureau of Labor Statistics has been directed by the Congress to do it, I have not directed it, and it has not been done since I have been in, for 10 months.

Senator DONNELL. And you have not been informed of the fact that anyone has been directed by Congress or anyone else in your Department to make a study of the experience in compulsory health insurance in other nations. I am right in that, am I not?

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. Yes.

Mr. Secretary, have there been some of the members of your Department assigned to work on S. 1606; that is, to study it?

Secretary SCHWELLENBACH. Well, whenever a bill is sent to us—

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. By the chairman of a committee it is sent to the Solicitor's Office and studied by the Solicitor's Office, to find out the various parts of the bill which various bureaus might be interested in.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. And that information is gathered together, and they have staff meetings about it.

Ultimately I meet with them separately or with them together, and discuss the various provisions of the bill.

And, so far as assigning anybody to work on S. 1606 in the sense that anyone had a special job to do that, the answer is "No".

Senator DONNELL. My recollection is that Dr. Weinerman, who testified here yesterday, stated, did he not, Mr. Chairman, that he is now employed in the Department of Labor?

Senator PEPPER. No. Agriculture.

Senator DONNELL. The Department of Agriculture. Very well.

Now, Mr. Secretary, this bill is divided into how many parts? You referred to part 1 and part 2. How many parts are there in that sense in this bill?

Secretary SCHWELLENBACH. Well, there is the title I and title II.

Senator DONNELL. Yes. I should have called them titles. How many titles are there in the bill?

Secretary SCHWELLENBACH. I have read this bill a good many times, and it has been an extremely difficult bill, Senator.

Senator DONNELL. Yes. Well, there are two titles, title I and title II.

The CHAIRMAN. Two main titles. The last title is general provisions, title III.

Senator DONNELL. That is the separability title.

Secretary SCHWELLENBACH. In title II there are a lot of definitions of words in title II that ordinarily come in the first part, a sort of preamble to the bill.

Senator DONNELL. Yes.

Now, Mr. Secretary, is title I of the bill prepared on the theory of grants-in-aid by the Federal Government to States for the operation of State plans, do you remember?

Secretary SCHWELLENBACH. Well, money is to be spent by the Children's Bureau, which was increased from about \$500,000, which is all we have had in the past, to \$5,000,000. To that extent, it is not a grant-in-aid exclusively.

Senator DONNELL. Where is that in the bill, Mr. Secretary, if you have it; that portion you are referring to?

Secretary SCHWELLENBACH. Page 25.

Senator DONNELL. 25.

Secretary SCHWELLENBACH. Section 130.

Senator PEPPER. Mr. Chairman, I would like to intervene just to make an observation to my good friend, Senator Donnell.

We are here for the purpose of trying to find out whether it is in the public interest to adopt this bill or not, and with all deference and respect to my colleague, he is conducting this examination as if the Secretary were a criminal instead of a Cabinet official, and he is trying to find out whether he is entitled to probity and credibility.

Secretary SCHWELLENBACH. Well—

Senator PEPPER. Whether there are two titles; what are the numbers? The Senator, I assume, knows the number of titles in the bill.

To ask a Cabinet official how many titles are in the bill can only be for the purpose of trying to show that the Cabinet officer does not know anything about the bill.

I do not think that the Senator, upon reflection, would want to encumber the record and take the time of the Secretary and his colleague with that kind of rather petty cross-examination, if he will permit me to say so.

I hope that, since the Secretary has indicated he has read the bill several times, and he has come here to testify about its substance and contents, that the able Senator will confine his inquiry to the substance and substantial merits of the matter and some of the substantial things which the Secretary said, which the Senator has every right to controvert in any way he might want to do so.

Is that not a fair suggestion?

Senator DONNELL. Mr. Chairman, I appreciate the suggestion from my friend, the Senator from Florida, but I may say this, that I think the Secretary would not at all coincide in the statement that I have conducted this examination as if the Secretary were a criminal.

Senator PEPPER. I withdraw that.

Senator DONNELL. Mr. Secretary, has there been anything like that presented to you this morning?

Secretary SCHWELLENBACH. No. I do not think there is much sense in some of the questions, but I do not mind it.

Senator DONNELL. There is a disagreement, and every person must use his own judgment.

I may say to the Senator from Florida, that the theory in which my questions are asked of the Secretary was that the Secretary of Labor comes here with great prestige, and justly so.

The statement that he makes goes out all over the Nation as the statement of the Secretary of Labor, and is entitled to great weight from that standpoint.

I think it is perfectly filled with sense, if I may use that expression, to interrogate the Secretary as to his own personal knowledge of the contents of the statement which goes out of here with the personal pronoun "I," expression of opinion.

I think we are entitled to know, and I think in any proceeding in the land, before a Senate committee, House committee, or a court, the examination I am making is perfectly proper.

Senator PEPPER. You are exactly right. In a technical court, where you were trying to break down the witness and show he had not personally observed everything he talked about, in a court of law, where a trial was being carried on, the Senator is absolutely correct, and he has followed that procedure all through this case, as if he were trying a bitterly contested lawsuit, and subjecting every witness to the most scrutinous and most severe cross-examination which he, as a very eminent lawyer, is able to apply; and I put, at rather long last, the point as to whether the Senator thought we were trying a bitterly contested lawsuit here, and that we had to apply to every witness all the cross-examination which the able Senator is able to apply to a witness in a lawsuit.

If we are trying a lawsuit, we can draw this thing out for 6 months, but I was hoping that the Senator would not ask every witness how many titles were in the bill and all the little things that have but one purpose, and that is trying to make a meticulous inquiry of every word. And all the time the Senator is asking these questions, he is sitting at the counsel table advised and assisted by an expert handing him papers and giving him counsel.

Senator DONNELL. Yes, which I think is extremely valuable.

Senator PEPPER. I do not complain about that, with all deference to the Senator. He has brought out some very fine points.

But could he not regard this as a hearing before a Senate committee, where we are trying to get the facts, and limit his cross-examination to questions that would be a little bit more to the general merit and content, rather than the character of cross-examination in the courts.

I submit that with all deference and friendship to the able Senator from Missouri.

Senator DONNELL. I appreciate the courtesy of the Senator from Florida.

I still submit, however, that inquiry as to the personal knowledge of a witness is of importance, and I think that the examination that I have conducted is entirely proper.

The CHAIRMAN. Well, of course, under our system, it seems to me that the witness here is representing the Department of Labor and could not be expected to know every detail and every ramification of every question that comes into the Department of Labor.

He is responsible to the President, and through him to the people, for everything that goes on in the Department.

He must identify himself, or disassociate himself from every departmental opinion or statement of fact publicly expressed.

He is here talking for the Department of Labor, not for himself.

He is here voicing what the Department of Labor, through all of the personnel that he has under his charge, thinks.

He could hardly be required to know every single item, every single detail of every problem that comes into the Department of Labor.

That is not expected, and I think that the questions that are being propounded to him are questions which should come up probably in an executive session of the committee, when we will consider the provisions of the bill, and when we could have sitting with us experts to aid us in the correct phraseology that should be put into the bill.

Senator DONNELL. Mr. Chairman, on the one hand I am confronted by the objection made by the Senator from Florida that it is improper to inquire into the knowledge of the witness; and in the second place I am confronted by the objection of the chairman that I am not entitled to go into the questions of detail of the bill with the witness.

He has come here. And I repeat again that there is no desire on my part to be in the slightest discourteous, and I do not think that I have been, and I think we will concur. He comes in here and says, after mentioning certain amendments which he says has been submitted to the committee, and which have been, undoubtedly, but I have not seen them, "I regard their incorporation into the bill as indispensable."

That does not say it is the opinion of the Department. It is the opinion of the Secretary of the Department, a man who served on the Federal bench, a man who served in the Senate, and whose testimony goes out of here with prestige all over the United States, arising from those distinguished services which he has rendered.

May I ask you this, Mr. Secretary: Have you read the testimony submitted by the Public Health Service to this committee? Have you read it yourself?

Secretary SCHWELLENBACH. No.

Senator DONNELL. Do you know who testified on behalf of the Public Health Service to this committee?

Secretary SCHWELLENBACH. No.

Senator DONNELL. Let me read you this sentence, and this again is not said critically of you but of the system—at page 3 you say:

I am sure you all must have been impressed, as I have been, with testimony submitted by the Public Health Service to your committee—

Et cetera.

Now, you have not read it and you never saw a line of it, did you?

Secretary SCHWELLENBACH. I think your criticism is absolutely right on that one.

Senator DONNELL. I think it is, too. I will not pursue this line of questioning further, but I think it has been developed here, first, that there has been a change in the plan that prevailed when the distinguished Secretary was in the Senate. In those days the Senate did not follow the practice of bringing in the top head man in the Department, at least to the extent they do now, like the Secretary of Labor.

In the second place, we have developed the fact that the Secretary did not write one word of this statement, although he said he struck out a portion of what was submitted to him.

Secretary SCHWELLENBACH. I made a lot of suggestions.

Senator DONNELL. I have no doubt of that, and I should amend my statement to that effect.

In the third place, as the Secretary himself correctly says without any qualification, he thinks my point where it says—

I am sure you all must have been impressed, as I have been, with testimony submitted by the Public Health Service to your committee—

that my criticism is sound, and is well founded. Am I right?

Secretary SCHWELLENBACH. I agree; I should not have said that.

Senator DONNELL. Yes, sir. In the next sentence, you say:

It is clear, I think, that there is ample basis for the conclusion reached by the Public Health Service that —

maybe you agree with that?

Senator PEPPER. Allow me, at that point, to say this: Will you note the two conclusions attributed to you, and state whether or not you do, as an individual sitting here persona, not in absentia, agree with those conclusions?

Secretary SCHWELLENBACH. Yes, sir. And I might tell the Senator I have had a little experience in the medical business. I practiced law in the city of Seattle for a good many years. I represented an insurance company.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. I have had personal contact.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. With all of the leading members of the medical profession there.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. And I had a lot of experience with reference to the matter.

About every night, I would get into an argument with one of them.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. About this general question.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. And I told them then. I remember, I made a speech before the Kings County Medical Association, probably in 1925.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. In which I told them unless they would change their system and start out immediately upon a voluntary system, that the time was going to come when the Government was going to take this up.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. I never got very far in any of my arguments or any of my discussions.

Senator DONNELL. Yes.

Secretary SCHWELLENBACH. This is not a new matter to me. I have been thinking about it for a long time.

Senator DONNELL. I think when the Secretary tells us that, he is perfectly within his rights, and we are glad to have him give that information.

But I do think that when a statement is made here, "I am sure you all must have been impressed, as I have been, with testimony submitted by the Public Health Service to your committee," and then Mr. Secretary testifies he never saw that testimony, and I take it did not know what was in it, I say that is not proper, and the Secretary agrees with me.

Secretary SCHWELLENBACH. Yes; I agree with you.

Senator PEPPER. At that very point, that language is:

I am sure you all must have been impressed, as I have been, with testimony submitted by the Public Health Service to your committee, showing that cancer, rheumatic fever, heart disease, and pneumonia "are accounting for an ever-increasing number of deaths."

Mr. Secretary, do you agree with that statement personally?

Secretary SCHWELLENBACH. Yes, I will agree with that statement. I do agree with the Senator that I should not have put in the words "as I have been."

Senator PEPPER. The substance of what is stated expresses your own personal conviction, "cancer, rheumatic fever, heart disease, and pneumonia 'are accounting for an ever-increasing number of deaths.'" That was the substance of the statement, and that expresses your personal conviction?

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. Well, Mr. Chairman, I may say that it appears to me, and I am not charging the Secretary with insincerity, as I understand it, this sentence says to the public of the United States that the Secretary had been impressed with testimony submitted by the Public Health Service to the committee, whereas the Secretary had never seen it and frankly admits it was a mistake to have put in the words "as I have been."

Senator PEPPER. Again, as I said, if there were a jury of 12 men sitting over here in the corner, and able counsel was trying to discredit the probity of this witness to that jury, it might be arguable to say that this witness had heard that statement given, but does the Senator think it makes any difference to this committee of the United States Senate, whether that particular thing is as stated by the Secretary or not?

Senator DONNELL. Yes. Here comes a statement to this committee, presented to this committee, and had it not been for the cross-examination of the Secretary, which was not due to any lack of probity, for I have the highest respect for the Secretary's integrity, but the committee would have understood that the Secretary had himself read this testimony and had been impressed with its contents, and he had not read it at all and admits that statement should not have been there.

Senator PEPPER. Does the committee care whether the Secretary heard the testimony or whether he saw it or whether he personally believes that "cancer, rheumatic fever, heart disease, and pneumonia 'are accounting for an ever-increasing number of deaths.'" Is that not the important thing about this hearing? As to whether they are or are not, and what do we care about whether the Secretary is technically inaccurate about some testimony.

What has that got to do with this case, unless you are trying to discredit the probity and credibility of the Secretary of Labor?

What has that got to do with the merits of the health bill?

Senator DONNELL. The question is asked, and I will answer it.

In the first place, I am not attacking the probity of the Secretary. I repeat again, I have the greatest respect for his integrity, but here comes a statement which purports to be a statement of Lewis B. Schwellenbach, Secretary of Labor. It does not say anything about it being the opinion of the Department.

I appreciate very much this opportunity to give to the Committee on Education and Labor my views on S. 606—

et cetera. And he says:

must have been impressed, as I have been, with testimony submitted by the Public Health Service to your committee.

I would say, if the committee had before it the information that the Secretary had studied that testimony and become impressed with its contents, it would carry a great deal of weight.

I will not discuss that further.

The CHAIRMAN. I would like to make a brief statement there.

Senator DONNELL. Yes, sir.

The CHAIRMAN. It seems to me that the Secretary has already explained fully the circumstances under which this statement was prepared.

He said that he sat in with the different officers in his Department and went over these matters. He made some corrections. He struck out some things, and discussed these amendments. And finally, as the result of his full conference, he accepted this as a statement which could be properly made before this committee.

Senator PEPPER. As representing his views.

The CHAIRMAN. As representing his views, and the views of his Department. He has a right to rely on them.

We could not operate our country on the basis of a single individual knowing everything that transpires in his Department. It is utterly absurd to question his right to come in here depending upon the advice and assistance he gets in his Department.

Senator DONNELL. There has been no such contention, Mr. Chairman. I think it is perfectly proper for him to come in thus.

The CHAIRMAN. And he has explained his position.

Senator DONNELL. He is giving his judgment, and I am glad to have him do so.

Do you recall whom it was you heard say that this bill goes too far? Do you remember who that was?

Secretary SCHWELLENBACH. I have read that in numerous newspaper articles and speeches made against the bill.

Senator DONNELL. Very well. You do not recall the particular individuals that made that statement, however, that the bill goes too far?

Secretary SCHWELLENBACH. I think Dr. Fishbein.

Senator DONNELL. Dr. Fishbein of the American Medical Association?

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. Yes. Now, Mr. Secretary—

Secretary SCHWELLENBACH. I could give you the names of some doctor friends of mind, but I do not care to do that.

Senator DONNELL. Very well.

I notice, on page 9 of your statement, that—

Laissez-faire is the traditional last resort of those who are dogmatically opposed to the assumption by the people of cooperative responsibility for the elimination of unnecessary hazards to employment at fair wages, to a secure old age, and to good health.

Are we to understand by that that you are opposed to the old ideas that used to be expressed, that that government governs best that governs least?

You do not agree with that?

Secretary SCHWELLENBACH. If you would examine my votes during the 6 years I was in the Senate, you would know.

Senator DONNELL. I would find the contrary on that?

Secretary SCHWELLENBACH. Very definitely.

Senator DONNELL. What is your thought there?

Secretary SCHWELLENBACH. The same sort of arguments were used against this bill which were used against every piece of social legislation we put through during that period of time.

Senator DONNELL. And you approach this problem with the view that the Government should take over more and more of the functions leading to the general public welfare; that is your general attitude, is it not?

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. That is what you mean by this comment on laissez-faire?

Secretary SCHWELLENBACH. Yes. The arguments being used are the same arguments which were used against the Social Security Act, and against every piece of legislation we put through trying to better the condition of the people of this country.

The CHAIRMAN. It was also advanced against the Utilities Holding Company Act and against the Securities and Exchange Act, and every other act that came up here for consideration during the entire time you served in the Senate.

Is that not right, Mr. Secretary?

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. Now, Mr. Secretary, you pointed out one respect in which title I has to do with something other than the operation of State programs.

I think you mentioned one.

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. Do you, generally speaking, favor the portion of the bill incorporated in title I insofar as it pertains to the grants-of-aid for the carrying out of State plans?

Secretary SCHWELLENBACH. Yes; subject to the amendments.

Senator DONNELL. To the amendments; I understand. Now, Mr. Secretary, that is on the theory, I think, at least in part, that the local State governments, the local people, the local administration, are able to analyze local needs generally speaking, somewhat better than the National Government, which is removed from the State to some extent; is that right?

Secretary SCHWELLENBACH. In some areas of the country, that is true, and in some areas, unfortunately, it is not true. If all of the States of the Union had as forward-looking ideas about the necessity of taking care of people as the State of Washington has, there probably would never have been any need for the Federal Government to have any social programs.

I am not making any comparison with Missouri. [Laughter.]

Senator DONNELL. I was going to ask about Missouri.

Secretary SCHWELLENBACH. There is at least one man from Missouri who has a very definite understanding of the needs.

Senator DONNELL. And that is the President, whom you have in mind?

Secretary SCHWELLENBACH. Yes, sir.

Senator DONNELL. Now, this legislation you understand to be favored by the Administration; is that right?

Secretary SCHWELLENBACH. Yes, sir.

Senator DONNELL. And you think it is in line with the recommendations of President Truman. Doubtless you are correct. That is your view, is it not?

Secretary SCHWELLENBACH. Yes.

Senator DONNELL. And your department is a department under the President of the United States, and you are giving expression to the views that were expressed in your statement as head of one of the departments in the existing administration; that is correct, is it not?

Secretary SCHWELLENBACH. That is right.

Senator DONNELL. Now, Mr. Secretary, have you personally studied the experience of other nations in compulsory health insurance?

Secretary SCHWELLENBACH. No.

Senator DONNELL. You have not. Have you studied the developments in recent years in the voluntary prepayment plans, such as the Blue Cross and like media?

Secretary SCHWELLENBACH. You say "study"? No; as I explained, I have had an interest in this subject for a number of years. I have probably a little more familiarity with them than most people have. However, as to making a study of it, I haven't done that.

Senator DONNELL. Not as you would brief a case before you as a judge. Now, Mr. Secretary, you say that—

The proposed National Health Act offers a firm foundation for the attainment of the objectives of better and more adequate medical care for all the people.

You are saying that without, therefore, as I understand it, the benefit of study of the experience of other nations in compulsory health insurance; am I right?

Secretary SCHWELLENBACH. That is correct.

The CHAIRMAN. I would like to ask: Is your judgment based upon your study of the situation in the United States?

Secretary SCHWELLENBACH. Yes. As I said a little while ago, I have had a very close contact with the medical profession, and I have great respect for them. It just happens that through the line of legal work that I did, I probably had more contact with the medical profession than any other lawyer in the city of Seattle. I attended a number of meetings of the medical association, which I was invited to attend, and the local chapter of the American College of Surgeons.

I know that the system that we have had, whereby individuals attempted to meet the necessities of medical attention, has not resulted in their receiving proper medical attention.

I said that, as I recall, at least 20 years ago, when I advised a meeting of the King County Medical Association at Seattle that they should take up these voluntary plans and work them out.

I think it was ten years after that before they even started. I do not mean that just because I told them that, they should have started out the next year to do it.

The voluntary system which I have seen working out in my own State provides a certain measure of protection. It is my understanding, which is general, that the State of Washington has about as many voluntary system plans, and the county medical associations have worked out plans there to as large an extent, as most any other State in the Union.

But people in low income groups, people who really need the assistance, are not the ones who get it. We have public clinics, but a lot of people do not want to go to a public clinic, since they are put through a means test and are required to answer a lot of questions before they are given the opportunity to get medical attention.

I think that the time has come when we have to work out a program whereby we can spread out the cost of medical care so that everybody will get it. It is not the fact that the person who gets really sick does not go to a doctor; it is the fact that 3 months before that person became really sick, he did not go to a doctor, for if he had gone to the doctor 3 months before, he would not have become really sick. It is a matter of prevention of that kind which is the proper and necessary thing; and the voluntary plan, as I have seen it work, has not included those people who need health protection the most in the country.

The CHAIRMAN. Mr. Secretary, in your statement here you set forth the medical expenditures of families in the various income groups at the bottom of page 5. Now, you do not know that statement to be correct of your own knowledge? You never made that study, did you, yourself?

Secretary SCHWELLENBACH. No.

The CHAIRMAN. Do you think that is any reflection on your credibility here today when you come to make a statement that this is true? You got the information, I assume, from somebody in your department?

Secretary SCHWELLENBACH. The Bureau of Labor Statistics makes those up.

The CHAIRMAN. And you feel that you have a right to rely upon that in giving your testimony here; is that true?

Secretary SCHWELLENBACH. Yes. I do not feel, however, that there has been any reflection on my credibility at all.

Senator DONNELL. No; there has been no reflection on the Secretary's credibility.

The CHAIRMAN. Well, as to the merit of your statement, the weight of your testimony, the fact that you do not know this of your own knowledge does not lessen the weight of your testimony it seems to me, in any degree.

Secretary SCHWELLENBACH. Many Senators go on the floor and use figures from the Bureau of Labor Statistics, and I do not think anybody has ever questioned their right to do that, to get information from recognized sources.

If we spent all our time gathering statistics, perhaps there would not be anything else done in this country.

The CHAIRMAN. Well, is it not the same thing with respect to all of the information and advice you have received in your Department on which you base this statement?

Secretary SCHWELLENBACH. Yes; all except the fact that I frankly state that I should not have said I was impressed with the testimony, because I did not read that particular piece of testimony, relating to the fact that they have reported to the committee that cancer, rheumatic fever, heart disease, and pneumonia "are accounting for an ever-increasing number of deaths."

It would have been correct if the sentence had read:

"I am sure you must have been impressed, as I have been, with the fact that testimony was submitted by the Public Health Service showing that cancer, rheumatic fever, heart disease, and pneumonia are accounting for an ever-increasing number of deaths."

The only reason I say I should not have used the words "as I have been" is that they imply that I actually have read that particular piece of testimony. I am perfectly willing to be criticized by the Senator from Missouri.

The CHAIRMAN. In using that language you had no intention of misleading or deceiving the committee in any way. You were merely relying on information that you received in your Department. Is that not it?

Secretary SCHWELLENBACH. Yes; except that I think the committee might very well have thought that I actually had read it; that is the reason that I withdraw that. The fact is that I did not read it.

Senator DONNELL. Mr. Chairman, there is one further question I would like to ask the Secretary.

ATTITUDE OF THE AMERICAN MEDICAL ASSOCIATION

Mr. Secretary, you referred to your contacts with the members of the medical profession while you were practicing your profession in the State of Washington.

Did you come in contact with the members of the American Medical Association?

Secretary SCHWELLENBACH. Oh, yes.

Senator DONNELL. Do you still from time to time come in contact with members of that association?

Secretary SCHWELLENBACH. On a little different basis than I did out there.

Senator DONNELL. Are you able to tell us whether or not you regard the members of that association as representative of the medical profession of this country?

Secretary SCHWELLENBACH. Every doctor that I have ever known, I have had great respect for.

Senator DONNELL. Most of them belonged to the American Medical Association?

Secretary SCHWELLENBACH. They all did; yes.

Senator DONNELL. Have you read the recommendations of the House of Delegates of the American Medical Association with respect to this measure?

Secretary SCHWELLENBACH. No, sir.

Senator DONNELL. So you did not take that into consideration in formulating your final opinion on the merits of this program?

Secretary SCHWELLENBACH. No; because my contacts were with the best doctors in Seattle and the best doctors in Spokane. I never agreed with them. They are part of the American Medical Association, the finest gentlemen I have ever met.

Now, that does not mean that because they happen to belong to the association and because the association as a whole takes a position, that I agree with them.

Senator DONNELL. I understand you disagree with them. You understand that your view here as expressed is diametrically opposed to the views of the American Medical Association?

Secretary SCHWELLENBACH. Yes. I have made speeches before the Seattle branch of the American Medical Association.

Senator AIKEN. I think, Mr. Secretary, that the members of the association as a whole have not had a lot to say about the policies determined upon by the house of delegates.

In other words, is Dr. Fishbein an example of the medical profession's views in this country?

Secretary SCHWELLENBACH. I do not care to comment on that. I do not know anything about the inside workings of the American Medical Association. I belong to some organizations myself, and I know how perfectly good organizations operate. They very many times do not represent the point of view of the members of the organization. But I am not saying anything there, because I know nothing about whether they have a referendum among all their members when the house of delegates passes upon a question.

Senator DONNELL. You are not undertaking to say whether the House of Delegates of the American Medical Association reflects the views of that association or not?

Secretary SCHWELLENBACH. No; I am not.

Senator AIKEN. I think all of us have heard a good many doctors criticize the association privately and quietly who do not dare to do it out loud for fear of consequences.

Senator DONNELL. You know, Mr. Secretary, as we do, all of us, that by far the great majority of all practicing physicians in this country belong to the American Medical Association; we know that, do we not, as a matter of general knowledge?

Secretary SCHWELLENBACH. It is pretty nearly necessary that they do.

Senator DONNELL. They do?

Secretary SCHWELLENBACH. If you want to get into that subject: Doctors like to get into hospitals, when they have patients who are sufficiently ill. They want to get their patient into a hospital.

Very often they have difficulty getting into a hospital if they do not belong to the medical association, which is a branch of the American Medical Association. I know of one doctor in Seattle whom I succeeded in keeping out of hospitals, but I had to do it because of the fact that he was not qualified as a member of the medical association.

Senator DONNELL. That is to say, he was a man that was not properly entitled in your opinion to be in the hospitals, and at the same time the Society had not taken him in either; that is correct, is it not?

Secretary SCHWELLENBACH. He was getting into hospitals despite the fact that every other doctor in town knew he should not be in the hospitals.

Senator DONNELL. And he was not able to obtain membership in the American Medical Association or the local medical society; is that right?

Secretary SCHWELLENBACH. Well, not on the basis of the methods and procedures that he used.

Senator DONNELL. But at any rate, Mr. Secretary, you are not undertaking to pass upon the question as to whether an expression by the house of delegates of the American Medical Association is fairly representative of the opinion of the medical profession; you are not undertaking to tell us that?

Secretary SCHWELLENBACH. No, I do not know anything about that matter.

The CHAIRMAN. You do not assume that every member of the American Medical Association is opposed to this proposed legislation, do you, Mr. Secretary?

Secretary SCHWELLENBACH. I cannot answer that question.

The CHAIRMAN. Do you know whether or not there are other groups of doctors in this country who belong to the American Medical Association but have organized themselves into separate groups for the purpose of supporting this kind of legislation because they believe it is necessary?

Secretary SCHWELLENBACH. I have been told that. I think if I would testify to it, the Senator would object.

The CHAIRMAN. It has been brought out here, I will say, during the course of the testimony, that a great many members of the American Medical Association are opposed to the position taken by that organization in opposition to this legislation, and they have organized themselves into groups for the purpose of making their feelings in this matter effective, and have been appearing here before this committee. So that there is no evidence here before this committee that every member of the American Medical Association is opposed to this legislation. In fact, the contrary is the truth.

Secretary SCHWELLENBACH. If I accept that, Senator, as being a statement from the Chairman—

Senator DONNELL. Mr. Secretary, I want to amend that statement very materially. For instance the only ones that I recall that have been mentioned as organizations are the Physicians Forum, which has a membership of 1,000, as compared with over 125,000 in the

American Medical Association, and one or two committees and other associations whose members have appeared here; plus two facts, first that it has been mentioned by different gentlemen who have testified here that they know doctors who are much opposed to the position of the American Medical Association, and plus the fact also that in a meeting held a few nights ago in New York City by the New York County Medical Association, the vote with respect to this pending legislation was slightly over 76 percent opposed to the legislation and slightly under 24 percent in favor of it. Now I would like to amend his statement to that extent.

The CHAIRMAN. I accept that amendment. I think that is very decidedly evidence that there is very considerable opposition right in the ranks of the American Medical Association to the position taken by the house of delegates, because in New York in the medical society that you just mentioned 24 percent of the doctors there opposed their position. That is in one single group.

Secretary SCHWELLENBACH. I have just as much confidence in the chairman of the committee and the Senator from Missouri as I have in the hands of my bureaus down here, and I will accept that. [Laughter.]

The CHAIRMAN. The next witness is Dr. Martha M. Eliot.

Dr. Eliot, you have a statement, I believe? Will you first state your name and official position that you occupy, and something with reference to your background in this field about which you are going to testify?

STATEMENT OF DR. MARTHA M. ELIOT, ASSOCIATE CHIEF OF THE CHILDREN'S BUREAU OF THE UNITED STATES DEPARTMENT OF LABOR

Dr. ELIOT. I am Dr. Martha M. Eliot, Associate Chief of the Children's Bureau of the United States Department of Labor.

I am a pediatrician by training. I received my basic training at Johns Hopkins Medical School. I have had about 4 years of hospital experience, in general medicine, a large majority of it in the field of pediatrics, in the diseases of children.

I got my first year of training in pediatrics at the St. Louis Children's Hospital in Missouri. That was followed by further training at the New Haven Hospital in New Haven, Conn. I joined the staff of the Children's Bureau in 1924 and became the director of the division of child hygiene which was the research division, but was stationed for a period of 10 years at Yale University School of Medicine, where I taught in the department of pediatrics.

In 1935, I came to Washington and was made assistant chief of the Children's Bureau and in 1941 I was made associate chief of the Children's Bureau.

I have been responsible for the health work in the Children's Bureau and the programs of the administration of title V, parts 1 and 2 of the Social Security Act since it was passed.

The CHAIRMAN. As associate chief of the bureau, you are responsible to the Secretary of Labor?

Dr. ELIOT. I am responsible to the Chief of the Children's Bureau and to the Secretary of Labor.

The CHAIRMAN. And you consult the Secretary of Labor sometimes in reference to some of the problems in your department?

Dr. ELIOT. I certainly do.

The CHAIRMAN. You may proceed with your testimony.

Dr. ELIOT. I am appearing here today in support of the national health bill, S. 1606. Miss Lenroot, the Chief of the Children's Bureau, has asked me to express her great regret that she cannot be here to testify herself in favor of the national health bill. She is in New York serving as the secretary of the temporary social commission of the United Nations, and for that reason cannot be here.

ENDORSEMENT OF S. 1606

Miss Lenroot has asked me to say that she endorses both title I and II of S. 1606, with the amendments proposed by Senator Pepper on the opening day of these hearings.

She is glad that consideration of the health needs of children is finding its place in the discussion of the health needs of all the people, and that the bill, with Senator Pepper's amendments, provides coverage for all maternity patients and for all children whether insured or not.

What is accomplished for children in a health program will determine to a great extent the success of the whole endeavor. We must begin with the mother and the child if we are to build health in our people, and conversely, the health of children is dependent in large part upon the health of their parents and other adults with whom they are associated, and upon the general health and medical-care program of the community.

Miss Lenroot urges, therefore, full consideration of the ways in which maternal and child-health services and medical care for children can be developed so as to bring complete protection and care wholly within reach of all.

At the same time, she has asked me to emphasize that the health and social needs of children are interwoven and cannot successfully be pigeonholed and treated in isolation, and to say that she hopes the committee at an early date will consider how child-welfare services may be expanded along with the child-health program so as to bring help and guidance to every child requiring such service, wherever he may live and whatever the economic circumstances of his family. Only through a combination of health and social services can the physical and mental health of our children be safeguarded and juvenile delinquency and other personality disorders eradicated at the source.

In presenting his testimony in favor of this bill, Senator Pepper proposed several amendments that had been agreed to by the Secretary of Labor and the Federal Security Administrator. It is to such an amended bill that the Children's Bureau is giving support. I will speak particularly to part B of title I that provides for maternal and child-health and crippled children's services through grants-in-aid to the States, inasmuch as the Children's Bureau is the Federal administrative agency for that part of the bill.

The objective of a national health program, if it looks to the future as well as the present, must be to assure that all the services and facilities that modern medicine and social science know how to provide are readily accessible to all mothers and children, without discrimination.

of any kind. Anything less is wasteful of our future man and woman power. This objective would, I am sure, be agreed to by all—professions and laity alike. Opinions as to the best way to accomplish it differ.

It will take time to reach this goal, but it can be reached to a large extent—probably in a 10-year-period—if the national health program is geared to give early and sustained attention and support to the provision of those special facilities and services required to put modern skills and knowledge in the care of children at the disposal of all families.

I am convinced of this because our experience under the Social Security Act, and the wartime maternity and infant-care program for servicemen's wives and infants, has shown the readiness of most State health agencies to build rapidly on their existing programs if funds for progressive expansion of facilities, personnel, training and demonstration units can be made available.

I would like to express my satisfaction that the sponsors of the national health bill are carrying forward the public policy established under the Social Security Act of special planning for children by the inclusion of title I, part B, in this bill.

I will present my testimony in support of S. 1606 under three general headings:

First. A brief comment on the clarifying amendments proposed by Senator Pepper.

Second. A review of existing health conditions among children and the unmet needs.

Third. The need for Nation-wide program planning for children and mothers with comment on what can be done under the provisions of this bill and how standards and quality of care can be raised.

COMMENT ON AMENDMENTS PROPOSED BY SENATOR PEPPER

The amendments proposed by Senator Pepper were prepared for the purpose of (1) clarifying the scope of the maternal and child health services; (2) broadening the intent of the bill to assure the provision of personal health services to noninsured mothers and children and supplementary services for the insured, so that coverage of mothers for maternity care, and of children up to 18 years of age for health and medical service would be complete; and (3) coordinating more effectively the services provided in the several parts or titles of the bill through a single State health agency.

The proposed amendments remove the effect of any limitations on the services for maternity patients or children that might be imposed on insured persons under title II, provided the States put up part of the funds to pay for the supplementary services.

They make more certain, though not mandatory, that the Surgeon General of the Public Health Service will utilize the same State health agency to which grants for maternal and child-health service will be made by the Children's Bureau.

Pediatricians and obstetricians are agreed, I believe, that there should be no breaks in the planning for preventive, diagnostic, and curative services provided for all children and for all maternity patients.

The next few paragraphs that I have inserted here are technical. They relate to these amendments.

If you want me to go into that, I will of course be glad to. Otherwise, I would ask to have them submitted for the record and go on to the question on health conditions.

The CHAIRMAN. Without objection, we will do that.

(The paragraphs referred to are as follows:)

Whenever the same State health agency is responsible for the operation of both the personal-health-service program under title II and the maternal and child-health and crippled children's services under title I, part B, there will be a unified program for health and medical care, and preventive and curative service will not be separated administratively. If, however, in some situations it is deemed necessary for the Surgeon General to utilize some other agency than that to which maternal and child-health grants are made, or if the crippled children's agency in a given State is not the State health agency, the community health services for maternity care and child health that are characteristically preventive medical care will be separated administratively from the curative service provided through title II or through the crippled children's service. The provision in the bill for cooperative working agreements between State and local public agencies and other amendments proposed by Senator Pepper provide the framework for a coordinated program.

The Surgeon General may use the agency responsible for the maternal and child-health and crippled children's programs under title I, part B, to provide care for insured mothers and children. Maternity care and personal health services for children in families of noninsured persons will be provided through section 121(a) of title I, part B, and the State agencies administering these services may utilize the facilities of title II.

The amendments specifying amounts of Federal funds to be authorized for appropriation during the first year of operation under title I, part B, would make it possible for State agencies to know the extent to which they could start expanding their programs, increasing facilities and services, and training personnel during the period intervening between the time when the bill is passed and the date set in the bill when insurance funds are made available to pay for care.

These amendments set up a distinction between maternal and child-health services in the community and personal health services. For the record, I would like to introduce at this point a statement setting forth what the Children's Bureau would recognize as included within the term "maternal and child-health services in the community" under section 121 (a). I believe the items listed are in accordance with the discussions between the Public Health Service, the Social Security Board, and the Children's Bureau, and the agreement reached by the Secretary of Labor and the Federal Security Administrator upon which Senator Pepper's amendments were based.

"Maternal and child-health services in the community" include the following types of service:

1. Fact finding necessary to determine the needs of mother and children.
2. Setting standards for maternity care and for complete health services to infants and children, including medical and hospital service.
3. Organizing community programs to provide for health education, case finding, and health and medical services which require the coordinated work of professional personnel—physicians, dentists, nurses, nutritionists, medical social workers—of hospitals and other institutions, and of agencies outside the health field, such as education and welfare.
4. Developing special programs such as school health services, child guidance clinics, maternity and pediatric clinics, and coordinating them with general programs.
5. Setting up demonstrations, special projects and research activities, local or State-wide, to test methods of providing services, or to serve as examples in the administration and provision of services—e. g., demonstrations of complete maternity care, including hospitalization; pediatric or obstetric consultation to local physicians and hospitals; special service to premature infants; nutrition programs; vision and hearing tests; school health projects; dental projects; special maternity or pediatric nursing projects; training nurse-midwives; maternity and pediatric hospital consultant service and inspection programs.

6. Recruiting and training administrative personnel, medical and nonmedical to organize programs and operate maternal and child-health services in the community.

7. Providing administrative consultation through the staff of the State health agency or local health department to local professional personnel and local institutions to enable them to perform a more satisfactory service.

8. Initiating or cooperating in plans to attract professional medical, dental, and other professional and technical personnel needed by mothers and children to local areas that do not have them, or that are served inadequately.

9. Making arrangements for or providing services of medical and dental clinical consultants and specialists to assist medical practitioners in the field of maternal and child health, and other professional workers, such as nurses and medical social workers, needed for medical and dental care of high quality for mothers and children.

10. Developing and promoting construction and staffing of needed facilities.

11. Arranging for, or providing, special training for doctors, dentists, and other professional personnel giving service to mothers and children.

Dr. ELIOT. I hope that the whole statement can be placed in the record even if there is not time for me to give it all.

The CHAIRMAN. Those paragraphs that you are omitting will be important to the committee when we come to executive sessions to consider these amendments, of course.

Senator PEPPER. And for the record, Mr. Chairman, Dr. Eliot's statement will appear as it is printed here?

The CHAIRMAN. Yes.

THE REVIEW OF HEALTH CONDITIONS AMONG CHILDREN

Dr. ELIOT. The Children's Bureau has had opportunity to study the health and welfare needs of children for more than three decades. In the past 10 years the Bureau has administered the maternal and child welfare provisions of the Social Security Act.

A good beginning has been made. Federal funds for maternal and child-health and crippled children's services however—all together only \$9,600,000 annually—are very far from sufficient to meet the needs.

The State agencies responsible for maternal and child-health services and for services to crippled children are practically unanimous in their expression of need for additional funds to expand and carry forward their programs.

Some crippled children are not given care because of residence or other legal restrictions, or because State administrative definitions of the term "crippling" limit the scope of service.

The chief barrier to care, however, is the ceilings on the amounts of Federal funds available under the Social Security Act. At the end of the fiscal year 1945, there were 20,000 crippled children on State registers who were not receiving the care known to be needed.

The emergency maternity and infant-care program has shown us how inadequate the facilities for good maternity care in many places are, especially in rural areas.

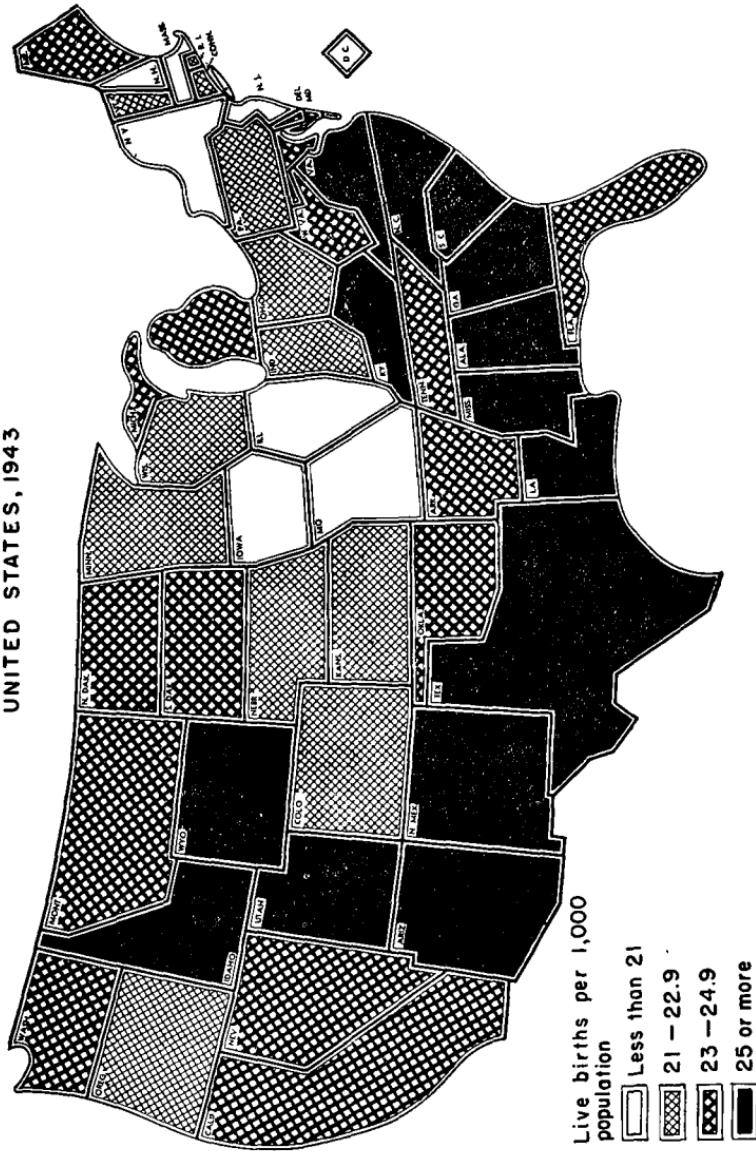
Many maternity hospitals and homes are ill equipped to give safe care; many physicians who include obstetrics in their general practice have had relatively little basic training and little or no opportunity for postgraduate training in this field. Good maternity care available to all is a goal that is attainable within the next 10 years if the authority to act and the resources to provide it become available.

The next series of paragraphs relates to the mortality among children in this country. First let me say, though, that there were 41,500,000 children in the United States below 18 years of age in 1944. They make up almost one-third of the people of the country. There are more than 2,500,000 infants born each year.

Attached to the statement I have given you are a series of charts that I would like to have submitted and if possible, when you print this record, printed with the record, because they tell a story which the printed word sometimes does not tell.

The first chart that I have given you shows the birth rate in the different States and the great variation in the different States.

BIRTH RATE IN EACH STATE
UNITED STATES, 1943



Based on data from U.S. Bureau of the Census

Senator DONNELL. Might I ask one question there of Dr. Eliot? On the chart with respect to birth rates in each State, I observe with great interest the fact that Iowa, Missouri, and Illinois, in one group, and over here New York, New Hampshire, and Massachusetts each appear to have less than 21 live births per 1,000 population.

I believe New Jersey likewise is included in that last. I do not find that that prevails in any other part of the country. What is the explanation of that?

Dr. ELIOT. I have no explanation, Senator.

Senator AIKEN. I think, Mr. Chairman, the Senator from Missouri ought to explain that, rather than Dr. Eliot.

Senator DONNELL. I could not do that with respect to the matter of the States of Vermont and New Hampshire as well as Senator Aiken could.

But it is a curious fact, right in the center of our country there, as to those three States.

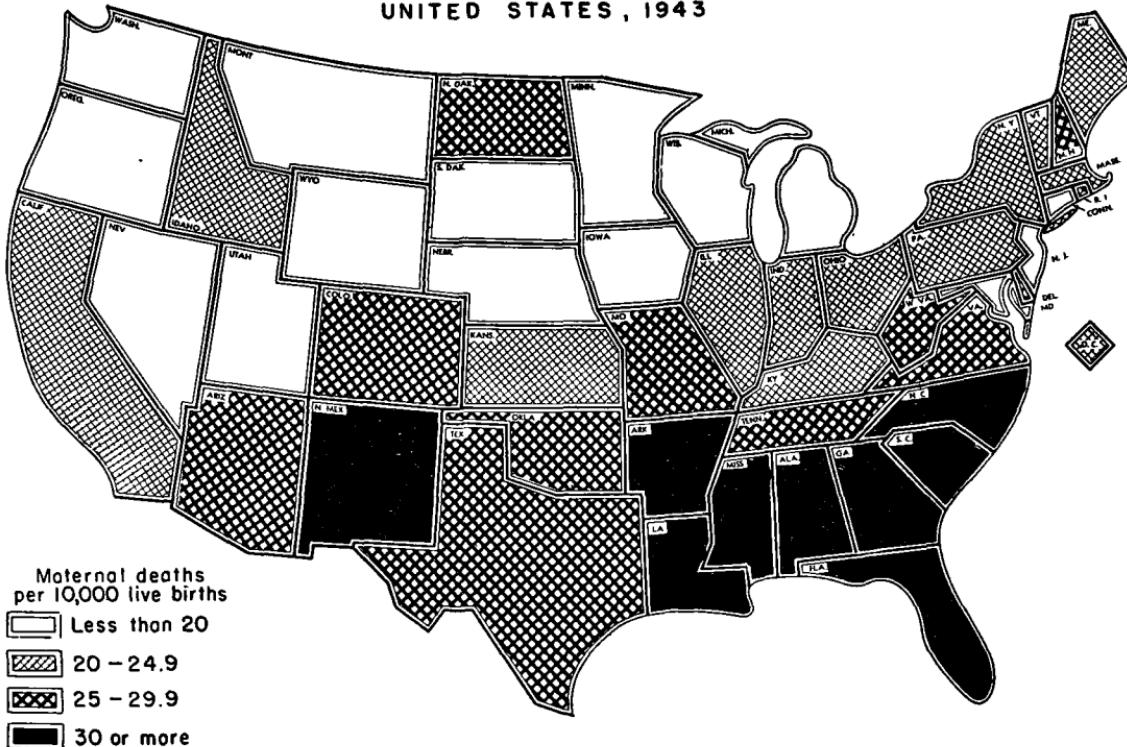
Dr. ELIOT. Then, you see, the second range, 21 to 22.9 births per 1,000 population, goes right across the center of the country. Of course, the highest birth rate is in the South and through the Southwest, where we have a large Negro population, and a population of the Americans who are of Spanish origin.

Indians come into the picture at that point. But that is the picture of the birth rates in the country.

Under the conditions which exist today, the prospect that the baby's mother will live through childbirth, that the baby will be born alive and will survive and grow into a sturdy, well child, varies markedly by reason of where he lives, the income of his family, and his race.

Over 7,000 mothers die from childbearing each year. In 1943 the maternal death rate in Minnesota was 14 mothers per 10,000 live births. In New Mexico it was 47, or over three one-half times as high. If every State did as well as Minnesota, the lives of 3,000 mothers would have been saved in that year. Chart 2 shows the maternal mortality rate in each State, 1943.

MATERNAL MORTALITY RATE IN EACH STATE,
UNITED STATES, 1943



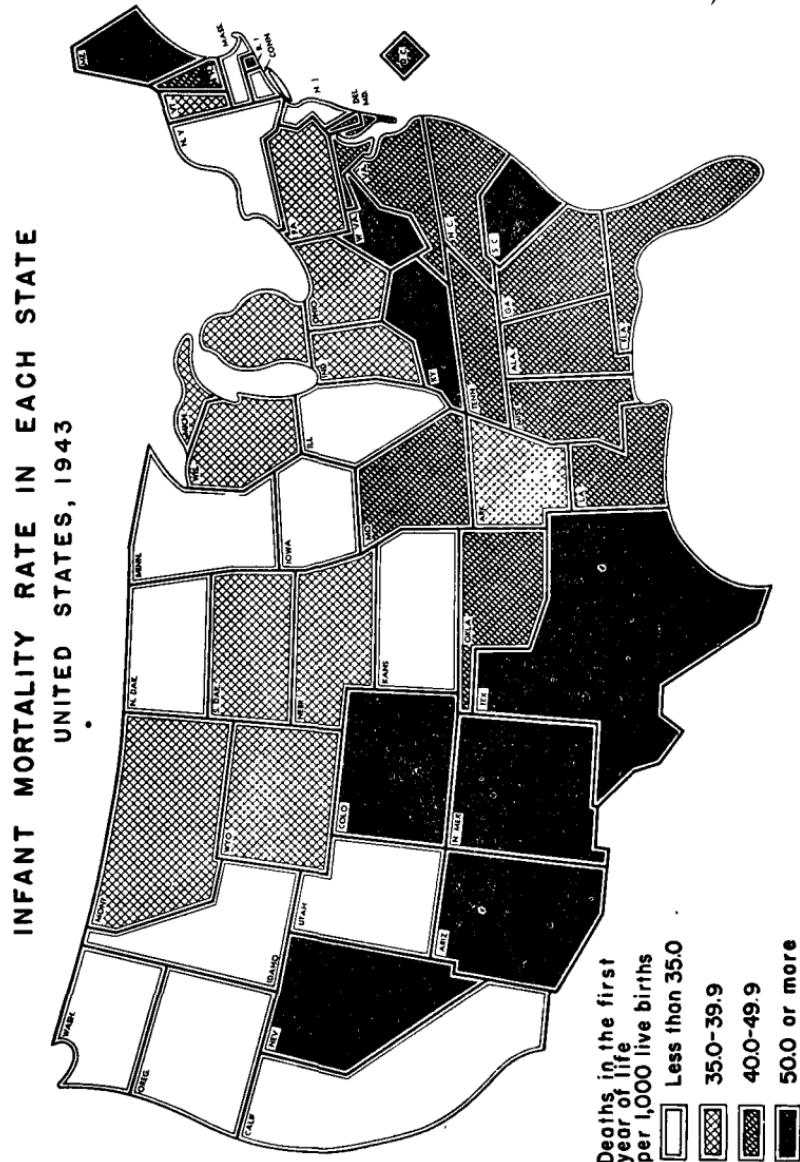
U.S. Department of Labor
CHILDREN'S BUREAU

Based on data from U.S. Bureau of the Census

Over 100,000 babies die in their first year of life in the United States. The lowest rate in 1943 was in Connecticut—30 per 1,000 live births.

In New Mexico, which is the State with the highest infant mortality rate, 92 babies died in their first year per 1,000 live births.

If every State had done as well as Connecticut in 1943, the lives of 31,000 babies would have been saved. Chart 3 shows the infant mortality rate in each State, 1943.



Not only do mothers and babies have a better chance to survive in one part of the country than in another, but they are better off if they are born into white rather than Negro families.

The maternal death rate for Negro mothers was 143 percent higher in 1943 than for white mothers. In the same year, the infant death rate for Negro babies during the first year of life was 64 percent higher than for white babies.

From Pearl Harbor to VJ-day, 281,000 Americans were killed in action. This was at a time when the risk to the adult population was greater than at any other time. In the same period of time 430,000 babies died in the United States in their first year of life. We must tackle this problem of infant deaths with the same ingenuity with which we organized ourselves for action during the war, but utilizing the lessons we learned from the wartime programs.

Senator DONNELL. May I ask Dr. Eliot: As to that figure of 281,000 Americans killed, does that include the war?

Dr. ELIOT. I will have to supply that for the record. I will be glad to look it up and have it reported to you.

Senator DONNELL. Thank you.

(The matter requested is as follows:)

The 281,000, or to be exact 281,475, deaths in battle status consists of 223,215 Army personnel killed in action and 58,260 Navy personnel who died as combat casualties. Combat casualties of the Navy include Navy, Marine, and Coast Guard. Deaths classified as killed in action by the Army include men who died of wounds, who died while captured or in interned status, were declared dead, or reported dead from missing in action.

These are the official reports as of December 31, 1945. The Children's Bureau obtained from the Public Relations Unit and Personnel Information Office of the War Department, and the Press Relations Division of the Navy.

Dr. ELIOT. Good maternity and infant care requires that babies be born in hospitals where all the facilities for providing the care needed are at hand—where complications and emergencies can be met more adequately. This is quite as important for the baby as for the mother. In 1943, one-half of the infant deaths occurred in the first week of a baby's life.

The proportion of babies born in hospitals varies greatly between city and rural areas, between whites and Negroes, and among the States.

Seven-eighth of all urban babies were born in hospitals in 1943, compared with only one-half of all rural babies. Three-fourths of white babies were born in hospitals in that year, compared with only one-third of Negro and other nonwhite babies.

States ranged from 31 to 98 percent for the year 1944. This represents a considerable progress over 1937, which can probably be accounted for by the increasing demand from physicians for the added safety that comes with good hospital care and a better understanding by the public of this fact.

Senator AIKEN. Good roads have something to do with that, too.

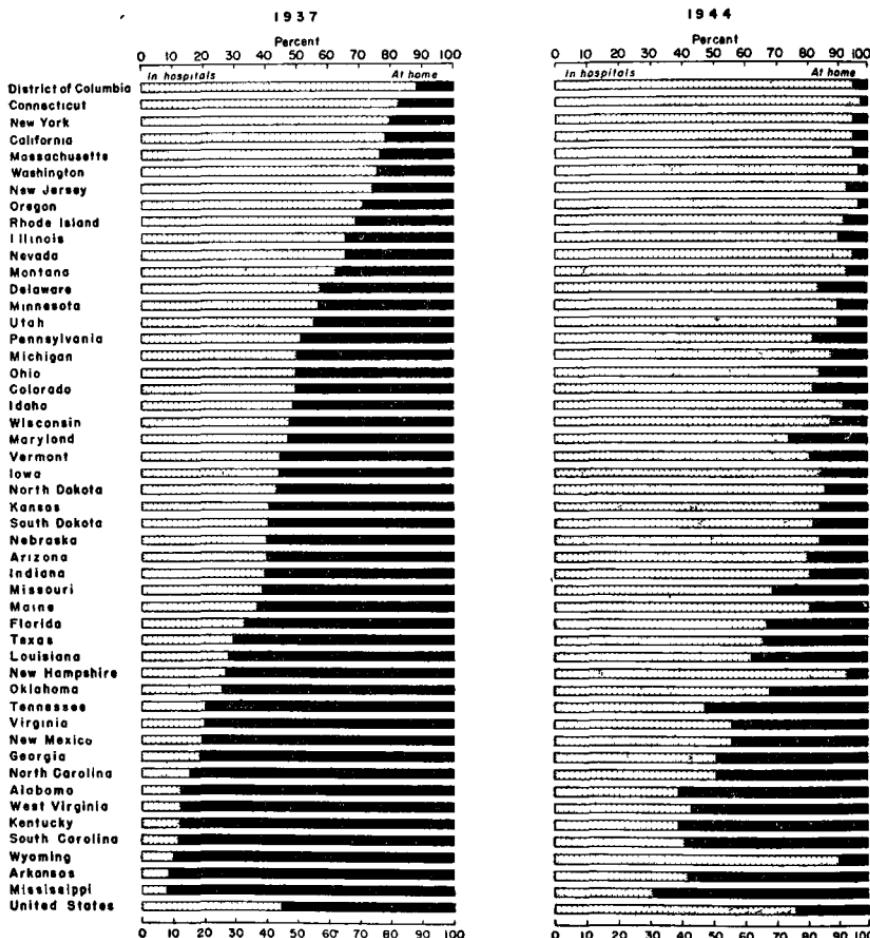
Dr. ELIOT. Good roads have something to do with that, no doubt.

Also, during the war years, the shortage of physicians made it imperative that obstetric care be given in hospitals in order to conserve the physicians' time. Chart 4 shows the proportion of births in hospitals and at home, 1937 and 1944, by State.

PROPORTION OF BIRTHS IN HOSPITALS AND AT HOME

1937 and 1944

By State



Senator PEPPER. Excuse me, Dr. Eliot. Are you going to give us the number of deliveries that are by midwives? Do you happen to have that in these figures?

Dr. ELIOT. I think we refer to them, but I can tell you now it is something over 200,000.

Senator PEPPER. In the country?

Dr. ELIOT. Yes; at least there are something over 200,000 women who do not have the care of a physician at the time of birth.

Senator PEPPER. How many births are there in a year in the country?

Dr. ELIOT. During the past few years, there have been between 2,500,000 and 2,800,000.

Senator PEPPER. That would be about 10 percent roughly?

Dr. ELIOT. Yes; or a little less than 10 percent.

Senator PEPPER. A little less than 10 percent, then, have no doctors, let alone hospital care?

Dr. ELIOT. That is right.

Senator PEPPER. Thank you.

Dr. ELIOT. We have recently seen, however, how much more can be accomplished by even the limited kind of planning that was possible during the war under the emergency maternity and infant care program.

As you know, this is the program under which Federal money became available to pay the cost of maternity care—medical, nursing, and hospital—for the wives of all servicemen in the four lowest pay grades.

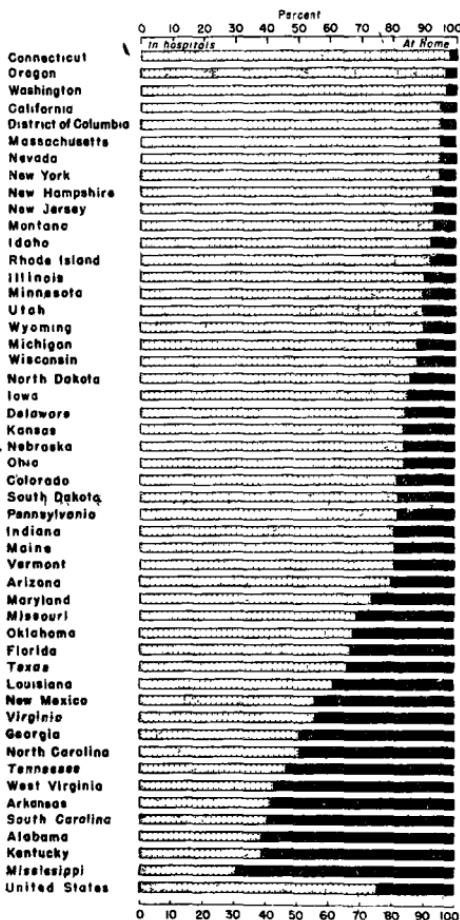
More than a million wives have been given care. I have a chart here which compares the proportion of births in hospitals under the Emergency maternity and infant care program in 1944 with the proportion for all births that year—chart 5—proportion of births in hospitals and at home, total births, and births under the emergency maternity and infant care program, by State, 1944.

PROPORTION OF BIRTHS IN HOSPITALS AND AT HOME

TOTAL BIRTHS AND BIRTHS UNDER THE EMERGENCY MATERNITY AND INFANT CARE PROGRAM

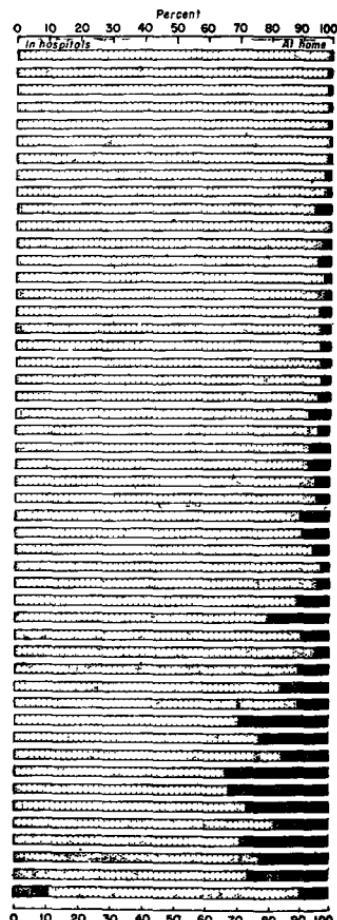
By State — 1944

Total births



Based on data from U.S. Bureau of the Census

Births under the E.M.I.C Program



Based on reports on deliveries including stillbirths and plural births

Some of the differences are striking. It is apparent that when funds become available to pay for care, and the State and local health departments register the cases and plan with family, physician, and hospital, the picture changes greatly.

For example, the State of Mississippi had the least favorable proportion of births in hospitals in 1944, when 69 percent of all the births in the State were at home.

Senator PEPPER. In Mississippi?

Dr. ELIOT. In Mississippi. This is practically reversed for the servicemen's wives. As you will see by the chart, there were 73.3 percent of these births in hospitals. Even the States at the upper end of the scale showed improvement. Minnesota, for instance, had 90 percent of all births attended by a physician in a hospital in 1944. Under the emergency maternity and infant care program, 97.8 percent of the births were in a hospital.

We in the Children's Bureau are anxious to analyze the effect of the planning done through the emergency maternity and infant care program on the maternal and infant mortality rates, and are asking the Congress to provide funds for this purpose.

We will not have information which has national validity until after such a study has been made because of the great amount of movement of servicemen's wives from one State to another. We have been interested, however, in a preliminary analysis which the Mississippi State Health Department made from its records of 2½ years of its own experience under this program.

If the maternal death rate for the entire population of that State had held for mothers covered by this program, 42 wives of servicemen would have lost their lives as a result of childbearing. Actually, 12 of the mothers who came under the program died. In other words, probably 30 mothers were saved.

The maternity care problem, however, is not merely a question of paying for hospital care for mothers at the time of delivery. It is also a question of the adequacy of the hospital care and the skills of the person attending the delivery.

I have already referred to the inadequacies of many maternity hospitals and homes. It should also be pointed out that in 1943 there were more than 200,000 mothers delivered without any medical care at all. These 200,000 newborn babies, therefore, did not have medical care at birth. Comprehensive planning is necessary if every maternity patient and her baby is to have the best available care and if the quality of that care is to steadily improve.

Senator PEPPER. Dr. Eliot, if you will allow me to interrupt you again, would you just put in a sentence or two for this record, if you do not have it somewhere else in your statement, what were the provisions of the Emergency Maternal Care program for veterans?

Dr. ELIOT. Yes, I would be glad to briefly state that: The Children's Bureau was given funds by the Congress, as grants to the States, to provide the care of a physician, the care in a hospital and nursing care, insofar as that kind of care could be made available in the town or county where that mother was living.

The State health departments were given the responsibility for carrying out this program, and the load of responsibility placed upon the State health departments, unexpected because of the rapid rise in the number of cases that applied for care, was borne exceedingly well

by the State health departments. I would be glad, Senator Pepper, to submit more of the statement for the record, if you would like.

Senator PEPPER. All I wanted was the degree to which the cost of providing medical care was provided by the Government.

Dr. ELIOT. The Federal Government has provided to date about \$112,000,000 of this program. The States have borne a very small proportion of it. They have provided, through their administrative staffs a considerable proportion of the cost of administration.

Senator PEPPER. Now, was the total cost of the medical and hospital care provided out of the Federal and State funds?

Dr. ELIOT. The total cost of the medical and hospital care provided was provided by the Federal Government.

Senator PEPPER. So that it cost the mother nothing?

Dr. ELIOT. It cost the mother nothing. That was one of the primary principles. And this program, as you know, referred to the wives and families of men in the lowest four grades. That applied to the noncommissioned part of the services, about 93 percent of all the individuals.

Senator DONNELL. Mr. Chairman, pardon me. Dr. Eliot referred to the State health departments. Now, what part was played by them in the carrying on of the program?

Dr. ELIOT. They operated this program.

Senator DONNELL. That is, the Federal Government did not operate. They provided the money, and the State departments operated it?

Dr. ELIOT. Yes. Because of the fact that this program had to be made available very rapidly all over the country, in every town, and even out into the rural areas, it meant that the Federal agency took rather more responsibility for outlining some of the policies with respect to the way in which it should be operated than we had taken under previous programs under the maternal and child-health or crippled children's programs. But in order to get a degree of—I was going to use the word uniformity or likeness or service for the wives of servicemen who applied for care wherever they might be living, during a given period of time, it was almost essential that the Federal agency should take more responsibility than we had taken under the other programs for seeing that this particular project was carried forward as effectively and as promptly as it was possible. This was essential for the sake of the wives and infants and for the sake of morale of the servicemen.

Because the purpose of the program, of course, was twofold. It was to help the wives and infants of the servicemen, but it was also to help the morale among the men in the armed forces.

It was a wartime program.

Senator DONNELL. Generally speaking, would you say that the State health departments did a good job of carrying on the actual operations?

Dr. ELIOT. Very decidedly, Senator Donnell.

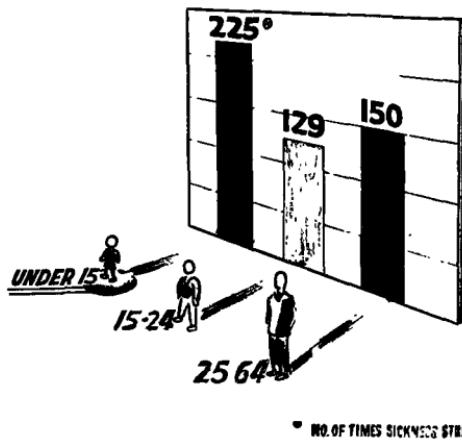
HEALTH NEEDS OF CHILDREN

I would like to go on to some of the medical and dental needs of children.

Sickness occurs more often in childhood than in any age period except over 64. In each year, disabling diseases strike 225 times among every 1,000 children under 15 years of age, as compared to 129 times among every 1,000 individuals between the 15 and 24, and 150 times among 1,000 individuals between 25 and 64 years of age. Chart 6 shows that childhood is a time of sickness.

CHILDHOOD IS A TIME OF SICKNESS

DISABLING DISEASES PER 1,000 PEOPLE



It is estimated that there are in this country some 200,000 children with epilepsy; 500,000 with rheumatic fever and heart disease; 175,000 with active tuberculosis; 500,000 with orthopedic and plastic defects; 1,000,000 with hearing defects; 4,000,000 with visual defects; and 20,000,000 with dental defects.

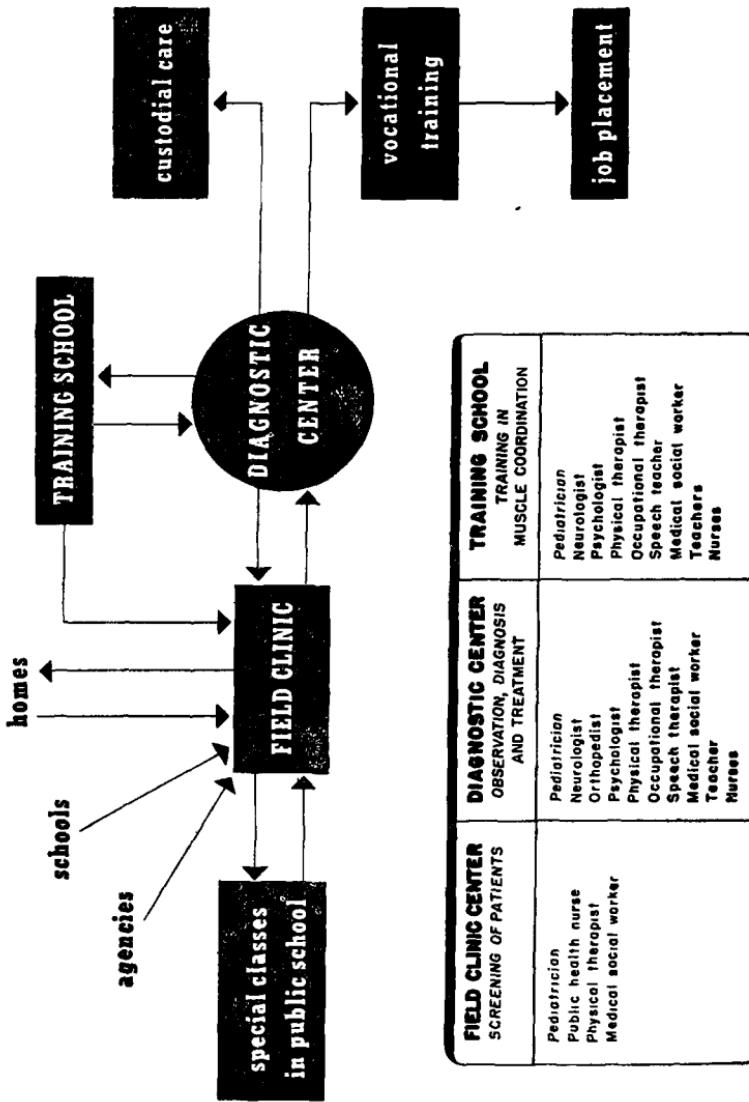
You, I know, heard a good deal from Dr. Jones the other day on the need for more service for people with rheumatic fever and heart disease.

Among those classified as having orthopedic defects are well over 100,000—perhaps 160,000—children with cerebral palsy, that tragic condition of the nervous and muscular system which ordinarily results from damage to the brain before or during the birth process.

These are the so-called spastic children. To treat them properly is costly and requires an organized team of highly trained professional workers and special treatment and appliances. There are very few organized programs for their care.

I have included as chart 7 here an outline of a suggested community organization plan for care of children with cerebral palsy. The need here is very great, and we have not scratched the surface as to doing anything about it as yet.

SUGGESTED COMMUNITY ORGANIZATION PLAN FOR CARE OF CHILDREN WITH CEREBRAL PALSY



The major cause of death among preschool children is pneumonia. A close second among children under 2 is enteritis or diarrhea.

In view of the great strides which have been made during the last few years in knowledge of how to treat pneumonia and to prevent enteritis, we know that many of these children die needlessly.

Among school-age children, the major cause of death is rheumatic fever and heart disease. Chart 8 shows the leading causes of death from disease.

LEADING CAUSES OF DEATH FROM DISEASE :



PRE-SCHOOL

PNEUMONIA - INFLUENZA



SCHOOL AGE

RHEUMATIC FEVER
RHEUMATIC HEART DISEASE

SINCE 1940

This problem must be approached through special programs organized not just to pay for care but to assume the additional responsibility for taking all steps necessary to prevent as well as to alleviate the effects of the disease.

Some large cities and a few counties have developed such organized programs for the care of children with rheumatic fever and heart disease, but most areas of the country are entirely without this service.

We know that large numbers of children are not receiving the health and medical care they need because appropriate facilities do not exist and there are too few trained specialists.

We know that many children who are receiving some care need more than they get, that frequently the medical knowledge we have does not get to the individual child to cure or better his condition if the condition cannot be cured.

The need for dental care is known to affect at least 75 percent of America's school children. The average child beginning school has six teeth already involved in the decay process.

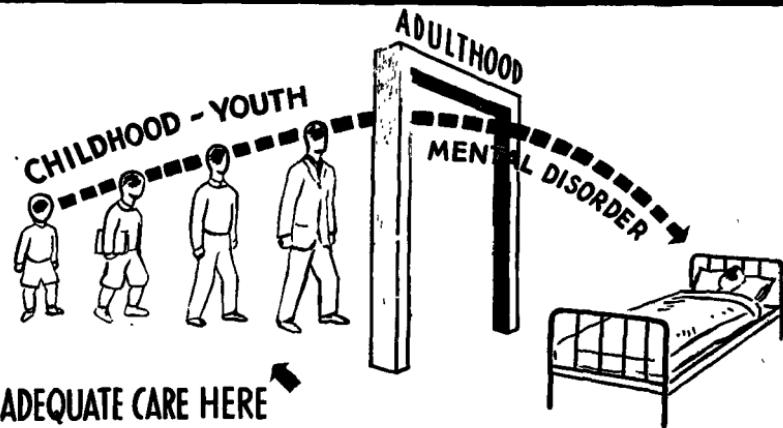
Various conditions of crooked teeth are present in a little over 40 percent of 6-year-old children.

These conditions become more pressing as age advances. Experience shows that the rate of development of cavities in the teeth is five times greater than the number of cavities filled. Less than 25 percent of all children under 19 years of age receive dental service.

We are also concerned with the many problems of the mental health of our children. On the basis of past experience, we can expect that 1 out of every 20 children born each year will spend some time in a

mental hospital. Many of the problems of these individuals start in childhood, but their full significance is not recognized. Chart 9 shows that many mental health problems start in childhood.

MANY MENTAL HEALTH PROBLEMS START IN CHILDHOOD - BUT ARE DISREGARDED



... MIGHT HAVE PREVENTED HOSPITALIZATION

As a consequence, nothing is done about them during the period when we could hopefully accomplish the most. We have had this problem brought sharply before us in many ways during the war. One of the most significant figures on those found unfit for the armed services is that 18 out of every 100 4-F's were rejected because of mental and personality disorders.

A few weeks ago, I appeared before the Subcommittee on Health and Education testifying to the need for Federal funds for research and training in the field of mental health.

This is fundamental, but I wish to state now, as I did then, that we must go further than this. We must assume responsibility for the establishment and maintenance of facilities and services as they are needed to assure that all children have an opportunity for mental health.

We must also assure that those who present behavior problems are given the help they need to overcome them and the chance to grow into self-reliant individuals; that this help be given before serious symptoms develop; that parents get this help early—even at the time the child is a new-born infant.

I am not say that the lives of all children could be saved or that perfect health is attainable for all. I am saying that it is wrong for 100 children to die of a disease if 50 could be saved. I am saying that no child should die whose death could be prevented.

No child should live in a state of ill health who could be cured, or made better. This is the goal we have not reached. This is the job with which we are confronted. We have many skills to do this job

which we are not using. Merely providing money to pay doctors and hospitals will not solve these problems; there must be community, State, and national planning which will assure that proper care is available whenever and wherever it is needed.

ECONOMIC FACTORS AFFECTING AVAILABILITY OF CARE

These, in broad outline, are the health and medical needs of individual children. What are the economic factors with which we must be concerned if we are to establish a sound public policy in relation to the organization of health service and to provide medical care to meet these needs?

We know that the economic status of the family in which the child lives affects greatly the amount and kind of health and medical care which he will receive. All of the studies which have been made show that the average annual expenditure for medical care increases steadily with increase in income. This is not because poor people are less likely to be sick—on the contrary, they have more disabling illnesses than those who are more well-to-do—but because they have less to spend for care when they are sick.

Sometimes it is said that the rich and the poor receive good medical care, and that the middle income groups are the ones with least adequate services.

This statement may be nearly true for a few large cities where specialists abound for the rich, where there are excellent diagnostic and treatment clinics for the poor, and where hospital care is of the best. The testimony of public assistance agencies and of private social agencies, however, often points to medical needs of the poor which are not met even in the large cities.

By that I do not mean testimony they have given before this committee, but what I hear myself from public-assistance people, and what I learned myself when I lived in New Haven and had experience in working on boards of public assistance or private social agency organizations.

It is certainly not true that the poor get all the care they need in our smaller cities and in the rural areas where more than half of our children live.

There the rich may get good medical care, but to get it they are often put to much added expense of time, effort, and travel because the services are not available where they live. As a general rule, neither the low nor the middle economic groups in these areas have the means or opportunity to seek medical care at good diagnostic clinics or medical centers because they lack the resources or the knowledge of how to get care, or both.

Or they may lack the resources to actually travel to the community in which they could get the care. I am thinking for the moment of the Middle West, where the people often go to the Mayo Clinic. They go into St. Louis to get good diagnostic service. But many families do not have the money to travel. They do not know what they could get there if they should go there.

Only occasionally are physicians practicing in such rural areas organized in groups which include specialists so as to give the complete diagnostic and treatment service needed by rich and poor alike.

ABILITY OF FAMILIES TO PAY FOR CARE

Some of the witnesses opposed to the prepaid personal health service benefits title of S. 1606 have endorsed payment for medical services from public funds for those unable to pay from their private resources for the medical care they need.

This raises the question as to what should be the relation of expenditures for medical care to the other needs of families with children. Fortunately, we have been given a clue in the testimony. It has been pointed out a number of times that proper nutrition and good housing have an importance almost equal to medical care in safeguarding health—especially the health of children.

In this, I certainly concur. Medical care at the expense of proper food and decent housing is shortsighted—but still we have to have medical care. It may also be wasteful, I believe, to set up administrative procedures in order to exclude those families who are able to provide adequate food, good housing, and good medical care unless this group makes up a substantial proportion of the total population to be served.

In looking into this matter, the Children's Bureau has consulted with the Bureau of Labor Statistics of the Department of Labor which, in cooperation with the Bureau of Human Nutrition and Home Economics of the Department of Agriculture, has made studies of the adequacy of nutrition for families of different sizes and different incomes.

The following table shows the total family income at which 60, 70, and 85 percent of the families of different sizes purchase "fair" or better diets:

Size of family	Incomes at which 60, 70, and 85 percent of families purchased "fair" or better diets (1935-36 price level)		
	60 percent of families	70 percent of families	85 percent of families
3.....	\$670	\$1,130	\$2,260
4.....	800	1,350	2,700
5.....	920	1,540	3,080
6.....	1,030	1,730	3,470

¹ Adjustments on the basis of the current price index (1946) would increase these amounts by 31 percent.

It will be seen that when the total family income for families of 4 persons reached \$1,350, 30 percent, or nearly one family out of three, bought poor or really deficient diets.

When income for families of 4 reached \$2,700 there were still 15 percent of the family diets which were seriously deficient.

Even the diets classified as "fair" were really borderline in adequacy. This being the case, one would certainly appear justified, when children are concerned, in selecting as a minimum standard, a scale of income that would make likely the purchase of "fair" or better diets by at least 85 percent of families.

SENATOR DONNELL. Pardon me, Mr. Chairman. I am not clear as to the meaning of the note asterisked, the heading being "Incomes at which 60 percent, 70 percent, and 85 percent of families purchased

"fair" or better diets (1935-36 price level)," and then an asterisk; and below there "Adjustments on the basis of the current price index (1946) would increase these amounts by 31 percent."

Oh, you mean the income figures?

Dr. ELIOT. Yes, the income figures.

Senator DONNELL. I did not understand. I see.

Dr. ELIOT. We have also to keep in mind that not all families with incomes above those shown in this table will be able to pay for their medical care. What we have come to call catastrophic illness creates serious financial problems every year for some families with much higher incomes than these that I have quoted. We in the Children's Bureau are not surprised, for instance, when a family with an income of \$5,000 to \$10,000 per year finds it difficult to meet the cost of care for a child with cerebral palsy, or other conditions which are costly to treat.

I know, for instance, at one of the very few institutions where a child can be cared for with cerebral palsy, that the weekly rate is \$43 a week to pay for care, and an average family would find it pretty difficult if that family had to pay for care in that hospital school, if you want to call it that, for a period of a good many months, as actually happens.

Actually, however, most children do not live in rich families. The figures for 1941, which was a year of high income with a relatively small amount of unemployment, show that approximately 3 out of 5 of our children were living in families with incomes of less than \$2,100 and 4 out of 5 in families with incomes of less than \$3,000.

Moreover, the majority of children live in large families; 80 percent in families of 4 or more persons.

The data, in the study referred to above, indicated that on the average, the larger the family, the greater the percentage of poor or deficient diets.

It is information of this sort, I believe, that should be taken into account when we are considering whether families with children can be expected to pay for adequate medical care and whether it is right or justifiable to establish the administrative machinery to exclude any portion of them.

All the data available would seem to point to the conclusion that it would be neither desirable nor feasible to undertake to exclude even a small proportion of children from the benefits of this program, and that we must talk in terms of all children, rather than selected income groups, when establishing public responsibility for their health and medical care.

Senator PEPPER. Mr. Chairman, may I interrupt just one minute? What you have said here is of particular interest to me. Dr. Eliot, in wishing to know what your attitude toward the means test is in furnishing this care to mothers and children. Do you favor a means test?

Dr. ELIOT. No, Senator Pepper, I would not. Under this bill, which would provide for personal health services through federally collected funds, whether it turns out to be what is known as insurance or some other method of collecting of funds so far not yet declared, all persons entitled to personal health benefits would presumably get their care as a right, as an entitlement.

Now, one does not want at the same time, certainly, to introduce in another part of the same bill, a provision which would establish a means test for noninsured children.

I certainly would like to see all children given the right to have the care that can be provided through this bill made available to all children; and the same is true for maternity care.

Senator PEPPER. I have known of some personal instances where it shows how difficult it is to define a means test. If I might be forgiven for referring to personal association, in the family of my sister, whose family had a gross income, I think, in that year of \$4,900, that family spent in 1 year \$1,300 out of its gross income upon medical services and care.

I knew of another case with a lady who lived in my mother's home, who worked for a State agency, who made \$115 a month. She was a very fine lady, but her gross income with the State Department was \$115 a month, and she had recurrent illnesses which should have required various kinds of hospital and other kinds of medical care.

My mother had a cook, and she was receiving, I think, about \$10 to \$15 a week, and she had medical needs, and I know from her recital that she, to get a doctor, had to be able to pay the \$5 for each visit that the doctor required to come to see her. She told me about that personally, and I gave her the money to meet the health calls of the doctor.

Now, you have three cases, all of them working and trying to get along to the best of their ability, and it just shows the difficulty of applying a means test to people in giving this kind of care. Surely the children have nothing to do with it?

Dr. ELIOT. Of course, that was one of the great advantages of the maternity and infant care program.

The CHAIRMAN. Would it be possible for these low income families, and especially the larger families, to be provided for under a voluntary insurance system?

Dr. ELIOT. To my way of thinking, the amount that it costs to provide for really complete medical care, of the kind that I visualize for these children under a voluntary scheme, certainly would be impossible in the lower groups. By lower groups I mean the type that we have been describing here—say, a family of four with less than \$2,700.

It does not seem to me reasonable to expect those families to do it in that way.

The CHAIRMAN. There was a lady testifying here yesterday who seemed to have great confidence in the idea that a voluntary system could be provided that would cover the entire country and give medical care to everybody in the United States. It seems to me, in listening to her testimony, that she had not given very careful study to the facts and was not familiar with the subject, as you seem to be. You have made a careful study of it, and I think your judgment on the proposition that a voluntary system would not provide proper medical care for those families should be accepted by the committee.

Dr. ELIOT. You see, I am interested that there be no gaps, and that all children receive care. I think if we are going to have a good strong healthy Nation, we have to have all children getting the services that they need.

There are certain special problems in low income States and in the rural areas that I would like to refer to briefly.

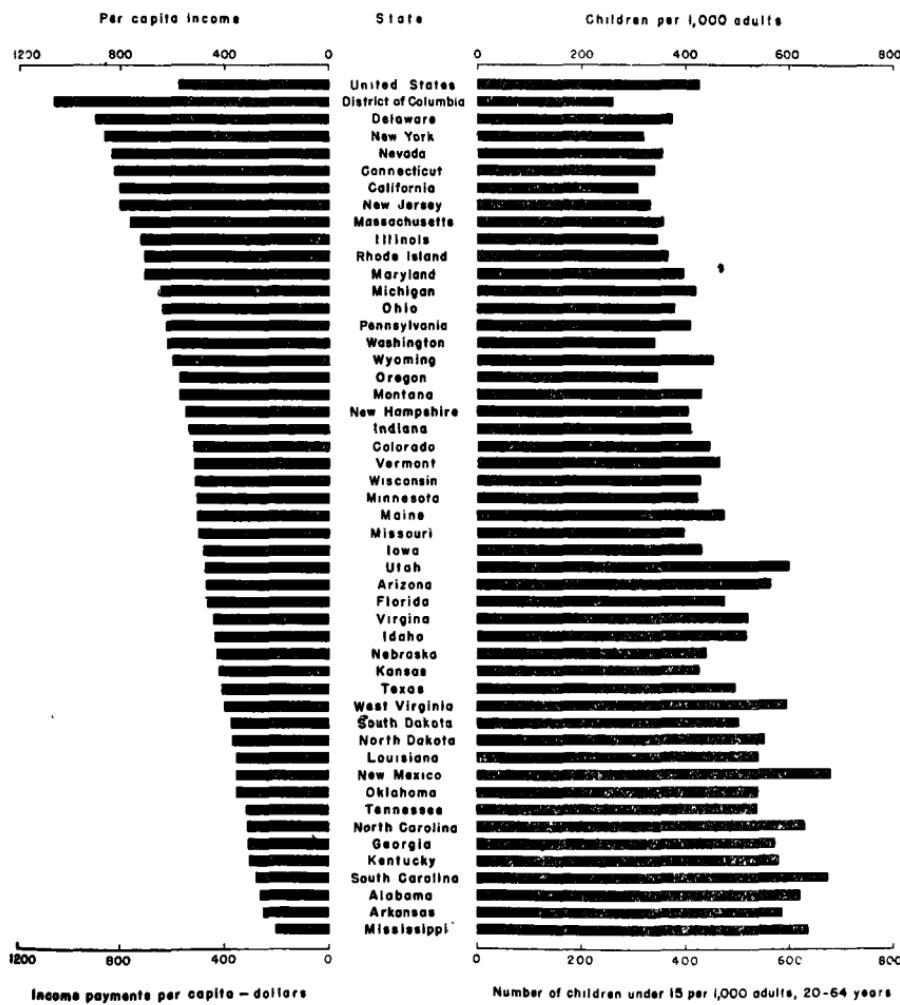
We have seen that children are concentrated in low income families. There are also proportionately more children in the low income States. The 1940 census shows that one-half of the children in the United States live in 32 States which get only one-third of the national income and conversely, half live in the other 16 States that have two-thirds of the national income.

These States fall into a pattern of regional differences. About one-quarter (28%) of all children live in the Northeast, which has 40 percent of the national income, while another quarter live in the Southeast, which has only 12 percent of the national income.

I have two charts here to illustrate this situation, one that shows per capita income and ratio of children to adults by States and the other by 6 regions in the United States. These are charts 10 and 11.

PER CAPITA INCOME AND RATIO OF CHILDREN TO ADULTS

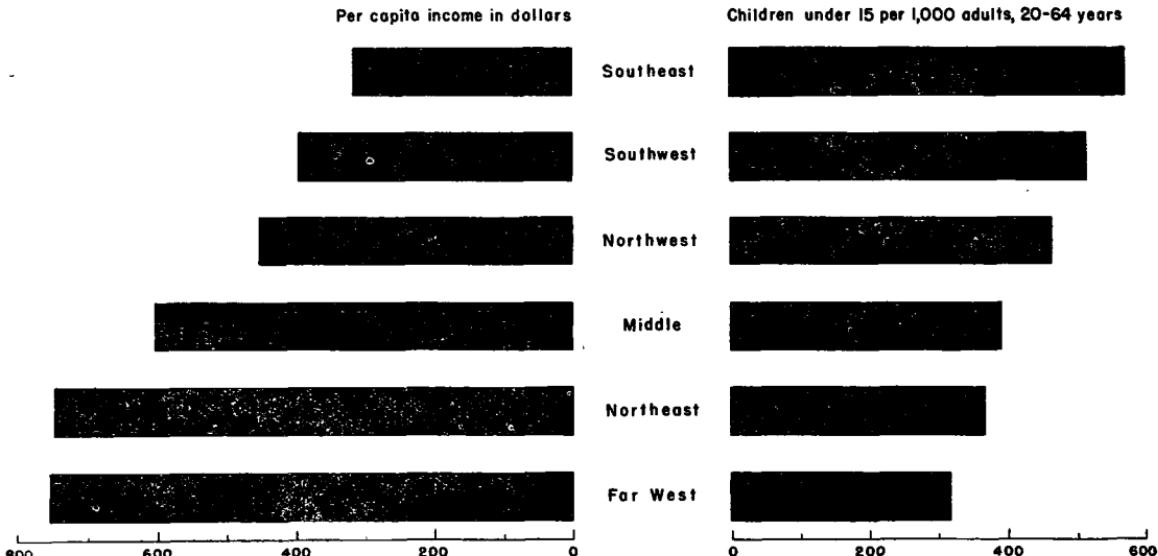
By State, 1940



Income payments per capita - dollars

Number of children under 15 per 1,000 adults, 20-64 years

PER CAPITA INCOME AND RATIO OF CHILDREN TO ADULTS BY REGION, 1940

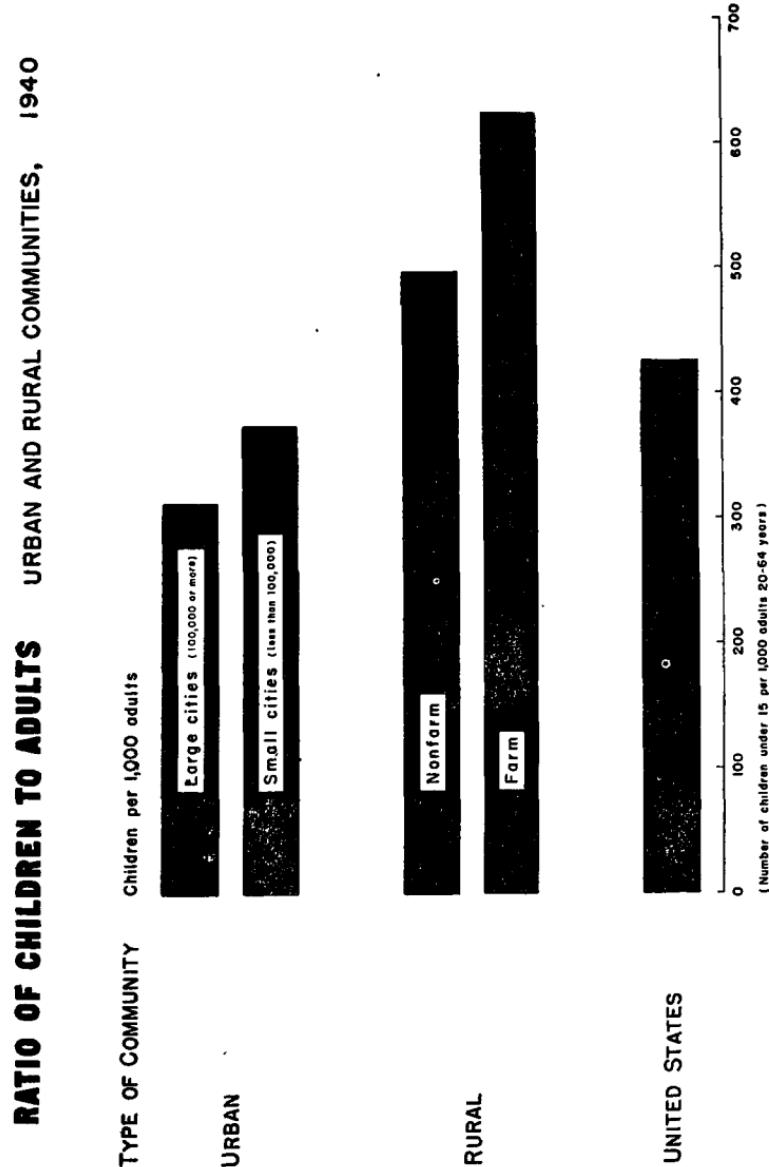


U.S. Department of Labor
CHILDREN'S BUREAU

Based on data from Bureau of Foreign and
Domestic Commerce and Bureau of the Census

Rural areas are particularly at a disadvantage. Many are continuously impoverished. Farm families have the highest ratio of children to adults, approximately twice that of the large cities.

You will see this on chart 12, which shows the ratio of children to adults in urban and rural communities in the United States, 1940. Chart 12.



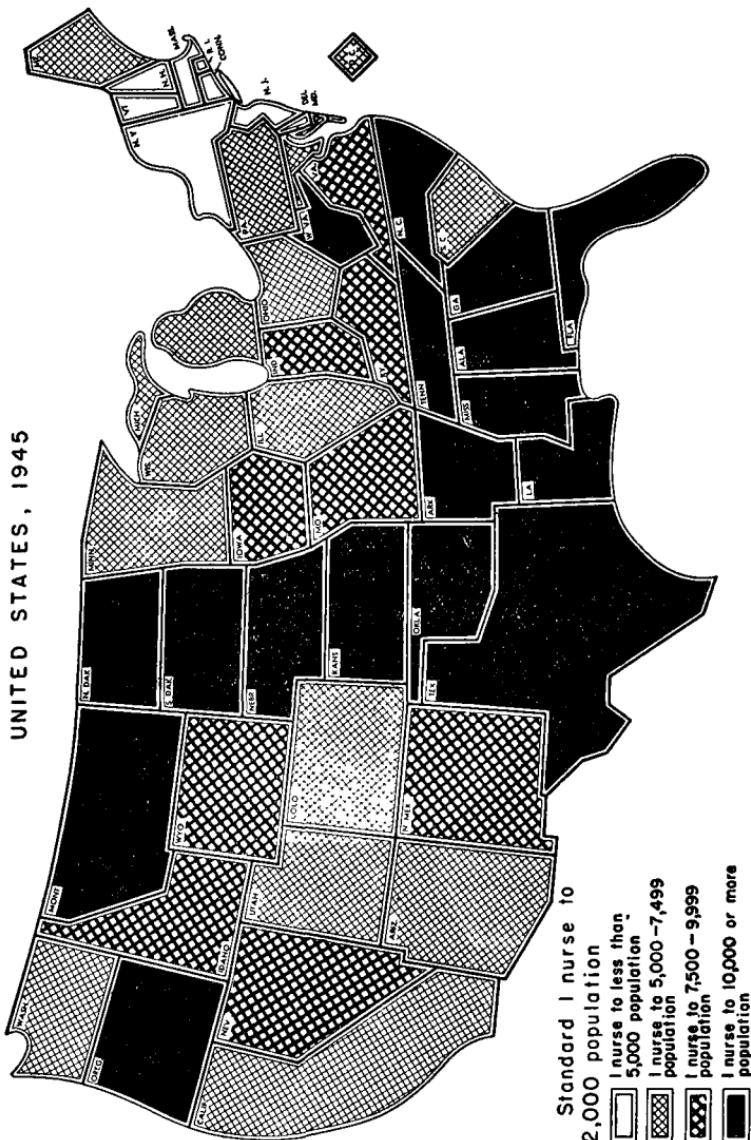
Based on data from U.S. Bureau of the Census

In 1941, farm families had 29 percent of the children in the United States but only 11 percent of the income. Their purchasing power in terms of health and medical care for mothers and children has necessarily been low. Federal funds under the Social Security Act, title V, part 1, granted for the purpose of assisting States in carrying out their maternal and child health plans have been sufficient to meet only a very small fraction of the needs of rural mothers and children.

The public health services which are the basic administrative structure for the maternal and child health program are lacking in many rural areas. In 1942 the State health agencies reported that there was no service from a full-time public health unit in 40 percent of the counties in the United States.

This situation must be corrected in the immediate future or we will not be able to develop a sound national health program. There was no public health nurse in one-third of the counties. I have a chart here that shows the discrepancy between States in this matter of public health nurses. Chart 13 shows population per public health nurse.

POPULATION PER PUBLIC HEALTH NURSE
UNITED STATES, 1945



Population data used are estimated by Bureau of Census as of July 1, 1944; number of public health nurses employed as of January 1, 1945 from reports of U.S. Public Health Service.

Three out of four rural counties had no regular maternity clinics, and two out of three rural counties had no regular monthly child-health conferences.

Rural areas are seriously lacking in professional personnel. It is estimated that there should be the equivalent of one physician including general practitioners and specialists, for each 750 people, no matter where they live.

In 1940, a prewar year, there were 1,642 counties which had one doctor for one to two thousand people. In slightly more than 300 counties, the ratio was one doctor to 3,000 or more people. In big cities, there was an average of one doctor for each 650 people.

There should be 4.5 general hospital beds per 1,000 population.

In 1942, there were two-thirds of the counties in the United States which had 2.1 beds or less per 1,000 population. This picture is typical of practically every kind of health and medical-care service in rural areas.

The tendency has been for highly trained personnel, the "experts" and "specialists," to concentrate in urban areas. In 1941, for example, only 4 percent of the certified pediatricians were located in places of less than 10,000 population and in the rural areas where 60 percent of the children live, while 38 percent were in places of 500,000 or more, where 14 percent of the children live.

The opportunity for adequate income for specialists is greater in the city than in the country. Hospital facilities can be had when needed in the larger cities and there is readier access to professional consultation and to the services of other specialists. General medical practitioners and dentists also tend to settle in cities—for the same reasons.

The CHAIRMAN. Now, would it be possible to get those hospitals in rural areas, in poorer sections of our rural areas of the country, without this insurance system that we are talking about.

Dr. ELIOT. Of course, one of the questions I raised when I was testifying as to that bill, S. 191, was: "Who is going to pay for care in the hospitals?"

It is fine to build them, but who is going to get the people into these hospitals? Either a provision has to be made in that bill, or somewhere else, because people simply cannot pay for hospital care needed for children, or for maternity care in many, many instances.

We need a lot more professional personnel, and I have listed some of them here. We have about 2,500 pediatricians. We reckon that we ought to have 7,400. We perhaps need 5,000 more obstetricians in the country to do a really good maternity-care job for every mother in the country.

We need probably 34,000 dentists trained in children's dentistry. We have now 19,000 public health nurses and we without question, I think, need 50,000 more. We need some 15,000 additional graduate nurses for institutional and private duty. We need some 10,000 additional psychiatrists. That is a round figure, because we do not know how many we will need finally to handle these services for children.

For instance, there are 25 States in which there is not a single child guidance clinic in any community in the State. Therefore, there is no question of the need in that area.

The CHAIRMAN. Are the present medical schools of the country adequate to furnish these?

Dr. ELIOT. It is awfully hard for me to answer that question, Senator Murray. I think we need more doctors. There is not any doubt we need more doctors. Now I do not know whether the present medical schools are sufficient if their facilities are expanded. But I know that certain of the medical schools are placed in smaller cities. One I am most familiar with is Yale in New Haven. You cannot undertake to teach too large a group of medical students within a given city where the clinical facilities for instruction are limited by the size of the city. So just whether there should be more medical schools or whether the existing ones should be expanded, I am not in a position to say. I should think there might be a need for some more.

The CHAIRMAN. It seems to me there is some opposition to the suggestion that we should have more medical schools. I understand the medical profession feel that we have adequate schools now for turning out doctors.

Dr. ELIOT. We certainly need more of these types of physicians to take care of children and mothers than we have now.

Now, if the existing medical schools can produce the number of doctors that are needed and provide the specialty training for some of these specialists, all well and good.

I think that is a question that the medical school people have to work on.

The CHAIRMAN. You think there is an undoubted need, however, for this expansion in the field of medical care?

Dr. ELIOT. For children, there is no doubt about it. We need more obstetricians, more child psychiatrists, and there is a very great need for added medical personnel in this country, I think, without any question.

NATIONAL PLANNING FOR HEALTH SERVICES

The third section of my testimony has to do with the need for nationwide program planning to provide these health and medical services.

We do not want one kind and quality of care available to children in our richest communities and another kind and quality in our poorest communities. That all children should receive the same kind of good health service and medical care, and that as advances are made in one area they should promptly be made available to all is in the national interest. I believe there is agreement on this principle.

Children—no matter where they live—do not get the health and medical services they need unless someone sees to it that the service is accessible to them.

Neither individual parents nor individual doctors can always of their own volition make care available. As we have pointed out, Federal, State, and local planning is needed. There may not be enough physicians and dentists to give the service needed. Public health facilities may be missing. Specialist and consultation services may not be available. Hospitals may be too far away. Laboratory facilities may be inadequate. The services which do exist may not be geared together, so that certain groups in the population may be getting good care while others are without access to care.

We must be sure that there are no financial barriers in the way of achieving this objective. The purpose of the personal health service benefits title of this bill is to pool our resources to eliminate economic barriers to care for insured individuals and their families. It is equally urgent that there be no economic barriers to adequate State and community services for all mothers and children, or to the provision of personal health services for the noninsured mother or child, in title I, part B, and the provisions made by Senator Pepper's amendment presumably will take care of the noninsured children.

The variable matching formula which is proposed for the grant-in-aid programs under the national health bill takes into account the differences in financial resources among the States through the use of per capita income. I am in favor of this principle.

There are two questions about the formula as it is used in title I, part B which I wish to raise for consideration by the committee.

My first question arises out of the fact that the State with the highest per capita income is required to put up 50 percent of the total expenditures in the program while the State with the lowest per capita income is required to put up 25 percent of total expenditures.

I do not question the 50 percent state matching for the richest State. Since the per capita income of this poorest state is only a little more than $\frac{1}{4}$ as great as that of the richest State, however, I am wondering whether a drop to 25 percent is sufficient to compensate for the differences in the relative financial position in the States. My concern is that the poorer States will not be able to provide as good maternal care and child health services for their children as will the richer States.

Senator PEPPER. Mr. Chairman, I wonder if Dr. Eliot has any suggestion as to what should be the matching formula applied to these poorer States? Have you any suggestions of your own?

Dr. ELIOT. My only suggestion is that the committee might consider whether that 25 percent level is the best level. Perhaps the reduction should be in proportion to the reduction in the per capita income in the States; namely, dropping it down, then, to, say, $12\frac{1}{2}$ percent or 10 percent if that seemed to be a desirable procedure. Something of that sort, I think, might be worked out.

It is perfectly obvious that the difference in financial resources between a State with an income of \$392 per capita and a State with \$1,432 per capita, is not compensated for by limiting the percentage differences within the range of 25 and 50 percent.

The CHAIRMAN. That would seem to be reasonable.

Dr. ELIOT. I think you might consider whether there is some other change that might be made there.

The CHAIRMAN. It would depend upon the variations in the incomes of the particular States?

Dr. ELIOT. Yes. You see it presently stops at 25 percent instead of dropping down a little further.

My second question arises from the fact that there is a backlog of current need for general health and medical services and special services for mothers and children that exists in many of the States, especially those with low per capita incomes.

This is further complicated by the fact that States with low per capita income need to improve all of their public social services for children and youth—education and welfare as well as health. I am

wondering whether there should not be some provision which would make it possible to give States with special problems additional help during the period when they are developing their programs.

Senator PEPPER. Now, Doctor, would you be good enough to give us what your individual views or suggestions might be about that, as to what could be done?

Dr. ELIOT. Well, I would have to go back to the Social Security Act. We have, of course, a very small program under the Social Security Act, but there is a device which has been introduced by the Congress there which I think you might consider. We have two funds. One is a fund that must be matched by the State. The other is a fund that does not have to be matched by the State.

Now, I do not know whether some formula might be devised by which a fund is introduced to be used to help the States, as the Social Security Act puts it—"To give them assistance in carrying out their State plan."

Senator PEPPER. A sort of a discretionary fund?

Dr. ELIOT. Yes, something of that sort.

Senator PEPPER. That is not strange to us, because as I recall yesterday we passed the conference report, which in substance was the passage of a national aid to airport construction program, and I am confident that there was a discretionary fund provided in that bill that was subject to the disposition of the national authority, to help areas where it was considered desirable to help beyond the matching principle.

Dr. ELIOT. We have been able to distribute this small amount of money that is available under the Social Security Act to the States that have greater health needs, of one type or the other, among the children.

When the money becomes available to pay for personal health services to insured persons it will have to be used to pay physicians, hospitals, and other personnel and institutions pretty much as they exist in each community at the time the expenditure is made.

The intervening time between July 1, 1946, when funds under title I, part B would be available, and April 1947—or whatever date is finally fixed for the personal health-services benefits to start—should be used to the fullest extent possible by the State health agencies for (1) extending existing community health services for mothers and children and the medical and hospital services for crippled and otherwise physically handicapped children; (2) organizing consultative relationships between the health centers; (3) training personnel for these services; and (4) reviewing the needs of communities and areas that do not have enough health centers, physicians, nurses, hospitals, and utilizing every possible chance to improve and add to existing facilities to meet the needs.

Each State will need to lay out a preliminary plan as to how it can effectively cover the State with essential services for mothers and children by the end of the 10-year period proposed in the bill.

This State plan will take into consideration the basic principle that each child needs preventive health services which are integrated with diagnostic and treatment services, regardless of the sources of funds that will pay for the care needed.

This means that the State agencies responsible for program planning and for community services for mothers and children, and for medical care of noninsured mothers and children will have to work very closely with the administrative agency that will be responsible for payment for personal health services to insured mothers and children. This joint action will be facilitated by the amendments proposed to S. 1606 requiring that, to the extent feasible, the Surgeon General shall utilize, and the Children's Bureau shall make grants for maternity and child health to the same State health agency.

Standards of maternity care and health services for children have been worked out in every State as part of its plan under title V, part 1, of the Social Security Act. Under the wartime emergency maternity and infant care program for wives and infants of servicemen, which was administered as a part of the maternal and child health plan in each State health agency, every State health agency has developed methods for paying physicians and hospitals, has worked out accounting and other arrangements and standards of care with hospitals and clinics, and has developed appropriate administrative machinery for handling applications, authorizations, and reports of care rendered.

I have already pointed out that since 1943 maternity care has been furnished to more than a million wives of servicemen and medical and hospital care to some 150,000 sick infants, many of whom have required prolonged hospital care in order to save their lives.

The experience gained under this program will stand the State health agencies in good stead when they expand their basic maternity and child care of other medical care programs.

Senator PEPPER. Doctor, if I may interrupt you again, there have been some who have cast some doubt as to whether hospitals and doctors would cooperate with such programs as this. Was it your experience that doctors and hospitals did cooperate with the emergency maternity and infant care program in the country?

Dr. ELIOT. There is no question about that. We have recently had reports from the States about that matter. If I remember it correctly, there were some 48,000 doctors cooperating under the program, and that, I think you should bear in mind, was during the war years, when such huge numbers of other doctors were with the armed forces. I think that there are some 5,000 hospitals that have cooperated with us, or rather with the State health agencies, because the arrangements are all made by the State health agencies under this program.

Under the existing maternal and child health and crippled children's programs physicians are being paid by State health agencies for the time they give in clinics and conferences, and for medical and surgical care, inadequately to be sure because the funds available have been so limited. The remuneration of physicians in these programs should be adequate and commensurate with an income appropriate to their training and years of experience.

Dental programs for children have been developed in 47 States. In 32 of these States dentists have been employed to correct dental defects, to fill teeth, as well as to provide educational programs.

Dental clinics are beginning to reach out to rural children. State health agencies have been exploring how dental services could be organized to reach larger numbers of children. At present the number reached is but a very, very small fraction of those who should have the benefit of the program.

By and large, in the past, dentists were not trained to treat children. Literally thousands of dentists will need to be added to the existing roster. Special training in children's dentistry will be required by large numbers of those in practice today if the needs of children are to be met.

The program of dental care and dental education for children must be tied in closely, or be a part of, the preschool child-health program and of the school health services in order to be related to the general medical care of the children.

We know that if we wait until a child enters school before we start care, the annual rate of defects will be higher.

The relationship between dental caries and nutrition is gradually being better understood. Physicians, dentists, and health administrators will need to develop a very close working relationship in providing service for each individual child.

School health services have been developed in many counties under the existing State maternal and child-health programs. The number of children reached each year—an average of about 1,700,000—is obviously too small compared with the number of children attending school.

In many communities school health examinations as well as health education are provided by the education authorities.

The provision for cooperative working agreements between State health agencies and other public agencies under title I, part B, would provide full opportunity for cooperation between the State health agencies and the State and local education authorities in providing adequate school health services.

Unless we have an adequate school health service with appropriate resources to take care of all conditions found, however, 15 to 20 years from now we will be in little better position than we are today with respect to the health and physical and mental vigor of our young people.

The primary need is for money to establish and carry out a program and to train personnel.

Let me remind you again that pediatricians, and obstetricians, specialists for eye, ear, nose, and throat, and children's dentists to whom county health officers should be able to turn are not to be found in many rural areas.

Specialists who practice or serve as consultants need hospitals and clinics where they can treat their patients as they do at medical centers.

There must be a plan to remunerate them adequately for the time they give to the local health agencies, for school work, or visiting sick children with local general practitioners.

Child experts who settle in smaller communities need to have means of keeping in touch with the large medical centers where special services are provided and where research is carried on. I have no doubt that many physicians would be willing and glad to settle in smaller cities that are the centers of rural population if conditions such as I have described are met.

A number of pediatricians returning from service with the Army and Navy have asked me where they can fit into the national program

of health service for children. Given appropriate hospital and clinic facilities, many other types of specialists could be made available to mothers and children who do not now have access to them.

A chain of hospitals and clinics and health centers is needed, as has often been advocated, reaching from the health center back through the small rural hospital and the district hospital to the large medical centers.

Consultation and diagnostic service and treatment could thus be provided for the people as well as postgraduate training for professional workers.

Itinerant health services and diagnostic clinics comparable to those developed under the crippled children's service could be organized to reach out to rural communities too sparsely populated to warrant permanently established clinics.

They should also be connected with the chain of health centers. The links in the chain may be forged together by the State and local health agencies who carry the public responsibility for seeing that the health interests of the people of the State are served.

There are a few examples today of this kind of organized health service for mothers and children in rural areas. If, for instance, every State had now at least one community children's clinic comparable to the children's clinic in the rural area of the northern peninsula of Michigan, linked as it is to the pediatric service of the great State University Medical Center at Ann Arbor, knowledge of how to organize and provide adequate health and medical service for children would be rapidly disseminated, and many new methods of effectively distributing health service and care would be devised.

General practitioners would have the benefit of working as a team with health officers and specialists. Local health departments would have the staff to organize the school health services and provide special clinics for preschool and school children who are suffering from such conditions as rheumatic heart disease or cerebral palsy, or with defects of vision or hearing.

An example of a service organized by a state health agency is the maternity hospital located at Oneida, Ky. Here a well-trained obstetrician, aided by maternity nurses—trained as midwives—provides in a hospital of 24 beds the best kind of maternity care for the women of that mountain area.

The demand for the service has already outstripped the capacity of the hospital. Still another is the health center and maternity clinic organized by the Birmingham health department with help from the State health agency to meet the needs of a section of the city where some 75,000 Negroes live.

Under the program of services to crippled children, the States have had 10 years of experience in the provision of medical care of highly specialized kinds, largely orthopedic and plastic surgery with the associated hospital and itinerant clinic care.

Ways of locating crippled children have been developed, techniques or organizing diagnostic and treatment clinics for rural areas and small cities and towns have been devised, methods of providing after-care in convalescent or foster homes or in the child's own home have been worked out with medical and other social workers.

Altogether, probably some three-quarters of a million crippled children have been given medical, surgical, and hospital care.

In 17 States, pilot programs for care of children with rheumatic heart disease have been started, in 10 States programs for children with cerebral palsy, and in 7 States there are special programs for children with cleft palates. Under this bill, S. 1606, this program of care for crippled children can go forward rapidly on the basis of this experience. I have here some suggested plans for the expansion of certain types of programs for which there is enough experience and basic knowledge to warrant immediate planning by the States. They include plans for care of prematurely born infants, for children with cerebral palsy, and with vision and hearing defects. I have here a description of the State programs for care of children with rheumatic fever which have been developed under the Social Security Act. These are the foundation on which the States will build.

Plans for providing dental care for children are in the process of development, starting with the youngest group of children and extending gradually to the older groups.

Other examples could also be cited. There is great need to develop broad demonstration programs on a community or area basis that can be expanded as fast as personnel can be trained and facilities can be made available to cover the States.

SUGGESTED STATE PROGRAMS

I would like to submit these suggested plans for the record as examples of what needs to be done if all children are to be reached with the kind of care we know how to give, and for which there is enough experience and basic knowledge to warrant immediate planning by the States. They include plans, for instance, for the care of prematurely born infants, for children with cerebral palsy, vision or hearing defects.

I have with me a description of the State programs now in effect, for care of children with rheumatic fever, that have been developed under the Social Security Act. These are the foundation upon which States can and will build if there is more money available to them.

Plans for providing dental care for children are in process of development, starting with the youngest group of children and extending gradually to the older groups.

Other examples could be cited, many other examples.

There is great need to develop broad demonstration programs on a community or area basis that can be expanded as fast as personnel can be trained and facilities can be made available to cover the States.

I would like to submit these plans for the record, if it is possible to have them in the record, as examples of what needs to be done if all children are to be reached with the kind of care we know how to give.

I do not know, Senator Murray, whether it would be possible to put these in the record, but they are suggestive of methods that could be used in working out programs.

The CHAIRMAN. It seems to me that they are of sufficient importance to be put in the record. They may be incorporated in the record.

(The plans are as follows:)

UNITED STATES DEPARTMENT OF LABOR, CHILDREN'S BUREAU
WASHINGTON, D. C.

SUGGESTIONS FOR DEVELOPMENT OF SERVICES FOR CHILDREN WITH CEREBRAL PALSY

What is cerebral palsy?

Cerebral palsy is a disorder of the brain in infants and children affecting the control and normal coordination of the muscles of the body. The nature of the muscular involvement depends upon the area of the brain affected. It may be so slight as not to be noticeable or it may involve all parts of the body and in some instances result in feeble-mindedness. It is sometimes called spastic paralysis or birth-palsy. It may be caused by injury to the brain during or following birth, by disturbances in the normal development of brain tissue, or by diseases of the brain.

Parents search everywhere for help

The parents of children with cerebral palsy are best able to tell what it means not to be able to find help for them. These are paragraphs from letters which have come to the Children's Bureau:

"* * * Why can't the same thing be done for spastic paralysis as for infantile paralysis? Maybe you've never heard of it for many doctors do not know the name. It isn't caused from a bug and it is not contagious. It is caused from a brain hemorrhage that destroys cells. Those cells can never be restored, but children can be taught to do things like other children with the proper training. Their bodies are inactive, but most of them have brilliant minds. Most of these children are put in hospitals for feeble-minded people, buried away for the rest of their lives because it costs too much to put the children in one of the two schools there are. One is in New York and the other one in Florida.

"My little girl will be 3 in June and she doesn't walk, talk, or sit up. The only way possible for her to be one of the lucky ones is for my father to cash in all his bonds, his nest egg, which I hate to do as he has worked so hard for them. My husband is in the Navy somewhere in the Pacific, so you can know that we are of only moderate means. We have a little boy 14 months old but he is normal. * * *"

"* * * Enclosed is an article from Good Housekeeping on 'What is spastic paralysis?' We, too, have a beautiful boy, David, who is 7 years old and a perfect body, but who also is a spastic child, unable to stand alone or walk. Would it be humanly possible for us to have a hospital and a school for these unfortunate children so they can get medical care and be educated, too?

"Our case is like the article I am sending you. We have done everything possible we can do for him. Also wrote to Dr. _____ but we are only working people, and his price was more than we could pay. Now we, too, have had to place this wonderful child who has a good mind but cannot sit up alone or walk, into a State institution, having nothing done in medical science or schooling. Isn't there something that can be done for the spastic paralysis children? * * *"

"* * * The editor of the Rotarian magazine published in the March issue an article on spastic paralysis. It interested me very much as I am a mother of two children, both spastic. I wrote him regarding this new program that is under way in several States for the cerebral palsied child to see how we could get behind it 100 percent.

"Tommy, 8, and Mary, 5, both spastic, neither walk nor talk; both appear to be so active. Their bodies are of normal growth and they have such intelligent expressions. They seem to understand most everything and both enjoy good health. We have had them to many doctors and they all say they are definitely spastic children and that nothing can be done for it. But reading several articles here lately telling of the work and the hope of modern medical science for greater improvements has brought a ray of light to us. We just can't give up as our children mean so much to us."

"I have an 18-year-old boy who is a spastic case and who has received very little education due to the fact that I have been unable to place him in any home where he would receive education as well as physical care. I have attempted to enlist the aid of the Salvation Army, Catholic Charities, Big Brothers, Child

Welfare Society, and other societies, but have been unable up to the present time to achieve any results. I am, therefore, taking the liberty of writing to you and asking you whether you take an interest in his case."

Thousands of children are affected

It is estimated that there are over 160,000 children in the United States under 21 years of age with cerebral palsy. On the basis of surveys conducted in a few States, it is estimated that 7 of every 100,000 babies born each year will have cerebral palsy. This means that there will be 7,800 new cases in the United States each year. One of these will die by 6 years of age.

Using these estimates, New York State is likely to have about 17,000 children with cerebral palsy while Nevada will have about 125. These children are pretty evenly scattered over the entire population of the United States.

Limited services are now available

There are some medical and surgical services available for the care of these children in all States through the crippled children's programs which are financed in part by funds under the Social Security Act. However, in no State has it been possible to provide all of the facilities and services which are essential for rendering adequate care for these children. When services are crowded and funds limited, the child with cerebral palsy is frequently placed on the waiting list, however, because his condition may be less acute than that of children with other conditions. Sometimes nothing is done for him because the physician is reluctant to start physical treatment, when he knows that there are so many other things which the child needs if he is to improve and which he will not be able to get and sees the difficulty in raising the parents' hope beyond what can be realized by a limited approach.

In a communication to the Children's Bureau, the director of the crippled children's services in a State where there is adequate provision for hospital and surgical care pointed out that what he could do was only 5 percent of what was needed. It left untouched "95 percent of the problem." This 95 percent is missing almost everywhere. In all States there is need for training personnel in the special services which these children require, need for more adequate facilities for the long-time care and training of children accepted for care and need for funds to provide the care.

There are only a very few private institutions which now provide the special services needed for children with cerebral palsy.

A team of professional workers is needed

The child with cerebral palsy has many problems: He has difficulty with his speech; his motor coordination is bad; he may have difficulty in balancing himself; sometimes he will not be able to stand alone or sit by himself. He is frequently unable to attend the regular school. He may need to get his education through special classes or at special institutions.

It takes the combined efforts of orthopedist, pediatrician, neurologist, psychiatrist, psychologist, physical therapist, medical social worker, occupational therapist, speech therapist, nutritionist, and educator working together as a team to provide the services which are needed by these children. If a coordinated plan can be made and carried out, however, the condition of 70 percent of these children can be improved. About 30 percent are not educable.

Services are very costly

It costs a great deal to make all the needed professional services available for an individual child. Institutional care may be required as part of the training process, where the child may have to spend many months at a time. Good care and training of this sort costs at least \$40 per week. When the child is at home—as it is planned he will be as much as possible—the special services which he needs in order to continue to make progress are also expensive. Even well-to-do families find this a financial burden which they cannot bear.

The economic barrier to care for these children must be removed. A public program needs to be organized as a health service in a community. Such services must ultimately be available to the parents of every child with cerebral palsy who wishes to use them, wherever they live.

What would be done under a public program

The State agencies using funds available under title I, part B of S. 1606 as amended, cooperating with the maternal and child-health services, would plan and develop a program with these objectives in mind. Something like the following might be done (see attached graph) to provide the special services needed by the cerebral palsied child.

- (a) Central observation and diagnostic centers connected with medical centers.
- (b) Field clinics to supervise the care and management of patients living at home.
- (c) Special hospital training school for long-time care and management of selected cases requiring more intensive supervision and training.

Central observation and diagnostic centers

These should be located in large metropolitan areas, preferably connected with a teaching medical center where expert professional services of all varieties can be called upon to render diagnostic services for the cerebral palsied child and a plan of treatment outlined on the basis of pooled information. In such centers, there should be made available the services of a pediatrician, a neurologist, an orthopedist, an otologist, an ophthalmologist, a psychologist, a physical therapist, an occupational therapist, a speech therapist, a medical social worker, and a teacher.

If in such center 10 beds could be reserved for patients requiring intensive observation and if the average stay of such patients was 14 days, the center would be able to serve 260 such patients per year. If such centers were so placed to serve population areas of 1,000,000 it would require eventually about 130 such centers. (The estimated number of cases in such population areas would be 1,260 cases under 21 years of age.)

General functions of staff:

- (1) Provide expert diagnostic and special treatment services. (Complete work-up of cases plus any special orthopedic surgical care when indicated.)
- (2) Train professional personnel within the State or area for special services.
- (3) Supervise special services being rendered at outlying training units and field clinics.

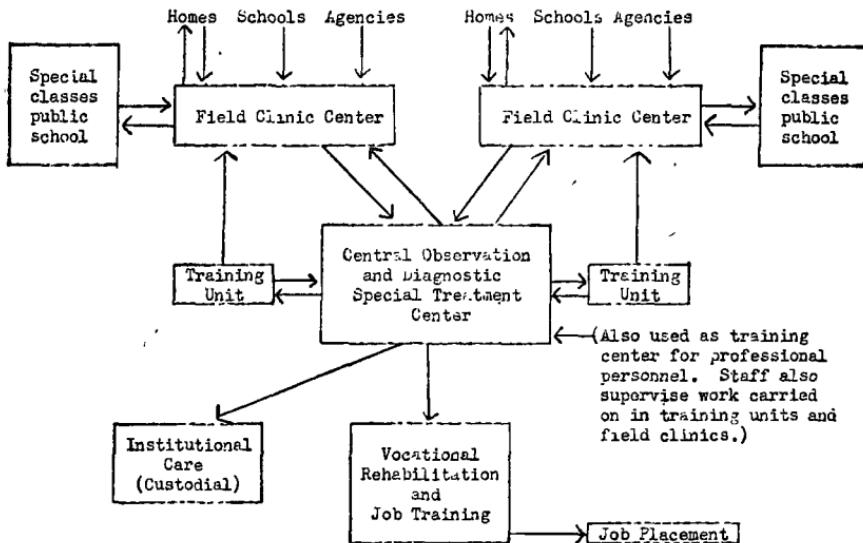
Field clinics

These should not be special clinic centers but rather a special type clinic service provided at the established local health or hospital centers used in the State crippled children's program. Some of these are connected physically with public health units, others are established in the out-patient clinics of local hospitals. These should be well distributed throughout the State with at least one in every county (or district in sparsely settled areas) and preferably developed on the basis of population areas.

These clinic centers would serve as diagnostic and screening clinics and also provide follow-up services. They would select patients for referral to the central observation and diagnostic center and would also accept patients from the central clinic for follow-up services, on the recommendation of the central clinic.

Training schools

The schools would be located in strategic areas throughout the State according to population areas. They would serve as centers for the training of cerebral palsied children who require a more intensive program of medical supervision and physical and educational training than would be possible in field clinics. Some children would be in residence (not more and preferably less than 50 to a school) and others would reside in their own homes or in foster homes and be transported to the unit for daily care and training. The average duration of stay would probably be about 6 to 9 months. All children admitted either in residence or as day patients would be referred from the central clinic. They may be returned to the central clinic at periodic intervals for reexamination or observation or may be referred directly to the field clinic when satisfactory progress has been made and they are ready to be returned home for follow-up in the field clinics.



PERSONNEL

Field clinic centers

Pediatrician.
Public health nurse.
Physical therapist.
Medical social worker.

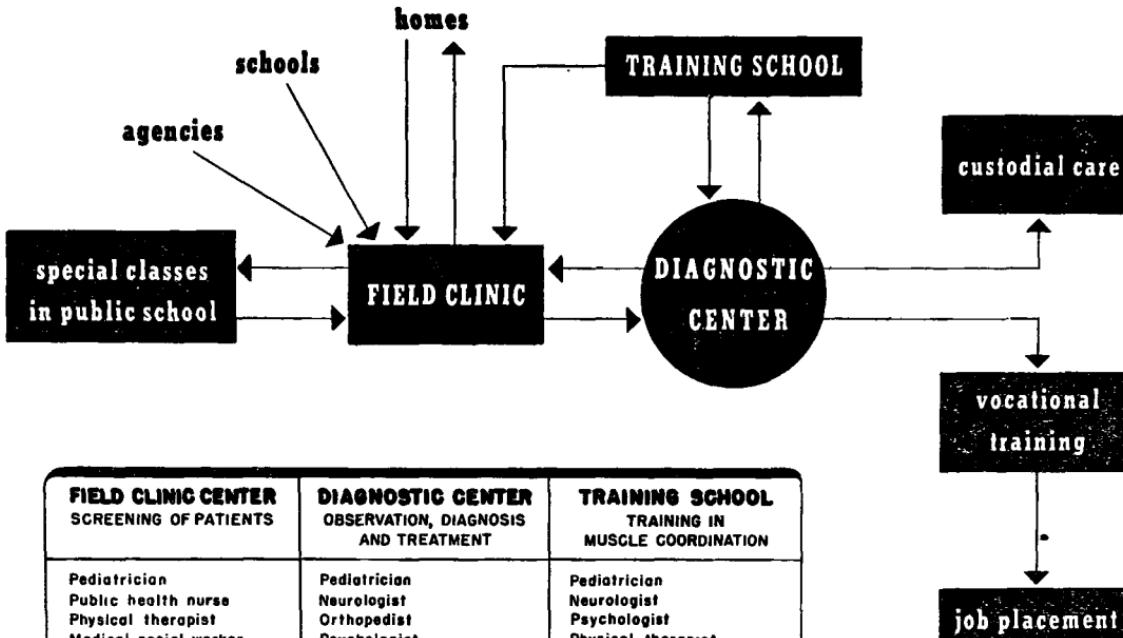
Central observation, diagnosis-

Pediatrician.
Neurologist.
Orthopedist.
Psychologist.
Physical therapist.
Occupational therapist.
Speech therapist.
Medical social worker.
Teacher.

Training unit

Pediatrician.
Neurologist.
Psychologist.
Physical therapist.
Occupational therapist.
Speech teacher
Medical social worker.
Teachers.
Nurses

SUGGESTED COMMUNITY ORGANIZATION PLAN FOR CARE OF CHILDREN WITH CEREBRAL PALSY



FIELD CLINIC CENTER SCREENING OF PATIENTS	DIAGNOSTIC CENTER OBSERVATION, DIAGNOSIS AND TREATMENT	TRAINING SCHOOL TRAINING IN MUSCLE COORDINATION
Pediatrician Public health nurse Physical therapist Medical social worker	Pediatrician Neurologist Orthopedist Psychologist Physical therapist Occupational therapist Speech therapist Medical social worker Teacher Nurses	Pediatrician Neurologist Psychologist Physical therapist Occupational therapist Speech teacher Medical social worker Teachers Nurses

UNITED STATES DEPARTMENT OF LABOR, CHILDREN'S BUREAU
WASHINGTON, D. C.

SUGGESTED PLAN FOR PREVENTION OF MORTALITY DUE TO PREMATURE BIRTH

A premature infant is an infant born more than 2 weeks before the end of 9 months of pregnancy. From the point of view of the type of care needed, any infant who weighs less than 5½ pounds at birth is considered premature.

Premature birth as an important cause of infant mortality

Premature birth is responsible for more infant deaths in the United States than any other cause.* In 1943, 12 out of every 1,000 babies born alive died because they were born prematurely. This was nearly one-third (29.2 percent) of all the deaths under 1 year of age, and nearly half (46.2 percent) of the deaths during the first month of life.

Studies indicate that a reasonable estimate of the frequency of premature birth is 5 percent of all live births. This means that for our present population and current birth rate, approximately 140,000 premature infants are born each year.

Many of the deaths due to prematurity are preventable, as has been shown by the records of hospitals that have developed services providing special medical and nursing care for these infants. General reduction of mortality from premature birth depends, however, upon the wide-scale development of special programs that provide the type of care that is essential if these infants are to survive.

The importance of prematurity as a cause of death, and the fact that a considerable proportion of deaths due to this cause could be prevented by proper care of all premature infants, indicate the need for wide-scale programs to provide such care.

Methods by which infant mortality due to premature birth can be reduced

Reduction of mortality due to premature birth depends upon (1) lowering the proportion of infants born before term, (2) prevention of injury at birth, and (3) improvement of the chances of survival of infants born prematurely.

Methods (1) and (2) are a logical part of any good maternity program. Even with the best maternity care, however, large numbers of infants will continue to be born ahead of time. To improve the chances of survival of infants born prematurely, there must be provided for them (a) expert medical care, (b) expert nursing care, and (c) special facilities for giving such care.

As a result of studies made within the last decade or so, new knowledge of the problems of prematurity and of the techniques for meeting these problems has been developed. Because so much of this knowledge is new, and because services in which it has been given full application are still relatively few, the proportion of physicians and nurses who have had special training and experience in this field is still small.

Not only should the physicians and nurses caring for premature infants have had special experience, but the medical and nursing care must be available at the moment it is needed. The physician should be on call at all times, and nursing care must be continuous. In a hospital nurses are needed in the proportion of one nurse for every four premature infants, both day and night. This is twice the number of nurses needed for care of newborn infants born at term.

The special facilities required for care of premature infants include apparatus for resuscitation of infants who do not breathe spontaneously, and for administration of oxygen, incubators and heated bassinets, equipment for blood transfusion and for administration of fluids subcutaneously and intravenously. The premature infant is especially susceptible to infection, so hospitals caring for premature should be equipped to provide protection against all sources of infection. This protection requires separate units for care of the premature, and provision for individualized nursing care. There must be ample facilities for sterilization and for observance of aseptic techniques in the handling of the infants and in preparation of their feedings. Air conditioning of the premature unit is desirable because the infants do better if temperature and humidity are kept constant at the optimal level.

All premature infants need hospital care. This is essential for the smaller, less robust infants. Some of the larger, more robust infants may do well at home if the family can be helped to obtain the equipment that will be needed and if medical attendance and guidance in the care of the baby are available from a

physician and nurse who are expert in such care. Assistance in home care is important for infants discharged from the hospital as well as for those kept at home.

Essential features of a suggested State program for reduction of mortality due to premature birth

The aim of a State premature program is to make available to all premature infants born in the State the type of care that offers the greatest opportunity for survival. Essential features of such a program include: (1) opportunities for physicians and nurses participating in the program to obtain special training and experience in the care of premature infants; (2) a program in each local public health unit for emergency medical and nursing services to premature infants born at home, and, either transportation to a hospital, or nursing guidance to the family in caring for the infant at home, with medical attendance on special pediatric consultation and assistance from a medical social worker, as needed; (3) in each local public health unit maintenance of a supply of special equipment for loan to homes in which there are premature infants; (4) establishment of special centers for care of premature infants in hospitals so distributed that hospital care will be accessible to all premature infants born in the State, each center to have sufficient medical and nursing personnel experienced in the care of premature infants, as well as all necessary facilities and equipment; (5) provision in the State health department for leadership direction, and coordination of the total program, and for special pediatric, public health nursing, and medical social service consultants to give consultation services to those engaged in local public health and hospital programs.

Illustration of planning for a State program for care of premature infants

The State which is used as illustration has a population of about 3,000,000 inhabitants, about one-fourth of whom live in four large urban communities, three-fourth in small towns and rural areas. Two-thirds of the births occur in towns of less than 2,500, or in rural areas. In 1943 there were 77,535 live births in the State, which would mean about 3,877 infants born prematurely. Approximately one-third of the births occurred in hospitals.

Studies of the distribution of physicians and hospitals in the 67 counties of the State, and of the public health organization, reveal serious inadequacies and unequal distribution. Remedy of these conditions lies outside the scope of the program for premature infants, but is basic to its success. Planning for the care of premature infants will be based on the assumption that essential hospital construction or remodelling will be possible and that recommendations made in 1945 for the establishment of 36 local health units, and for the employment of additional medical and nursing personnel (140 part-time clinicians in place of the 82 employed in 1942, 570 public health nurses instead of 212) will be put into effect.

Direction and pediatric consultation.—To assist the director of the general maternal and child health services in giving leadership and direction to the total program, and to provide consultation service to private physicians and to clinicians employed by local health units, a medical consultant who is a specialist in children's diseases and who has had, or can be given, advanced training in the care of premature infants, should be appointed to the staff of the State health department.

Public health nursing consultation and supervision.—Public health nursing services to infants in their homes will be given by generalized public health nurses, working in the local health units under generalized supervisors. Consultant nursing service should be provided by special nursing consultants in maternal and child health on the staff of the State health department. To assure good care for premature infants, at least one generalized nursing supervisor in each local health unit should have had special experience in the care of newborn and premature infants. The nursing consultants in maternal and child health should have had advanced training in pediatric nursing, including care of newborn and premature infants. The program for premature infants must assume responsibility for providing opportunities for the supervising and consultant nurses to obtain the special training and experience that they need.

Medical social service consultation.—Medical social workers already on the staff will aid public health nurses and local social workers in helping families to meet special social problems that affect the care of the premature infant.

Equipment for loan to homes and for transportation.—The amount of equipment needed in each of the 36 local health units for loan to the homes and trans-

portation of infants to hospitals will vary according to the population served, but will average about as follows: 2 incubators; 4 small tanks of oxygen; 1 "ambulance" incubator; 2 hand carriers; and a frequently renewed supply of emergency kits containing blankets, clothing, and feeding equipment.

Hospital centers for premature infants.—Establishment of centers for premature infants in 11 existing hospitals, selected because of appropriate distribution, and in a twelfth hospital that would have to be constructed, could provide for hospital care of all premature infants born in the State, either in their own county or in a county immediately adjacent. The 3 large cities would need 2 or 3 hospital centers each, so a total of 16 centers should be established in 12 selected counties.

As a basis for determining the number of bassinets (including incubators) needed in these centers it may be assumed: That in the counties in which the hospitals are located all premature infants will be hospitalized; that at least 30 percent of the smaller (under 4½ pounds) prematures from adjoining counties will be hospitalized; that smaller infants will require on the average of 40-day hospital stay and larger prematures a 30-day stay; and that the bassinets will be 100-percent occupied. It can be calculated from this, and from known distribution of births in the State, that a total of 205 bassinets (including incubators) will be needed, 7 to 10 in each of 8 centers and larger numbers in the remaining 8 centers.

Each center should be under the direction of a part-time physician with special training in the care of infants and children, and each will need at least part-time services of a resident physician. Each will need at least one well-qualified head nurse, the larger centers will need two. Medical social service should be available either from the hospital staff, the local public-health unit, or other community agency.

Special equipment needed will include incubators and bassinets in approximately the following proportions for each center: Incubators equipped for continuous administration of oxygen, 30 percent; heated bassinets, 30 percent; simple bassinets, 40 percent. In addition, each hospital should have a resuscitator in the premature unit, and a second resuscitator and a heated bed in the delivery room. Less specialized equipment will be supplied by the hospital.

UNITED STATES DEPARTMENT OF LABOR, CHILDREN'S BUREAU
WASHINGTON, D. C.

PLAN FOR CHILDREN WITH DEFECTIVE VISION

Protection of eyesight during childbirth is of inestimable importance because of the need of the individual for good vision during both the developmental years and in adult life. The child needs to be able to see well to obtain full benefit from his formal education and from all of the other activities which form a part of normal physical, mental, emotional, and social development. The adult needs good vision for economic independence and for personal satisfaction. The child who has a visual defect but tries to use his eyes as if they were normal places a strain upon his eyes that may result in added impairment. If, even with strain, he cannot see well, he falls behind in his school work because he cannot see the blackboard or because the page of his book is blurred, or he loses contact with his playmates because he cannot partake in sports or cannot recognize a friend across the room.

Classification of visual defects according to degree of handicap

Children whose vision is less than normal can be divided into four groups according to the severity of the handicap. The blind, strictly speaking, are those who are unable to perceive light, but for practical purposes they may be considered as those who have no useful vision. The partially seeing are those who have some useful vision but who, even with the aid of the best possible correction by glasses, are still unable to use for close work materials that other children may use safely and easily when properly fitted with glasses. A third group are those that have defects that can be corrected by treatment or properly fitted glasses so as to give normal vision or at least a higher degree of useful vision than that possible to the partially seeing children. There remains a fourth group who have less than normal vision but whose defect is so slight that their eyes can accommodate to the defect without developing undue fatigue, and who do not, therefore, require correction by glasses.

Incidence of defective vision in childhood

In 1930 it was estimated that there were 15,000 blind children in the United States; estimates based on more recent figures suggest that the number may be approximately the same at the present time. There are approximately 50,000 partially seeing children. Most surveys indicate that at least 30 percent of all school children have less than perfect vision, and it is estimated that of the children aged 3 to 17 about 4,000,000 have refractive errors requiring correction. One to 1.5 percent of school children have crossed eyes. Conjunctivitis, or inflammation of eyelid lining, often an acute infectious condition, may vary in frequency from time to time; one survey found 3 percent of school children had conjunctivitis.

Causes of visual defects

Of children in schools for the blind, about half are sightless because of conditions of prenatal origin other than syphilis, and nearly one-fourth as a result of infectious diseases. Injuries are responsible for loss of vision of 8 percent; general diseases, tumors, and unspecified conditions account for the others. Of the infectious diseases resulting in blindness, ophthalmia neonatorum caused 11 percent of the total number of cases, prenatal syphilis 5 percent, and meningitis 2 percent.

Causes of defective vision other than blindness are chiefly developmental abnormalities in the growth of the eyeball or related muscles.

Prevention and treatment of blindness and visual defects

Blindness due to congenital syphilis and to ophthalmia neonatorum can be prevented by proper medical care of the mother during pregnancy and of the infant immediately after birth. It may be hoped that new methods of treatment of infectious diseases will reduce the number of cases due to other infections. Accident prevention should reduce the amount of blindness due to trauma.

At present we have no means of prevention of the refractive errors responsible for most cases of defective vision.

With few exceptions, once vision is truly lost to the child, it cannot be restored.

Defective vision due to strabismus can in most cases be improved by proper medical or surgical treatment.

Refractive errors include nearsightedness, farsightedness, and strabismus which usually causes blurred vision. These cannot be cured by treatment, and it is debatable to what extent treatment and general eye hygiene can check their progress. Correctly fitted glasses can, however, restore good functional use to the majority of eyes with refractive errors, and through good eye hygiene it is possible to avoid adding eye strain to the existing impairment.

Conjunctivitis and other local infections are usually amenable to appropriate medical treatment.

Detection of children with visual defects

For the detection of visual defects the ideal would be for each child to have an examination by an ophthalmologist annually. Limitations of qualified personnel make this impracticable for the present, so it is necessary to use screening procedures that will select for ophthalmological examination those children who give some evidence of visual impairment.

Screening tests have been used in many school systems for a number of years, but in a large proportion of cases the tests have not been successfully carried out. Testing with the Snellen eye charts, which is the method most widely used, gives variable results according to the techniques followed, and fails to pick out certain types of defects. Progress has been made in standardizing the methods of giving the Snellen test and in the development of supplementary inspection and tests, but further study is needed to develop a generally acceptable screening procedure. Standards need to be developed not only as to tests to be used and techniques to be followed, but as to qualifications of the personnel administering the tests and inspections, and as to classification of results so that those children who require medical attention will be recognized.

Despite the limitations of screening tests as frequently applied, they have shown their value in discovering children in need of ophthalmological examination, and improvements in the screening procedures may be expected to increase their usefulness.

Content of a suggested program for medical care of children with visual defects

A program for conservation of vision in children should include: (1) Provision of schoolrooms and teaching facilities that permit observance of good hygiene, and education of the public as to the observance of good eye hygiene in the home; (2) special classes in the schools for children who cannot see to do regular classwork without due eyestrain, and (3) a medical program for detection and treatment of children with visual defects and for consultation with educational authorities regarding planning for these children as a group and as individuals.

The medical program begins with screening procedures. For preschool children, recognition of those in need of ophthalmological examination will be chiefly the responsibility of physicians in child health conferences and of private physicians caring for young children. For children of school age, an acceptable screening procedure should be part of the school health program, so that each child will be given an eye inspection and vision test each year. An ophthalmologist should examine all children selected by the screening procedure, to determine whether the eye condition is one which requires more thorough examination and medical care.

Facilities for thorough ophthalmological examination and treatment should be available to all children. Children with defective vision whose school work is retarded should have psychometric study and those whose emotional and social adjustment is affected by their visual defect should have special help from a medical social worker and, as needed, by a psychiatrist. The medical program should, therefore, provide for the establishment of eye clinics as needed. The clinic should have staff and equipment for examination of the eyes by a specialist and for all types of eye treatment not requiring hospitalization, including the provision and fitting of glasses. Either in the clinic or through related services there should be arrangements for pediatric examination and, when indicated, psychometric study of the children referred. The services of a public-health nurse and a medical social worker should be available to the clinic and consultation services from a psychiatrist. In communities where the majority of children found to need treatment by an ophthalmologist will be referred to the one eye clinic, the ophthalmologist may make all of his examinations in the clinic and thus be able to combine the preliminary and the complete examination in most cases.

The medical program should also include provision for hospital care of children who need surgical correction of strabismus or other eye defect.

The school program for eyesight conservation includes the inspection and testing of the vision of all school children and the provision of special classes for children with partial vision. The coordination of this program with the community services for ophthalmologic treatment is an important part of the medical program. It is useless procedure to discover that a child has imperfect vision if there is no follow-up to assure that the child receives the necessary treatment. Sight-saving classes should be only for children whose visual defects cannot be corrected by glasses or other treatment to a degree that will enable them to carry on the usual classroom work without undue eyestrain.

UNITED STATES DEPARTMENT OF LABOR, CHILDREN'S BUREAU
WASHINGTON, D. C.

PLAN FOR CHILDREN WITH HEARING DISABILITIES

Children with hearing disabilities fall into two general groups: The deaf, and the hard of hearing. Various definitions are given for these terms, but a practical distinction is to classify as deaf those children who cannot hear ordinary speech even with the use of a hearing aid, and to classify as hard of hearing children with a hearing impairment who have enough residual hearing to understand ordinary speech if the sounds are sufficiently amplified. The minimal amount of hearing loss that must be present for a child to be classified as hard-of-hearing has been set at different arbitrary levels in different surveys; this is probably one reason for the differences in the proportion of children with hearing defects reported.

Defective hearing as an important childhood handicap

Loss of hearing is a serious handicap, whether the loss is complete or only partial. To the child a hearing disability is even more serious, partly because many such defects are progressive and tend to become worse with time, and

partly because the child needs to utilize all forms of contact with the world around him for the full development of his intellect and his personality. The child with even a partial defect is handicapped during early life in the acquisition of speech and, later, in his school work. His personality is affected by difficulties in maintaining normal contacts with family and playmates. These side effects, as well as the defect itself, will hamper his social and economic adjustment when he grows up. The more severe the hearing disability, the greater, of course, are the handicaps.

Prevalence of hearing defects

Recent reports of the prevalence of impaired hearing in children of school age have varied from 4 percent to 6 percent. Using 4 percent as a conservative estimate, this means that there are probably a million children under 18 in the United States who have hearing defects. There is evidence that the proportion of children with impaired hearing is higher in rural areas than in cities.

Causes of hearing defects

Statistics as to causes of deafness show that developmental defects are responsible for 50 to 60 percent of all cases, and that of the remaining 40 to 50 percent, the majority result from infections, especially meningitis, scarlet fever, measles, and influenza.

Frequent causes of less marked hearing impairments are such conditions as a foreign body or impacted wax in the ear canal, acute or chronic otitis media or other infection of the upper respiratory tract, and overgrowth of adenoid tissue in the nasopharynx. If untreated, these conditions usually lead to progressive loss of hearing.

Many of the hearing impairments of children are progressive. Slight hearing loss has a tendency to become marked when not properly treated.

Prevention and treatment of hearing defects and the resulting handicaps

With the present state of our knowledge, nothing can be done to prevent or cure deafness due to developmental defect. It may be expected that the incidence of deafness due to infectious diseases will decrease with the widespread use of new drugs now available or being developed for the treatment of infection. Loss of hearing due to active infectious processes, foreign bodies, overgrowth of adenoid tissue, etc., can often be cured, or at least its progress checked, by medical or surgical treatment. The earlier such treatment is given the better the chance of success, so it is important that the hearing difficulty and its cause be recognized promptly.

For the many children whose hearing cannot be restored by treatment, the great hope lies in the reduction of the handicapping effects of the disability. All children with even a minimal progressive deafness should learn lip reading and be aided in speech conservation. Hearing aids can help many to hear better. Educational programs should be adjusted according to individual needs: For one child this may mean merely having a seat near the front of the class, another will need to attend a special class for the hard of hearing. The child whose defective hearing has resulted in poor speech will need speech training, one who has practically total loss of hearing should attend a special class or a school for the deaf. A large proportion of the children can be aided in making a psychological adjustment to their handicap through the help of a medical social worker; some will need aid from a psychiatrist.

Before trying to help the hard-of-hearing child it is necessary to discover which he is, and the nature and degree of his disability. Mass audiometer tests, in which a special phonographic testing device is used for the testing of the hearing of children in groups, followed by individual tests with the pure-tone audiometer for those who fail to pass the group tests, are an effective means of evaluating the hearing of children of school age. The preschool child's hearing must be tested individually. Examination by an ear specialist of all children found to have a significant impairment of hearing is necessary in order to determine the nature and prognosis of the defect and whether it is amenable to treatment. Psychometric tests are needed to evaluate the child's intellectual development.

Content of a suggested program for the prevention of deafness and for medical care of children who are hard of hearing

Since prevention of deafness depends chiefly upon prompt and correct treatment of infections which may cause deafness, a preventive program must include education of the general public, and especially parents, physicians, and

public health nurses, to make them more aware of the importance of such treatment. The program should also undertake to keep physicians informed of new developments in methods of treating the infections that may lead to deafness.

For children whose hearing is impaired, the earlier treatment of the condition is begun, and the sooner steps to reduce its handicapping effects are undertaken, the more successful such measures are likely to be. The educational part of the program should therefore include information given to parents and all persons in contact with children as to the signs of imperfect hearing and the importance of otologic examination for children who exhibit such signs.

Provision is made in special classes or in State schools for the deaf for the care of children who are totally deaf, but for the care of children who are hard of hearing other special programs are needed. Such programs should include reexamination of children who have been placed in schools or classes for the deaf, to discover those children who, with proper medical treatment or with hearing aids, could recover sufficient hearing function to be educable in regular school programs.

A program to provide medical care for children who are hard of hearing should include (1) audiometric screening tests to discover children with impaired hearing; (2) examination by an ear specialist for diagnosis, prognosis, and determination of need for treatment; (3) pediatric examination; (4) psychometric examination to relate otological findings to the total physical and mental status of the child; (5) appropriate medical or surgical treatment for suitable cases; (6) fitting of hearing aids when indicated and provision of hearing aids for those whose families cannot provide them; (7) medical-social service and, when indicated, psychiatric study and treatment; (8) co-operation with educational authorities in (a) development of the teaching of lip reading, of speech conservation and correction, and of special classes for the hard of hearing, and in (b) determination of suitable adjustment of educational programs for individual children.

Status of present programs

State programs for hard of hearing are being promoted by both State departments of education and public health. Audiometer testing has been introduced in most States; in some of these annual testing is required by law, but in many States the program is still very limited. Reports, admittedly incomplete, indicate that testing programs now cover annually about 7 percent of the children 5 to 20 years of age. Even allowing for incomplete reports, this indicates that a large proportion of the children of school population are not now being tested.

Little information is available as to the proportion of children found to have deficient hearing who receive medical care. Several States have recently organized special clinics for the treatment of hearing impairments as part of their programs for crippled children under the Social Security Act. Though few in number, these clinics are demonstrating their value. Hearing aids are being provided under some of the State programs.

Illustration of planning for a State program of prevention of deafness and medical care for children who are hard of hearing

The first step is the appointment by the State agency of a person trained in hearing conversation problems, who will direct the State-wide program and work with the medical profession and the appropriate State and local agencies in the development of the program. We will direct the general educational and medical programs, and will work with school authorities in planning the development of special educational facilities for the hard-of-hearing children.

Educational program.—The general educational aspect of the program can be carried on concomitantly with the development of the program for medical care. As the latter part of the program develops, increasing opportunities for educational activities will appear, and additional personnel who can contribute to the educational program will become available.

Development of medical program.—The program of medical care for the hard-of-hearing should be developed as a whole, county by county, rather than by introducing it State-wide on a piece-meal basis. Tests of hearing are valueless without adequate follow-up services, except as they are utilized to reveal the need for such follow-up care.

Case-finding.—Case-finding among children of preschool age must depend chiefly upon the examinations given in child-health conferences and upon recognition of evidences of hearing impairment by parents, private physicians, nurses, and nursery-school teachers.

Children of school age are best reached through audiometer tests in the schools. Provisions should be made for enough audiometers and technicians to make possible a test of each child annually. If this is not possible at first, the absolute minimum should be a test every third year, preferably in the first, third, sixth, and ninth grades.

Otolological examination.—There should be an ear specialist who will examine all children selected by the screening test, to determine whether the condition is one for which the child should be referred for more thorough examination and treatment. A parent should be asked to be present at the child's examination so that the ear specialist can explain the need for medical care.

Special clinics for medical treatment of hearing defects.—An important part of the medical program is the development of clinics for medical diagnosis, prognosis, and treatment of hearing impairment and conditions leading to hearing loss. Such clinics are now available to few children outside of the large cities. The clinic staff should include an ear specialist, a pediatrician (or at least a physician with training and experience in the care of children), a public health nurse, a medical social worker, and a clerk. Consultation services from a psychologist and a psychiatrist should be available. Transportation service should be provided to enable children who live at a distance to attend the clinic as often as necessary for diagnosis or treatment.

If no other clinic is available in the community for diagnosis and treatment of conditions of the ears, nose, and throat, this should be included as part of the program of the clinic for conservation of hearing because of the importance of such diagnosis and treatment in the prevention of hearing impairments.

The clinic should be equipped to fit hearing aids when these are indicated.

After examination of the child's physical condition, with special reference to his hearing, has been completed, and his mental status and emotional adjustment to his defect have been studied, the clinic staff should confer to evaluate his needs, and decide what treatment—medical, psychiatric, and social—is indicated. Whatever treatment is necessary should be instituted.

A conference with the appropriate educational authorities should make available to them all information that will be of value in planning an appropriate educational program for the child.

Hospital care.—Provision should be made for hospitalization and appropriate treatment for children who need surgery or other therapy that cannot be given in the clinic. Provision for necessary operations on tonsils, adenoids, and mastoids are an important part of the program of hearing conservation.

Organization of services.—Audiometric testing, and preliminary examination by an ear specialist of children shown by the test to have defective hearing, should be a part of the school health program. Special clinics for conservation of hearing and hospital care for medical treatment of conditions related to hearing should be a part of the general community health services for children.

UNITED STATES DEPARTMENT OF LABOR, CHILDREN'S BUREAU

WASHINGTON, D. C.

SUGGESTED PROGRAMS FOR MENTAL HEALTH OF CHILDREN

There is abundant evidence to show that the personality stability of the adult is directly a reflection of success or failure of earlier childhood physical and mental health. Most of the mental illness of adults can be traced to adverse personality factors and environmental causes which began to be operative in childhood and early youth.

It has long been recognized that stability of the individual personality is greatly influenced by the stability of the family and the attitudes of parents toward their children. The first 7 years of a child's life seems to be an especially critical period in this regard. Professional workers who give services to children and parents are in an especially opportune position to do something about the relationships of parents and children which may not be productive of future mental health.

The extent of the problem

When it is realized that 1 child out of every 20 will spend some time during his life in a mental hospital, and that one out of every 10 will be afflicted by less incapacitating emotional illness in his lifetime, we can begin to appreciate how vast and important a health problem of the Nation this is. Fifty-eight percent of all hospital beds in the country are occupied by the mentally ill, and it has been estimated that about 50 percent of patients seen by family doctors and pediatricians have emotional disorders as whole or part of their illness.

The need for service is not the only startling element in the present health picture. The inability to supply services to meet this need is equally stark. In a survey of psychiatric resources in the United States in 1944, 25 States were without a single community mental health clinic, and in vast areas in most of the other States, no psychiatric help was available.

In 1938 it was estimated that full-time clinical service for child guidance was provided in only 27 of the largest cities in the United States. One-quarter of cities of 100,000 population or over, and two-thirds of cities with between 50,000 and 100,000 population had no psychiatric clinic facilities for adults or children. Recent studies by the National Committee for Mental Hygiene indicate that there is now provided only 20 percent of the minimum amount of clinical hours of service necessary to provide care to meet the psychiatric needs of the country. No one has been able to estimate the time needed to be supplied by personnel other than those working in a clinic to help people with their emotional troubles.

In 1945, 38 of the 52 States and Territories of this country, expressed a need for further mental health services for children when they submitted State plans to the Children's Bureau for the use of Federal funds for State programs under the Social Security Act.

Even so, the foregoing figures express the need in only a limited way, for they represent only estimates in terms of curative services. What is needed even more, because they are practically nonexistent, are preventive mental health services for children. If our communities and country are to undertake the responsibility of providing an adequate program for children, a program to reduce the incidence of mental illness must be planned and undertaken. The psychiatrist, psychologist, and psychiatric social worker of the treatment clinics cannot do this alone. The effort must also come through personnel who are now giving general specialized services to children: Doctor, dentist, nurse, teacher, social worker, and others.

How can this need be met?

Planning for mental health services for children must recognize two aspects of treatment: (1) Direct services for the personality problems already full blown, and (2) preventive services for the emotionally healthy parent and child, and for children's emotional problems in their incipiency. If we recognize that the serious maladjustment of the adolescent and the adult has its roots in the earlier childhood of the individual, the most fertile field for the application of mental health principles is certainly at the time the child is attempting to reach an adjustment about his emotional problems. This means the child of preschool and school age, and it also means inclusion of the "normal child" and his parent as well as the ones with emotional problems already apparent.

In the distribution of services to children, there are two areas where almost every child in a community can be reached. These are the school, and the health services of a community. Where a health department has responsibility for school health, well-baby clinics and prenatal clinics, it has the unique opportunity of reaching practically the total child population of the community, of both school and preschool age, and thereby can become the one agency which offers services to the people of a State where preventive mental health measures will be most valuable to apply. The professional persons giving service to children in the health department must, therefore, be reached and influenced and educated so that they can incorporate into their techniques and professional work the newer knowledge that can help children to better emotional adjustment. In the health clinics, the premature baby clinic, the prenatal clinic, and the classes for mothers, can be educated to be aware of the emotional needs of their

children and better their feelings, which if left alone might eventually lead to a future emotional illness.

These workers need not learn difficult techniques, and need not become psychiatrists in order to help parents and children with early emotional problems. These workers can learn to incorporate into their ways of rendering professional services new attitudes toward and new awareness of child-parent frictions and their meanings for the growth of the child's personality. The great majority of these frictions appear as complaints against the child in regard to his eating, toilet training, sleeping and other functions. Parents want to talk to doctors, nurses, social workers about these problems, but all too frequently these workers can't help them because they haven't been trained to handle them, and they are put on the defensive by being asked about such problems.

Curative services for those children already exhibiting symptoms of emotional disturbance must also be available. The most efficient method so far invented to treat these disorders is the child guidance clinic. A chain of clinics should be planned by each State to fulfill this goal. Some start toward this has been made by many States, but all States are far from the goal of good coverage. As with preventive mental-health services, the great need everywhere is to put more of these services within reach of more people. To develop an effective program, State-wide coverage in preventive and curative mental-health services becomes the sine qua non.

The translation of a broad mental-health program into action calls for a program of training, a program of extension of direct clinical service, a program of demonstration and research. Training of personnel is the most acute need at present. It must be recognized that training for mental-health services is both time-consuming and expensive. One of the first needs is to study, analyze, and plan better courses on psychiatry and mental health in the professional training schools in our country: Medical schools, nursing schools, graduate psychological courses, teachers' colleges, law schools, and schools of social work. This is vitally important and will have tremendous influence in the services rendered to our citizens in the following generations of professional personnel.

Concurrently, training must be found for present workers. There is a dearth of good clinics and hospitals at which sound training may be secured and new ways must be found to orient workers in mental-health practices.

Psychiatrists, clinical psychologists, and psychiatric social workers must be trained as rapidly as possible. Even so, with the present training facilities available there would be a period of 10 to 15 years before the country attained anywhere near its needs of mental-health services. The greatest possibility in this direction lies in helping the workers already giving services to children to incorporate mental-health practices and principles in their daily work. This can be done by adding mental-health consultants who can consult with and advise administrative and field personnel in departments of health and welfare on ways in which preventive mental-health practices can be brought to the children being served. On a small scale, this procedure has been successfully tried in a few private and public agencies in the country.

In such ways as mentioned, a program of mental-health services for children might be developed by each State and Territory, each modifying its program to fit its own particular needs. The essential elements are that personnel be made available for its development and that the program eventually grow to give coverage to potentially all children in the State.

If we are to do anything significant about the mental health of our citizens of 25 years hence, we must do it with the children of today, who are the parents of tomorrow.

STATE PROGRAMS FOR CARE OF CHILDREN WITH RHEUMATIC FEVER UNDER THE SOCIAL SECURITY ACT, TITLE V, PART 2

(U. S. Department of Labor, Children's Bureau, 1944)

1. HOW HAVE STATE PROGRAMS FOR CHILDREN WITH RHEUMATIC FEVER DEVELOPED?

The Social Security Act, as passed in 1935, authorized the annual appropriation of \$2,850,000 Federal funds for services for crippled children. These funds are paid to the States after annual State plans for such services have been approved by the Chief of the Children's Bureau of the United States Department of Labor.

No definition of "a crippled child" has ever been made by the Children's Bureau. During the first 5 years of administering services for crippled children under the Social Security Act the States gave major attention and care to

children with orthopedic or plastic conditions, but there was a growing interest among both lay and professional groups in making services available to children with other crippling conditions. The recommendations of the American Academy of Pediatrics at its regional meeting in Rochester, N. Y., November 1938, that heart disease should be considered a crippling condition, gave special impetus to the idea that children with rheumatic fever and heart disease should be eligible for services under programs for crippled children. Consequently, in 1939, when the need for additional Federal funds for crippled children's services was brought to the attention of Congress, the special need of children with rheumatic fever for such funds was pointed out. An additional annual appropriation of \$1,020,000 was authorized at that time with the understanding that a portion of the funds would be used for assisting State agencies in developing services for such children.

As a first step in the development of programs of care for children with rheumatic fever, the Chief of the Children's Bureau called together a small committee of pediatricians and other recognized authorities in this field. General policies for the development and administration of a program of services for children with rheumatic fever were outlined by this group, and these policies served as a guide in the planning of State rheumatic-fever programs. A national conference was held in October 1943 for the purpose of evaluating the existing State programs for children with rheumatic fever and discussing future objectives and policies in the further development of services for these children.

Several State plans for rheumatic fever programs were developed in the spring of 1940, and others have been developed since that time. At present 17 States have approved programs for the care of children with rheumatic fever or heart disease (California, Connecticut, District of Columbia, Idaho, Iowa, Maine, Maryland, Michigan, Minnesota, Nebraska, Oklahoma, Rhode Island, South Carolina, Utah, Virginia, Washington, and Wisconsin). About 15 additional States have informed the Children's Bureau of their serious interest in such a program. It will be impossible for every State in the Union to receive additional Federal funds for the provision of services to children with rheumatic fever until further funds are made available through amendment of the Social Security Act.

2. HOW DOES THE TYPICAL STATE RHEUMATIC-FEVER PROGRAM WORK?

The typical State rheumatic-fever program serves a small area of the State, usually from one to four counties; it is set up in a locality where it is possible to organize a complete program of care for children with rheumatic fever or heart disease, including good medical, medical-social, and nursing services, and facilities for adequate diagnostic, hospital, and sanitorial care and aftercare.

Continuity of care for these children has been considered of the utmost importance in the planning of State rheumatic-fever programs. Children with rheumatic fever or heart disease are kept under continuing care for long periods of time, not only because rheumatic fever—the most important cause of heart disease in childhood—is a chronic disease requiring long periods of hospital and sanitorial care, but also because the danger of recurrence is ever present. In the typical State rheumatic-fever program, in accordance with good general medical principles, children under care are examined periodically in order that early signs of recurrence may be detected and treatment instituted; and, in addition to the treatment of conditions specifically related to rheumatic fever or heart disease, any treatment necessary to improve the general condition of the child is arranged for, either through the crippled children's program or through other community resources.

It was believed that if a small number of children in a limited area of a State were taken care of completely and adequately and their problems studied, it would be easier later to extend services to other areas of the State. Already the State agencies that have begun rheumatic-fever programs have received many requests for the extension of services to new areas, and in some States the program has been expanded to include several additional counties; but expansion of any considerable extent must await the granting of additional funds under the Social Security Act or funds from State or local sources.

a. How is the program administered?

The official State agency that administers services for crippled children is also responsible for the administration of the rheumatic-fever program. This agency is, in the majority of States, the department of health; in others it is the State department of public welfare, the State department of education, a special State

commission, or the State university hospital. In a few State departments of health the rheumatic-fever program is placed in the maternal and child-health division rather than in the crippled children's division.

Medical leadership in planning and developing services for children with rheumatic fever or heart disease is provided by the State agency through the employment of a physician with special knowledge of this field; almost without exception the State agencies have chosen pediatricians to fulfill this function.

The State agency also appoints an advisory committee, which usually includes interested lay members as well as representatives of the various professional fields involved in a program of this type—medical, social, nursing, education, and so forth.

Consultation on administrative, medical, medical-social, and nursing problems is made available to the State agency by the Children's Bureau.

b. What children are eligible for care?

Children under the age of 21 with heart disease or conditions leading to heart disease are eligible for care. All the State programs give emphasis to the care of children with rheumatic fever or rheumatic heart disease, particularly early in the disease, but children with other types of heart disease that offer a reasonable expectation of improvement through treatment are also eligible for care. Diagnostic services are available to all children who live in the area served by the program. Continuing treatment is provided to all children whose families are otherwise unable to obtain for them the care recommended by the physician. Services are available to children living in the selected area whether or not their parents have established legal residence there.

c. How are children in need of care located?

Many children in need of diagnosis or care have been located by physicians who have discovered them in their private practice and in schools, hospitals, clinics, and so forth. Other children have been located and referred to the State agencies by public health nurses, health departments (especially in places where rheumatic fever is a reportable disease), school nurses and teachers, child-health conferences, crippled children's clinics, social agencies, and parents. Since rheumatic fever has a high familial incidence, a number of State rheumatic-fever programs place special emphasis on the examination of all the brothers and sisters of children found to have rheumatic fever or rheumatic heart disease.

d. What basic professional services are rendered to these children?

(1) *Medical services.*—A pediatrician employed by the State agency on a part-time or a full-time basis is directly responsible for medical care of these children in all stages of treatment whether in clinic, hospital, convalescent home, foster home, or the child's own home. In this way continuity of medical care is assured. The pediatrician in every case is certified by the American Board of Pediatrics or is eligible for such certification. When possible, the State agency has selected a pediatrician who has had special training and experience in the field of rheumatic fever and heart disease in children. In some States where it was impossible to find such a person, well-qualified pediatricians were appointed and subsequently were given special training. Consultation services by cardiologists, surgeons, and specialists in other branches of medicine and surgery are provided when necessary by qualified consultants who are certified by, or eligible for certification by, the boards of their respective specialties. Fees for such services are paid by the State agency.

(2) *Medical-social services.*—The medical-social consultant on the State agency staff is responsible for seeing that any family and environmental difficulties, or the feelings of the child about his condition, do not prevent him from following the treatment recommended or getting maximum benefit from this treatment. The medical-social consultant becomes familiar with the needs of individual children in many ways, such as by talking with them and their families in the clinic, during hospital and sanatorial care, and at home when necessary. In order to meet these needs, the medical-social consultant helps community social agencies understand the kinds of problems that interfere with adequate care of the child, and helps to stimulate development and improvement of the necessary services.

(3) *Nursing services.*—A public-health-nursing consultant is responsible for supervising the nursing services for children under this program. In the areas served by State rheumatic-fever programs generalized public-health-nursing services are available almost without exception. The nursing consultant is responsible for developing the nursing program in collaboration with other members of the professional staff, for teaching and otherwise assisting the local public-health

nurses to provide good nursing care for the child with rheumatic fever or heart disease, and for maintaining standards of nursing care in convalescent homes and hospitals in which care is provided.

e. How are diagnostic services made available?

Diagnostic services are provided by the pediatrician in clinics where there is access to all the necessary diagnostic laboratory facilities, including fluoroscopic and electrocardiographic machines. In addition to the pediatrician, a medical-social worker and a public-health nurse are present in order that medical-social and nursing services as well as medical services may be provided. The clinics are held at regular intervals, and appointments are made in advance. Because 6 to 8 children are seen in a half-day clinic session, it has been possible to study each child thoroughly by means of careful medical history, physical examination, social history, and laboratory tests.

Sometimes when a child must be studied further before a diagnosis can be made, he may be kept in a hospital for a few days for close observation. When diagnostic services are needed for a child who is too sick to come to the clinic, the pediatrician makes a home visit.

Consultative services are made available to private physicians, school physicians, county health officers, and other physicians who wish help in the diagnosis or management of children with rheumatic fever or heart disease.

f. What treatment services are available?

(1) *Services for the child who is acutely ill.*—During acute illness children receive care in a hospital that has a special children's ward with a pediatric staff, both medical and nursing, and that meets other standards recommended by the Children's Bureau Advisory Committee on Services for Crippled Children. The pediatrician employed by the State agency either takes care of the child during his hospital stay or acts as a consultant during this period.

(2) *Services for the child who needs prolonged rest in bed.*—Children are kept in the hospital only during the acute stage of the disease, and then are transferred elsewhere for a period of prolonged bed rest during the chronic stage of the disease which usually precedes recovery. Although the children still need medical and nursing care during this period, they can be better protected from infections and can have more normal social, educational, and diversional activities if they do not remain in a regular hospital ward for sick children during this long period of rest in bed. This type of care, which may be termed sanatorial care, is provided in various ways, by the various State programs: In a special sanatorial ward in a hospital, a convalescent home, a foster home, or the child's own home.

(a) *In sanatorial wards in hospitals.*—In several States children are transferred from the general children's ward to a special ward in the same hospital for sanatorial care. No children with infectious illnesses are admitted to such wards, and special care is taken to keep the children occupied and happy and to give them appropriate school work.

(b) *In convalescent homes.*—In about half the State programs children are given sanatorial care, during the chronic phase of rheumatic fever, at convalescent homes that are adequately staffed and equipped to care for the sick child in bed. The convalescent homes that are being used in State rheumatic fever programs meet the standards recommended by the Children's Bureau Advisory Committee in regard to medical, nursing, social, and nutritional supervision, isolation facilities, records, and provision for recreation.

(c) *In the child's own home.*—Although it is often difficult for the mother to take care of a child who must remain in bed for a long period, it is sometimes possible for the child to receive at least a part of his sanatorial care in his own home. In such cases regular home visits are made by the pediatrician for medical supervision. A public-health nurse also visits the home as often as necessary to help the mother with the nursing care of the child. The medical-social consultant helps the family to meet any personal or environmental difficulties in the home situation that might interfere with the treatment and care of the child.

(d) *In foster homes.*—In some States, where no suitable convalescent homes are available and where a special ward in the hospital cannot be set aside, foster homes are the only resource available for providing long-time bed care for children in the chronic stage of rheumatic fever, if the child's own home cannot be made adequate for this purpose. In other States, which have facilities for sanatorial care in hospitals or convalescent homes, care in a foster home seems preferable to institutional care for some individual children.

Plans for care in foster homes are developed in cooperation with child-welfare agencies. Standards for foster homes to be used for sick children under this program include medical, nursing, social, and nutritional supervision, and provision for recreation and education.

g. What follow-up care is available?

When the child has completely recovered from his rheumatic infection, he is encouraged to live as normal a life as possible; at the same time, every effort is made to prevent a recurrence of the infection. He returns to the State rheumatic-fever clinic periodically for medical examination and advice. The child and his family are helped to understand that if he is to stay well he must keep as healthy as possible through good food, appropriate clothing, decent housing, and good general health habits. If difficulties in the home situation threaten to prevent the child from having these fundamentals of health, efforts to meet the difficulties are made, either by the personnel of the State agency or by other local or State agencies, after joint planning by the pediatrician, the medical-social consultant, and the public-health-nursing consultant.

h. How are children transported to the treatment center?

If means of transportation are not available to the child through his own family, transportation is usually arranged in cooperation with local community agencies. Ambulance service is provided by the State agency when necessary.

i. How are the child's educational needs met during his illness?

Although education of the physically handicapped child does not fall within the scope of services which may be provided by the use of social-security funds, State agencies have recognized that the education of these children must be provided for in some way.

Provisions for the child's education while he is on prolonged bed rest are usually made by the State board of education. In many States provisions are made for bedside and group teaching in hospitals and convalescent homes, and in some States visiting teachers provide education for the child in his own home or in a foster home. In several States in which the State board of education previously made no provision for teaching outside of the classroom, the crippled children's agencies have made successful efforts to promote this type of service.

j. What vocational guidance is given?

Arrangements are made through State vocational-rehabilitation services for the vocational guidance of adolescent children with cardiac damage necessitating limitation of activity that must be considered in training the child.

3. STATE AGENCIES ADMINISTERING SERVICES FOR CRIPPLED CHILDREN

The crippled children's agency in your State might be able to answer any special question you have in mind about services in your State for children with rheumatic fever. A list of these agencies follows:

Alabama-----	State Department of Education, Division of Vocational Education, Montgomery.
Alaska-----	Territorial Department of Health, Division of Maternal and Child Health and Crippled Children, Juneau.
Arizona-----	State Department of Social Security and Public Welfare, Division for Crippled Children, Phoenix.
Arkansas-----	State Department of Public Welfare, Crippled Children's Division, Little Rock.
California-----	State Department of Public Health, Crippled Children's Services, San Francisco.
Colorado-----	State Division of Public Health, Division of Crippled Children, Denver.
Connecticut-----	State Department of Health, Bureau of Child Hygiene, Division of Crippled Children, Hartford.
Delaware-----	State Board of Health, Services for Crippled Children, Dover.
District of Columbia-----	Health Department of the District of Columbia, Bureau of Maternal and Child Welfare, Washington.

Florida	Crippled Children's Commission, Tallahassee.
Georgia	State Department of Public Welfare, Division of Institutions and Children's Services, Crippled Children's Division, Atlanta.
Hawaii	Territorial Board of Health, Bureau of Crippled Children, Honolulu.
Idaho	State Department of Public Health, Bureau of Maternal and Child Health and Crippled Children, Boise.
Illinois	University of Illinois, Division of Services for Crippled Children, Springfield.
Indiana	State Department of Public Welfare, Services for Crippled Children, Indianapolis.
Iowa	State Board of Education, Crippled Children's Services, Iowa City.
Kansas	Crippled-Children Commission, Wichita.
Kentucky	State Department of Health, Crippled-Children Commission, Louisville.
Louisiana	State Department of Health, Division of Preventive Medicine, Division of Crippled Children's Services, New Orleans.
Maine	State Department of Health and Welfare, Division of Medical Service, Augusta.
Maryland	State Department of Health, Service for Crippled Children, Baltimore.
Massachusetts	State Department of Public Health, Services for Crippled Children, Boston.
Michigan	Crippled-Children Commission, Lansing.
Minnesota	State Department of Social Security, Division of Social Welfare, Bureau for Crippled Children, St. Paul.
Mississippi	State Board for Vocational Education, Jackson.
Missouri	University of Missouri, State Crippled Children's Service, Columbia.
Montana	State Board of Health, Division of Crippled Children, Helena.
Nebraska	State Board of Control, Division of Child Welfare and Services for Crippled Children, Lincoln.
Nevada	State Department of Health, Division of Maternal and Child Health and Crippled Children's Services, Reno.
New Hampshire	State Board of Health, Division of Maternal and Child Health and Crippled Children's Services, Concord.
New Jersey	Crippled Children's Commission, Trenton.
New Mexico	State Department of Public Welfare, Division of Crippled Children's Services, Santa Fe.
New York	State Department of Health, Division of Orthopedics, Albany.
North Carolina	State Board of Health, Division for Crippled Children, Raleigh.
North Dakota	Public-Welfare Board of North Dakota, Division of Child Welfare, Bismarck.
Ohio	State Department of Public Welfare, Division of Social Administration, Services for Crippled Children, Columbus.
Oklahoma	Commission for Crippled Children, Oklahoma City.
Oregon	University of Oregon Medical School, Division of Crippled Children, Portland.
Pennsylvania	State Department of Health, Crippled Children's Service, State Hospital for Crippled Children, Elizabethtown.
Puerto Rico	Insular Department of Health, Bureau of Infant Hygiene, Division for Aid to Crippled Children, San Juan.

Rhode Island-----	State Department of Health, Crippled Children's Division, Providence.
South Carolina-----	State Board of Health, Division of Crippled Children, Columbia.
South Dakota-----	State Board of Health, Division of Crippled Children, Pierre.
Tennessee-----	State Department of Public Health, Services for Crippled Children, Nashville.
Texas-----	State Department of Education, Division of Crippled Children, Austin.
Utah-----	State Department of Education, Division of Service, Salt Lake City.
Vermont-----	State Department of Public Health, Crippled Children's Division, Burlington.
Virginia-----	State Department of Health, Crippled Children's Bureau, Richmond.
Washington-----	State Department of Health, Division of Maternal and Child Health and Crippled Children's Services, Seattle.
West Virginia-----	State Department of Public Assistance, Division of Crippled Children, Charleston.
Wisconsin-----	State Department of Public Instruction, Bureau for Handicapped Children, Crippled Children's Division, Madison.
Wyoming-----	State Department of Health, Division for Crippled Children, Cheyenne.

OTHER CHILDREN'S BUREAU PUBLICATIONS ON RHEUMATIC FEVER

Recommendations of the Children's Bureau Advisory Committee on Services for Crippled Children With Reference to Services for Children With Heart Disease, March 4, 1940.

Preventive and Public-Health Aspects of Rheumatic Fever in Children, by Louise Fry Galvin, M. D. Reprinted from the Southern Medical Journal, February 1943.

Rheumatic Fever in Children. Reprint from the Child, May 1943.

Social Planning for Children With Rheumatic Heart Disease. Reprint from the Child, January 1941.

Some Facts About Rheumatic Fever, 1943.

The Virginia Program for Children With Rheumatic Fever. Reprint from the Child, January 1942.

Proceedings of the Children's Bureau Conference on Rheumatic Fever. October 5, 6, and 7, 1943.

Dr. ELIOT. Each State will begin with the program that exists today—spreading its basic health services; starting as rapidly as possible new types of organized health and medical service for children on a broad demonstration basis; training medical, dental, and other professional workers to administer and operate the growing programs; drawing into their councils and service general practitioners and specialists, paying them adequately for the kinds of service and care they render.

In the cities, where there are great hospitals and clinics and highly trained specialists and laboratories and a high ratio of physicians to population, to make money available to pay for care will probably at once increase the amount of good care received by children.

In areas where today these services are inadequate or almost completely lacking it will require the kind of planning that I have been describing to make expert service accessible to mothers and children. This is obviously the reason why you have included title I in this bill.

Now it has been asserted by various witnesses appearing before this committee—almost as a truism—that the quality of medical care

will deteriorate under a national-health program financed by an insurance plan which entitles all insured persons to care and permits per-capita methods of payment to physicians, and the establishment of panels.

The Children's Bureau's experience in administering medical care programs, however, is that the quality of care can actually be improved. The result under a national health program will depend upon the amount of responsibility assumed by the Federal, State, and local health agencies, with the advice and assistance of the medical and allied professions for: (1) the provision of adequate facilities; (2) the establishment of standards of medical and institutional care; (3) making available or arranging for consultation service, and for facilitation of group practice of specialists and general practitioners; (4) review of care rendered; (5) recruitment, training, and adequacy of remuneration of professional and technical personnel; and (6) effective and fair administration in the interests of the people to be served and the persons and agencies furnishing service and care. Improvement in quality of care can be accomplished even under conditions that call for a rapidly expanding service provided as a "right." This has been shown in a relatively small and limited way in the maternity and infant care offered the wives and infants of service men during the war.

Under this program, improvement in quality of care depended on what could be done after the program has started—a situation not unlike that which will exist when insurance funds are made available to pay for care.

A program of service was organized under which the State health agency was responsible for making arrangements. This is what Senator Pepper was asking about earlier this morning, and I have listed them here.

(1) Care of the mother by a physician throughout pregnancy, delivery, and the postpartum period.

(2) Advice and help of a public health nurse in the home or clinic.

(3) Hospital care, without time limitation for either mother or baby in a hospital or maternity home reaching certain minimum standards of service.

(4) Consultation by specialists when required.

(5) Care of special nurses, if necessary.

(6) Laboratory service.

(7) Blood transfusions, special drugs as penicillin, ambulance service.

(8) Other special care for mother or baby as required.

I would like to add, perhaps, to this little series of items, that under this program the cost of care for any one individual mother or baby was not limited. That, in itself, helps improve the quality of the care.

Length of care was not limited, nor was it limited for, say, a premature baby.

The same is true for sick children.

Bills as high as \$1,500 have been paid in a single case for the wife of a serviceman.

Standards of hospital care have been raised. Physicians have been made available in all cases. There have been a number of prenatal visits. They have applied referral to public health nurses. All of that means better care. All of that means improving quality.

It took some months to make the machinery work, and even now, after 3 years, the quality of care continues to improve in proportion to the effort of the State and local agencies to improve standards.

In 10 years' time, under the crippled children's program, there has been steady and marked improvement in the quality of care. Hospital standards have been raised in accordance with the recommendations of the Children's Bureau Advisory Committees. State agencies have set high standards for the selection of surgeons, consultants, and other professional personnel to give the expert care needed.

Special training for nurses and physical therapists has been made possible.

Children have been brought under care earlier, diagnostic clinics have been made available in many rural areas where none existed before, and the social needs of children have been increasingly met.

The CHAIRMAN. Has that condition been improving under the system that you have had in operation for child health and crippled children, and so forth?

Dr. ELIOT. The quality of the care?

The CHAIRMAN. The quality of the care.

Dr. ELIOT. I think there is no question, Senator Murray, but that that has been true. Not only have we had an Advisory Committee of Orthopedic Surgeons and Pediatricians and others to advise us on standards, but the States have had their technical committees, as they call them, to advise them on the kind of care that ought to be given to children.

The CHAIRMAN. How are the physicians paid for their services under that?

Dr. ELIOT. The physicians, under the crippled children's program, are paid by the State health agencies with money, part of which comes from the Federal Government, and part of which comes from the State. They are paid either on a case basis, or they are paid salaries.

In about half of the States, they are paid part-time salaries. For certain types of service, such as individual consultations, there will be a special fee for that consultation, but by and large, that is the way it has been handled.

Take an orthopedic case, for instance, a child that needs care for, we will say, tuberculosis of the hip or the spine. As a rule, it is a flat amount for the care of that child, say, for 3 months' time.

The CHAIRMAN. Under that system, there has been no deterioration of the quality of service?

Dr. ELIOT. I would think that it had improved, Senator Murray.

The CHAIRMAN. It has been urged before this committee that the system which we are proposing here will result in a deterioration of the character of medical care and services that will be rendered.

Dr. ELIOT. The orthopedic surgeons have taken great interest in how the quality of care can be raised. They have given us enormous assistance.

Dr. Oscar Miller, of North Carolina, is chairman of our advisory committee, and he and others have worked with us through the years now in seeing what could be done to help the States, help the physicians in the States, and of course, the other professional workers in the States. Because this is not just a doctor's job. This is a job that has to be done by a team of workers, by doctor, nurse, medical social

worker, nutritionist, physical therapist, occupational therapist; they all come into the picture.

When I talk about program planning, you have to get this team of people into operation together, and that is what the States are doing today.

The CHAIRMAN. Do you find that the medical men who are returning from the service are inquiring about this system and are willing to associate themselves with that kind of a program, which is not the system that has prevailed generally in the country in medical care?

Dr. ELIOT. A good many physicians have come in to see me to ask what the future prospects are. I always have to say, "Well, everything will depend on whether the Federal Government, the States, and others, make money available to extend a program of this sort." They certainly are showing a great deal of interest in seeing how they can assist in the program.

Senator DONNELL. The States are operating these various programs?

Dr. ELIOT. The States are operating these programs as they exist today.

Senator DONNELL. Under grants from the Federal Government, and in many instances, contributions by the States also?

Dr. ELIOT. That is right. In all instances, there is a State contribution under the Social Security Act program.

The CHAIRMAN. That system, of course, is confined to children?

Dr. ELIOT. That system is confined to children, and I think that when we expand into a program where personal health services—and that is one way of speaking about medical care for the individual—when medical care for the individual is involved to a very considerable extent, like the emergency maternity and infant care program, for instance, there is a question in my mind how the money should be raised for that purpose.

Under S. 1606, there are really two methods proposed in title II of raising money. In one, it is suggested that there will be money raised through some sort of contributory insurance scheme; but there is also suggested the use of general tax funds.

I know that Mr. Altmeyer, in his testimony, said that possibly money might be collected federally through an earmarked income tax, some part of the income tax; it might be raised through this contributory insurance.

But I must say when large numbers of individuals need to have their individual personal health service, personal health and medical care service, taken care of, it is a great question whether the money should not all be raised federally, and then distributed appropriately in accordance with the needs of the people in the several States, or in accordance with the number of mothers and children to whom care should be made available or will be made available.

I think those are questions that your committee has to decide as to how that money should be most appropriately raised.

In my discussion of the quality of care, I have gone to the question of opportunity of postgraduate education, the great necessity for providing that, and also the need for research. Because you cannot raise quality of care unless, along with the funds for service, you provide funds for research to increase our knowledge.

Pediatricians, obstetricians, orthopedic and plastic surgeons, cardiologists, dentists, nurses, medical-social workers, and many other allied professional workers have made their contribution to raising the quality of care. Advisory committees at Federal, State, and local level to advise on standards of care have been effectively used. By this kind of pooling of administrative and clinical knowledge and judgment, and with the help of members of the public informed on the needs of children, the level of care has gradually been raised.

The degree of improvement in the quality of care rendered by an individual professional worker will depend on whether he has time to do a good job with each patient—that is, limitation of case load and adequacy of remuneration—on his or her basic training and opportunities for postgraduate education, on contact with medical centers, and on the facilities at hand that make possible modern practice. Physicians know that an unlimited number of patients and high quality of care do not go hand in hand.

THE IMPORTANCE OF RESEARCH

Finally, the quality of care for children under the national health program can be maintained at a high level only if opportunities for good basic and postgraduate education of professional personnel are available to persons desiring to participate in furnishing care under the program, and if research and investigation into the causes of abnormal growth and development and sickness, and into methods of prevention and cure, are undertaken on a broad scale by competent investigators. This requires sustained and coordinated effort by private research institutes and medical centers and by Government agencies.

The training of personnel must include not only clinical opportunities for physicians, dentists, and other professional and technical personnel, but also opportunities for the training of administrative personnel. The provisions in title I, part B, of S. 1606 to allow the States to undertake such training is very desirable.

The inclusion of research as one of the functions which may be performed by the State agencies responsible for the maternal and child-health programs will give an opportunity to assist medical research centers to undertake constructive investigation and will allow the States to study administrative methods and techniques. The authorization for the appropriation of funds to Children's Bureau and the authority to utilize such funds to aid research as well as to undertake it independently, will put the Bureau in a position to assist in coordinating investigations dealing with problems affecting the lives and health of children. There have been many requests for assistance with important pieces of medical research in recent years, but it has not been possible to meet them because of the limited amounts now appropriated to the Bureau for this purpose. Such requests have come from the National Research Council, various medical schools, national organizations concerned with special studies of the care of crippled or otherwise physically handicapped children, and from individual investigators. The Bureau could effectively extend its fact-finding functions as proposed in this bill.

I am inserting for the record a recommendation made by the Children's Bureau advisory committees on maternal and child-health services and on services for crippled children in November 1945 on this subject of research:

Research is so basic to the efficiency of any program for maternal and child health that this committee recommends:

That much larger funds should be allocated to research than are provided in the bill S. 1318 or than have been available to the Bureau in the past.

Such funds are to be available to the Children's Bureau for such purposes as:

1. To undertake with its own personnel only such projects as can be best studied on a national scale; for example:

(a) The evaluation of previous programs, such as maternal and infant mortality under the emergency maternity and infant-care program, as a basis for administration of present and future programs.

(b) A study of the effect of prolonged institutionalization on mental, physical, and social development.

(c) Determination of the incidence of epidemic diarrhea in the newborn; methods of its prevention and control.

(d) Evaluation of the facilities for the proper care of mental defectives.

(e) In cooperation with other Government agencies, study of the incidence of poisoning of children by household products and methods of general education as to their dangers.

2. Allocation to medical schools or other organizations for specific research projects.

3. Coordination of the results of significant research studies throughout the world dealing with the problems of maternal and child welfare.

The committee recommends that the Children's Bureau establish a special advisory committee on research to aid them in the use of such funds as become available.

So I want you to realize that the need for research is very great. The amount of money that we have in the Children's Bureau for research is so limited that we are not able to do nearly as much as we should.

THE COST OF HEALTH SERVICE FOR CHILDREN

I will finally take up a brief section on cost; that is, what we think the cost of good health and medical services for children will be.

If children are to be healthy we must place added emphasis and expend more money on the preventive services we know are effective. This is common-sense economy.

To be good, preventive medical service must begin in the prenatal period, be particularly intensive at birth and immediately thereafter, and continue through infancy, childhood, and adolescence. For the infant and child it consists of medical examinations and observation by a physician at intervals of about a month in the first year and of 3 or 4 months in the second, every 6 months in the next 4 years, and then once a year during the school years. Both physician and parents need the help of a public-health nurse, and often other special workers, such as a nutritionist or social worker. The preventive dental program starts at least by the third year. These are the years when the mental health service should begin. When defects and adverse conditions requiring treatment are found medical and dental care must be given as part of the preventive program.

In other words, you cannot really separate what you do as a preventive program and what you do as a treatment program. Often, minor illness leads to major illness, or permanent physical handicap and if you do not take care of the minor illness, you are in trouble.

The setting for this preventive service may be the community health center, the child-health clinic, the hospital clinic, the school or physician's office. To reach all infants and children there must be a planned program of health services organized by the community authorities, including a maternity service, infant and preschool program, and a school-health service through the high-school grades.

I might say at this point that we have been working on this problem of cost for some time now. We do not think our figures are invulnerable. But we have reached certain estimates with respect to costs.

We estimate that such a complete child-health service, excluding the cost of dental care and treatment for illness would cost somewhere in the neighborhood of \$8 a child per year (averaging the costs of all age groups up to 18 years at current money values). This is less than 3 cents a day per child—less than the cost of your morning newspaper or the cost of one 3-cent stamp. If we add dental care, beginning when the child is 3 years old and continue it through the school years, we would add another 3 cents a day. Add to this the cost of medical care, including care of minor and major illness for children up to 18 years and the care of crippled children and we come out with a total of approximately 13 cents a day per child.

This, we must remember, covers pretty complete care—preventive, diagnostic, and curative—health services and dental care for the child when well and care by doctor, nurse, hospital, or clinic when he is sick. It would cover much more than we have facilities and personnel today to provide. It may take 10 years or more before we can make these health services fully available, and the expenditures for them will necessarily rise above what we are spending today. As the preventive program is increased, however, the cost of medical care should decrease.

In conclusion, may I say this. I have discussed what seems to me to be the more important aspects of this legislation as it will affect the quantity and quality of health services and medical care reaching the children of the Nation. I have talked as a pediatrician, one who has specialized in the medical care of children. I have talked as a public-health administrator, who has been responsible for 10 years for the direction of the small but pioneering Social Security health programs for children, and for the past 3 years in directing the maternity and infant-care program which has cared for more than a million wives and babies of servicemen. I would like to speak, now, as a citizen.

The prime objective of this bill, in regard to children, as I see it, is to give the people of our Nation a chance to work together to bring greater health and strength to all children. Letting fathers and mothers struggle unsuccessfully to find what care they can for their children is not good enough. I have given you a picture of the results. Thousands of children each year die needlessly. The medical profession and the health services could save many of these lives, prevent much of the sickness, and correct many of the deformities, if they could only reach these children.

Here, in this bill, is a way to bring parents and professional workers together in the service of children. Title II spreads the cost of medical care so that insured parents can afford to buy care for their children. Title I makes State and local governments responsible for seeing that care is within reach.

Maybe this blueprint is not perfect. Maybe it needs amendment here or there. The first blueprint for winning the war, I venture to say, was not perfect in detail, nor satisfactory to all the experts. That imperfection did not stop us in our prosecution of the war. We moved ahead, resolved to reach an objective, changing our blueprints as necessary.

We know what our objective for children is in better health. Delay in reaching that objective is costly. Since this bill was introduced, more than 13,500 babies and 1,300 mothers have died whose lives might have been saved.

And in arriving at those figures, I may say, I have used the same figures that I used earlier; namely, that if the rate for babies that has prevailed in Connecticut could prevail everywhere, all these lives might have been saved. Each day debate goes on, we lose 8 more mothers and 85 more babies needlessly.

Senator DONNELL. Just a very few questions, Mr. Chairman.

Dr. Eliot, you referred to the fact that you have discussed what seemed to you to be the more important aspects of this legislation, with various physicians.

You mentioned, I think, on page 25 of your testimony, that you have done so.

Have you discussed these aspects with Dr. Getting, secretary of the Association of State and Territorial Health Officers, and himself the health officer of Massachusetts?

Dr. ELIOT. Yes; I know him very well.

Senator DONNELL. Did you hear his testimony before the committee?

Dr. ELIOT. No; I could not come that day, but I have seen his written testimony.

Senator DONNELL. He is a man widely known over the country in connection with work of that kind, is he not?

Dr. ELIOT. He is secretary of the Association of State and Territorial Health Officers.

Senator DONNELL. And stands as a man well known in that connection; that is right, is it not?

Dr. ELIOT. Yes.

Senator DONNELL. Now, I was interested to note also, Doctor, your emphasis at different points upon the importance of planning by the States.

For instance, on page 19, you say:

I have here some suggested plans for the expansion of certain types of programs for which there is enough experience and basic knowledge to warrant immediate planning by the States.

Then I notice on page 20, in referring to the matter of quality of care, you say:

The Children's Bureau experience in administering medical-care programs, however, is that the quality of care can actually be improved. The result under a national health program will depend upon the amount of responsibility assumed by the Federal, State, and local health agencies, with the advice and assistance of the medical and allied professions for * * * certain detailed items.

And then again, on page 22, you mention in the last paragraph that:

The inclusion of research as one of the functions which may be performed by the State agencies responsible for the maternal and child-health programs will give an opportunity to assist medical research centers to undertake con-

structive investigation and will allow the States to study administrative methods and techniques.

I take it from these references, and doubtless others, that you do regard the assumption of responsibility not alone by the Federal Government but by the State and local governments, as of importance in the development of a health program in the country?

Dr. ELIOT. Oh, I think so, Senator Donnell, and I think that is provided for in both parts of this bill. I think that the provisions, for instance, in title II, to authorize and direct the Surgeon General to utilize State agencies wherever it is—I cannot quote the language exactly at this moment, but I can find it readily enough—I think that that is important.

Now, one of the amendments Senator Pepper proposed has a bearing on that, because his proposal was that insofar as it is feasible, the Surgeon General, in developing the programs under title II, and the Chief of the Children's Bureau, in developing programs under title I, should utilize insofar as is feasible, the same State health agency. That, I think, is terribly important.

Senator DONNELL. Title II does, however, vest the ultimate administration of the compulsory health insurance plan in the Federal Government, does it not?

Dr. ELIOT. Oh, yes.

Senator DONNELL. And the ultimate decisions are to be made by the Surgeon General, subject to the over-all power of direction, the supervision and direction, of the Federal Security Administrator. That is correct, is it not?

Dr. ELIOT. Yes.

Senator DONNELL. And you have found, I think you said, that in the administration of the specific programs that you referred to, you have found the States to be very helpful and the quality of the work which the States generally have done to be of very high class; that is correct, is it not?

Dr. ELIOT. Yes; I certainly will agree to that. Of course, some States have had more facilities than others and some States have done better jobs than others.

Senator DONNELL. But you do feel, as I understand it, that it is important that the interest of the local State communities be sustained, and that so far as possible the State be permitted to cooperate in the development of the national health programs?

Dr. ELIOT. Yes; that that is true is shown by the fact that in this bill, not only is title II there, through which the personal health services will be provided, but title I exists. Title I is the title of the bill that tells us, federally, in the Children's Bureau, that there is a planning job to be done as well as a job of collecting the money and paying for the care.

Senator DONNELL. It is true, is it not, however, that in title II of the act, as indicated a few minutes ago, the administration of the compulsory health insurance is not vested in the States.

Dr. ELIOT. That is right.

Senator DONNELL. But is vested in the Federal Government?

Dr. ELIOT. That is right.

Senator DONNELL. And the making of the rules and regulations, and the making of the decision, is in the Federal Government and not in the State under title II?

Dr. ELIOT. That is right.

Senator DONNELL. That is all.

The CHAIRMAN. You do not regard that as a fatal provision, do you? You think that vesting it in the Federal Government does not prevent the utilization of the States?

Dr. ELIOT. Certainly not, Senator Murray, and I think where agencies work together, the program can be worked out without question.

In all my conversations with the Surgeon General on this program, I think it certainly is his desire, as he has expressed it to me, to work with the States, just as certainly it has been throughout the years our desire to work with the States.

The CHAIRMAN. And you feel quite convinced that it is only through some kind of Federal or national health insurance system that we will be able to carry on effectively this program that we are talking about?

Dr. ELIOT. I think it is only through a system by which the money to pay for this care is collected federally in some way from the people who can contribute to that pool of funds at the Federal level.

That method may be of several kinds. The way in which the money may be collected may be of several kinds. It may be done in several ways.

The CHAIRMAN. There has been considerable talk before the committee with reference to the right of choice, as to the physicians.

In your experience, in the operation of your Department over there, do you find that that is a very important matter?

Dr. ELIOT. Under the emergency maternity and infant care program, the State health agencies opened the program to physicians. The women were allowed to select their physicians from lists of doctors who met qualifications as set up by the State health agencies. I think there was essentially no problem under that program with respect to the choice of the physician.

Often, Senator Murray, we are today limited in our choice, because we do not have money enough to pay a certain physician. Very often we may be limited in our choice because a physician himself is so busy that he cannot take us on. I know that my friends have had that experience.

The CHAIRMAN. So that under this legislation, people would be given far more opportunity to exercise choice than they would under the existing situation?

Dr. ELIOT. At least, the barrier that relates to the payment for care will be removed, and that, I think, is a help, a very great help.

The CHAIRMAN. Thank you very much.

Senator DONNELL. If you will pardon me a moment, Mr. Chairman?

The CHAIRMAN. Certainly.

Senator DONNELL. Have you read Dr. Getting's testimony?

Dr. ELIOT. I think I have read it all. I am not certain of that.

Senator DONNELL. Am I right that generally speaking, he is opposed to the compulsory health insurance? Is that your interpretation of his testimony?

Dr. ELIOT. My interpretation of that testimony would be that the health officers, realizing what the administrative problems would be,

in putting into effect rapidly a general medical-care program, have felt that they should get their basic health services established before they would be in a position to take on the administration of a medical-care program of this extent.

I have, however, great confidence in the State health agencies, perhaps more than they have themselves, because I have had some experience as to what they can do when they are faced with a problem and have to take it on to do a job.

Senator DONNELL. At any rate, your impression, I judge, is that Dr. Getting did not express himself as in favor of the enactment of the provisions of title II of this bill?

Dr. ELIOT. I think the association did not express itself as in favor of it, but I do not think that they expressed themselves as not in favor of extending medical care, if I remember their statement. I must say this is entirely from memory.

Senator DONNELL. I think doubtless we would all agree that it is highly important to see that the proper provision is made through some voluntary or involuntary plan for extension of medical care.

You mentioned the fact that the funds for carrying on this extended medical care should be collected in some way.

I take it that the main point in your mind, if I am correct, is that you are favorable to some plan by which there may be an extension of the medical care to cover more and more people in our country and that you are not undertaking to pass here upon whether the method that should be adopted would be by compulsory insurance participation or by some other plan; such as, for illustration, an earmarking, of income taxes, as mentioned by Mr. Altmeyer.

Dr. ELIOT. Yes; I believe that money has to be collected by the Federal Government, and it may be that the collection by the pay-roll deductions is the best way. We of this country are insurance-minded. We believe that we are entitled to a service that is to be obtained through that method. There is a great virtue in that.

I think there is a great advantage to children if their parents realize that they will be entitled to care. That is the advantage of the insurance method.

Under the other plan of income tax, general income tax, I think that that, too, should be interpreted as providing whatever service is to be provided, whether it is educational or health, as a right of the people.

I can not see much difference between the two. The two probably need to be combined.

Senator DONNELL. Doctor, in many respects, if I am right in this, the thought that you have, namely, as to the extension of additional medical care through additional hospital facilities, through other means that you have discussed, might be accomplished by Federal grants-in-aid to the States, and carrying on the plan of State administration of many of those facilities.

That is correct, is it not?

Dr. ELIOT. That this whole program could be done that way?

Senator DONNELL. I say, in many instances, at any rate, it could, could it not?

Dr. ELIOT. Well, certain types of service, certainly, I think, might be worked out; just as this bill provides.

As to crippled children, for instance, the bill provides for the care of crippled children through that method. It does not mean that the

insurance funds may not be used to care for the crippled children. They may. But I would think that it might be done through a grant-in-aid plan, or it might be done through the Federal administration.

Senator DONNELL. Obviously, the framers of the bill, so far as part 1 is concerned, in their constant reference to the submission of State plans for approval, contemplate that in that respect at any rate, the health plans could be advanced in our country by the grant-in-aid plan combined with State programs of administration.

Dr. ELIOT. Yes; that is the intent, because that is the program planning, and the section of the bill that will see to it that the facilities are available and accessible to the people when they need them.

Senator DONNELL. Has Dr. Getting been an active man in this type of State administrative work?

Dr. ELIOT. Dr. Getting has been health officer, commissioner of health in Massachusetts, I think, for about 3 years, not very long. He was in one of the counties of Massachusetts, or one of the districts. I think he was a district health officer before he was made commissioner of health in the State of Massachusetts.

Senator DONNELL. And this national organization, of which he is an officer, is, truly speaking, a national organization, is it not; in the sense that it has members from all or substantially all the States of the Union?

Dr. ELIOT. It includes just the State health officers and health officers of the Territories. It is a small body made up of those 52 persons.

Senator DONNELL. One of whom comes from each of the respective States?

Dr. ELIOT. That is right.

Senator DONNELL. For instance, in my home State, Dr. James Stewart, I think, was the member, and he was the health officer of that State, the head of the department of health of the State of Missouri.

Dr. ELIOT. Yes.

Senator DONNELL. And that is the organization of which Dr. Getting is one of the officers; secretary, I believe it is.

Dr. ELIOT. That is right.

Senator DONNELL. Thank you.

The CHAIRMAN. Thank you very much for your very able statement, Doctor.

(Thereupon, at 1:40 p. m., Wednesday, May 1, 1946, the committee recessed.)

NATIONAL HEALTH PROGRAM

THURSDAY, MAY 2, 1946

UNITED STATES SENATE,
COMMITTEE ON EDUCATION AND LABOR,

Washington, D. C.

The committee met at 10:30 a. m., pursuant to adjournment, the Honorable James E. Murray (chairman) presiding.

Present: Senators Murray, Smith, Donnell, and Pepper.

The CHAIRMAN. Gentlemen, the hearing will come to order, please.

I would like to introduce in the record a statement which the committee has just received from the California CIO Council. This undertakes to analyze the California Physicians Service plan.

(The document referred to is as follows:)

CALIFORNIA CIO COUNCIL,
San Francisco 2; April 29, 1946.

Senator JAMES E. MURRAY,

Chairman, Senate Committee on Education and Labor,

Washington, D. C.

DEAR SENATOR MURRAY: Hearings on the National Health Act (S. 1606) are being held now before the Senate Committee on Education and Labor. I understand that the committee heard testimony from the AMA and from component medical societies. These organizations have fought bitterly every serious attempt to make medical care really accessible to the majority of our people. Despite advances in medical knowledge and in part because of these advances, the cost of good medical care is prohibitive for the average wage earner. A high level of health for the Nation is too vital an objective to be frustrated by selfish minority groups.

Poll after poll and survey after survey have indicated overwhelmingly that the American people want and need a national health insurance system. It is of the utmost importance the Senate committee hear fully from the consumers of medical care. Organized labor, representing millions of our citizens, supports unequivocally the National Health Act.

The A. M. A. which not so long ago opposed even the so-called voluntary prepaid plans, now offers these plans as a solution to the tragic medical care problem. As a Member of the Congress it is vital that you be fully aware that these plans have failed miserably to meet the needs of the people.

The CIO in California has had considerable experience with voluntary plans. We have studied with particular care the State-wide plan of the doctors, California Physicians Service. We are completely convinced that this type of plan can never bring good medical care to those who need it most, the middle and lower-income group. I am listing below the principal reasons which have led us to this conclusion. Many of these faults are inherent in all voluntary plans.

(1) C. P. S. costs too much for the service given.—Administrative and acquisition costs are very high and are not subject to control by the membership or any public body. The tremendous turn-over in voluntary membership destroys the actuarial integrity of the plan. The cost of selling the plan is tremendous. These two factors negate the advantage of the insurance principle of spreading the risk. According to C. P. S. figures, in the months of October and November a total of 27,489 new members were acquired. The net gain in membership, however, was only 2,349.

(2) The coverage is too limited. C. P. S. offers only surgical and hospital coverage to the majority of members. Medical care is not offered to families

The day-to-day medical and dental expenses of the average family are not met. Many members of C. P. S. report annual medical expenses of hundreds of dollars despite their C. P. S. coverage. Preventive medicine has not any part in the C. P. S. plan.

(3) The quality of care is poor. C. P. S. physicians tend to treat C. P. S. patients with less care than private ones. C. P. S. is totally unable to control professional standards and practices of its physicians. In the C. P. S. Housing Project program, completely controlled by the doctors, the average quality of care was so poor as to be scandalous. The large turn-over in membership is largely due to dissatisfaction with the service.

(4) C. P. S. cannot control overcharges by member physicians. These doctors are not satisfied with C. P. S. fees and attempt to collect additional fees from the patients. Hundreds of complaints on this score have reached us from members of C. P. S.

(5) C. P. S. does not encourage the growth of group practice. The benefits of pooling skills, reducing costs, etc., which make a group practice desirable, are lost to C. P. S. members.

(6) C. P. S. does not seek bona fide consumer representation on its controlling board. The plan is completely dominated by the physicians. Members have nothing to say about dues, medical coverage, or administration. C. P. S. seeks to perform a vital public function, while controlled by a very small minority, the physicians. Unlike a Government body, C. P. S. has no responsibility to the people and cannot be controlled by them.

(7) C. P. S. has not shown good faith in an honest attempt to devise means to make medical care available to all. It is openly admitted by the California Medical Association that C. P. S. was created and is maintained in an attempt to prevent the enactment of health-insurance legislation. This very attempt is proof that the physicians are aware of the need for health insurance and the desire of the people to have it.

(9) C. P. S. failed utterly to prove its soundness in the largest mass attempt to provide care on a prepaid basis. In the housing-project program C. P. S. demonstrated that voluntary enrollments are doomed to failure. C. P. S. and the California Medical Association officially demanded of the Government that membership of public housing tenants in C. P. S. be made compulsory. Their contention was that only thus would the plan succeed.

I hope you will consider carefully the above evidence of C. P. S. failure. The same is true of other voluntary plans. The Permanente Foundation plan here, while superior to C. P. S. in organization and quality of care, has now come face to face with the dilemma faced by all voluntary plans. Permanente has been forced to retreat from a full-coverage program to one of partial coverage at less cost to the family. The inescapable conclusion is that without wide spread of risk, elimination of acquisition costs, efficient administration, and tax support, it is not possible to give complete medical care to our people at a price they can afford. These objectives can be accomplished only through a national system of health insurance such as is embodied in Senate bill 1606.

Sincerely yours,

MERVYN RATHBORNE, *Secretary-Treasurer.*

POLICY STATEMENT ON HEALTH INSURANCE

The need to make medical care available to the great masses of our people is increasingly acute. Despite the great advances of medical knowledge, the average worker and his family cannot afford the costs of good medical care. Illness remains the greatest cause of suffering and economic hardship faced by the wage-earner. Preventable disease and premature death are a tremendous economic burden on the whole Nation.

Attempts to overcome the economic barriers between good medical care and our people by means of so-called voluntary prepaid plans have failed. The high cost, inadequate coverage, lack of consumer participation, and small membership in these plans, and, in most instances, the poor quality of care has made it very clear they can never meet the need. In California, the doctors' plan, California Physicians Service, has failed in the 8 years of its existence to enroll more than a tiny fraction of the people in the State. The California Medical Association has shown that it has no real interest in, and is not capable of providing, a real solution to the problem.

The Congress of Industrial Organizations is firmly convinced that only a national health insurance program can assure the people's right to medical care.

The Congress of Industrial Organizations unequivocally supports the National Health Act, Senate bill 1606. The Congress of Industrial Organizations calls on the Congress to enact speedily this legislation, so vital to the welfare of the American people.

Approved by executive board, California Congress of Industrial Organizations Council, March 29, 1946, Los Angeles, Calif.

The CHAIRMAN. Also, I have a report that the committee has received on S. 1606 from the Honorable Max Gardner, Acting Secretary of the Treasury, which I would like to insert in the record at this time.

(The document referred to is as follows:)

TREASURY DEPARTMENT,
Washington, April 30, 1946.

Hon. JAMES E. MURRAY,

*Chairman, Education and Labor Committee,
Washington, D. C.*

MY DEAR MR. CHAIRMAN: Further reference is made to your request for the views of this Department on S. 1606, to provide for a national health program.

The health of its people is of vital concern to the Nation. Yet millions of our citizens do not have the opportunity for adequate medical attention, nor do they have any security against the economic effects of sickness. The proposed bill recognizes the necessity of a national health program since it would provide Federal assistance to States for health services and would make provision for a system of prepaid personal health benefits. Hence, I am heartily in accord with the general objectives of the proposed legislation.

Some method of financing will be required to implement the program, particularly with respect to the system of prepaid health benefits. Although the bill is primarily concerned with specifying the nature of the benefits to be paid and the conditions under which they are to be paid, and does not provide a method of financing, it contains certain implications with respect to financing. The bill defines covered employment and provides that the wages to be taken into account in determining eligibility for benefits will be limited to a maximum of \$3,600. Only those covered persons who meet qualifications similar to those of the existing old-age and survivors' insurance program would be entitled to benefits. Moreover, the bill authorizes appropriations providing for credits to a personal health account equal to 3 percent of covered wages. The effect of these provisions would be to exclude substantial numbers from the benefits of the program and restrict the choice of methods of taxation to be employed since they seem to imply the imposition of pay-roll taxes such as are now imposed under the old-age and survivors' insurance program.

The President, in recommending a system of prepaid medical care, has stated that the system is expected eventually to require amounts equivalent to 4 percent of earnings up to \$3,600 a year. A program involving expenditures of this magnitude and type requires careful consideration of possible methods of financing. The bill would result in expenditures by the Federal Government that would replace to a substantial extent expenditures now made by individuals for their personal health care. Although it would therefore seem desirable to provide for some form of specific contribution, in order to assure public understanding of the purpose of the program and appreciation of the services to be rendered, this should not be made unduly burdensome. The President has stated that "Everyone should have ready access to all necessary medical, hospital, and related services" and that the services should not depend on how much a person can afford to pay at the time. A heavy compulsory contribution from the lower-income groups would conflict with the achievement of the objectives of the program. Finally, the contributions for prepaid medical care should be coordinated with other social-security measures, and the financing of the entire social-security program should be accomplished in such a way as to promote the objective of full production and full employment.

The general problem of financing social-security measures will no doubt be considered by congressional committees having jurisdiction over taxation, and the Treasury will be prepared to make specific recommendations on the financing of the health program to such committees.

The Department has been advised by the Bureau of the Budget that there is no objection to the submission of this report to your committee.

Very truly yours,

O. MAX GARDNER,
Acting Secretary of the Treasury.

The CHAIRMAN. The first witness this morning was to have been Philip Murray, president of the CIO, but unfortunately he is unable to appear this morning, because negotiations in the iron ore industry have been resumed, and his presence in those negotiations is absolutely indispensable.

We will hear from Mr. Carey, who will give us Mr. Murray's statement.

Mr. Carey, will you state your full name and your official connection with the CIO.

STATEMENT OF JAMES B. CAREY, SECRETARY-TREASURER, CONGRESS OF INDUSTRIAL ORGANIZATIONS, ACCCOMPANIED BY ROBERT K. LAMB, LEGISLATIVE REPRESENTATIVE OF THE UNITED STEEL WORKERS OF AMERICA

Mr. CAREY. Mr. Chairman and members of the committee I am James B. Carey, secretary-treasurer of the Congress of Industrial Organizations.

I testify on behalf of President Murray for the members of the Congress of Industrial Organizations.

The American people want better medical care and believe they can get it under S. 1606, the Wagner-Murray-Dingell bill to provide for a national health program. Certainly this has been made clear by a host of witnesses before this committee. In fact, I feel sure a majority of this committee needed no argument even at the start of these hearings.

The 6,000,000 members of the CIO and their families have long known from bitter personal experience the hazards of ill health. They know, too, that nothing short of a national health insurance program offers the needed protection. They believe that the risks of illness should be federally insured.

I appear on behalf of the Congress of Industrial Organizations to lend the support of our affiliated unions to this legislation and to President Truman's health message of last November on behalf of such legislation.

Let me remind this committee of our long-standing position on it. In 1943 at our Philadelphia convention the CIO went on record for the principles of this bill, and we have from time to time brought to the authors of this legislation our suggestions for its improvements. We believe that with a few minor perfecting amendments, which I shall mention later, this bill will meet the nation's needs.

I want to take this opportunity to congratulate the authors, Senators Wagner and Murray and Congressman Dingell on their courageous efforts for the people's health.

Let me describe now some of the reasons for our support:

CIO members know that today medical care costs the American people about \$4,000,000,000. We know that this same amount of money, used to support the current medical establishment, could be paid by employers and by each gainfully employed person in insurance. We know that for this relatively small annual outlay from our incomes we could take care of the health needs of our families and ourselves.

THE NEED FOR ASSISTANCE IN PAYING MEDICAL COSTS

American Medical Association figures show that 75 percent of all American families need financial assistance to pay for any serious illness.

According to a study made by the American Medical Association's bureau of medical economics in 1939, all families with incomes under \$3,000 usually need assistance in paying for proper care of serious illness. When illness strikes those families, they may be plunged into debt. Or worse, if the breadwinner is stricken, they may be thrown on public or private charity. The doctor, if the family calls one, may see at the start that he cannot hope to collect, or not for a long while.

What is the family to do? What is the doctor to do?

BENEFITS UNDER S. 1606

These hazards lead the average worker to want prepaid personal health benefits. He knows that under Senate bill 1606 he and his family are entitled to the following medical and hospital services:

1. All needed medical care for himself and family from the doctor of his choice; from specialists, if he needs them; hospital care up to 60 days—120 days if funds permit; laboratory services, including chemical, bacteriological, pathological, diagnostic, therapeutic, X-ray, and related laboratory services; special appliances, including eyeglasses, properly prescribed; dental and home-nursing services—these may have to be limited at outset because of shortage of dentists and nurses.

2. Better medical care through support of medical research, through more training of doctors in new methods, through specialist, consultant, and laboratory services.

3. Prepaid costs by the worker, by his employer, and by the Government.

4. More and better public-health services through assistance by the Federal Government and States, for improved sanitation, for control of contagious diseases, for special services for mothers and babies, for public-health education.

While this catalog of needed benefits for the worker and his family—and the 85 percent of all Americans whom S. 1606 would cover—is long, it is not complete.

To round out the benefits provided by S. 1606, the American people need the passage of other parts of the Wagner-Murray-Dingell social-security bill (S. 1050), which the CIO also heartily supports. This includes the hospital-construction program now provided in S. 191, which has already passed the Senate, and which the CIO supports with certain proposed strengthening amendments, now embodied in the Priest bill (H. Res. 5628).

In S. 1050 here are also provided cash disability benefits to yield an income for the families of workers who are sick or permanently disabled, and these the CIO also actively supports.

Think of what this program could mean to the average worker and his family. Think of what the National Health Act alone, S. 1606, could mean to the American people within 5 years of its passage.

Under this legislation it is to be expected that the United States death rates for mothers and babies should be the lowest in the world. To improve our record, we must have more than public health and maternal and infant hygiene services. Mothers and babies need good and regular day-to-day medical care, possible only through universal health insurance.

Death rates from many diseases should decline rapidly. Within a 5-year period we should see great progress in the conquest of diseases like tuberculosis and cancer. We know that this can be done by early diagnosis and treatment.

Between 1900 and 1942 typhoid fever and diphtheria were all but wiped out through public health measures of sanitation and immunization.

The new frontier of preventive medicine lies in the application in personal medical care of some of the lessons learned from cooperative community efforts against the communicable diseases. Under this bill we can expect marked reduction in the toll of the chronic and degenerative diseases.

This legislation gives the general practitioner an incentive to keep his patients well. We believe that when the average doctor knows of the benefits to him under S. 1606, he will want it, too.

We are glad to see that a group of this country's outstanding doctors, in the Physicians Forum, who have been studying this legislation for many years, support it. We notice that they say:

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.

In their summary of the bill, the Physicians Forum says:

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.

SAFEGUARDS UNDER THE BILL

Our own reading of the bill leads us also to conclude that private medical practice and the doctor-patient relationship are carefully safeguarded. Not only are doctors or groups of doctors free to choose whether or not they operate under the insurance system. They can freely choose their patients, and likewise choose how they shall be paid from the insurance fund, if they agree to operate under it. Patients or doctors may change the arrangements after they have been made. The bill specifically provides for public hearings and appeals if disputes arise.

Some spokesmen for the opponents of the bill are mocking the able proposals of the authors of this bill for protecting freedom of choice. They are saying that because a limit is proposed on the number of patients from whom an individual doctor may be paid under the insurance plan, this limits the patients' freedom of choice of doctor. This is, of course, ridiculous. As the bill states, "to maintain high standards" some limit must be established. The physical limits on the doctor's own energies place some natural limits anyway. The question is whether to draw the line.

Millions of Americans today are hopelessly limited in their freedom of choice of physicians. This bill will enormously increase their opportunities for some physician's care, to say nothing of freedom to choose which physician attends them.

Specialists, practicing individually or in groups, are entitled to special rates of payment. To be eligible they are to be chosen according to general standards prescribed after consultation with the National Advisory Medical Policy Council. All rates of payment under the bill will take into account the doctor's professional experience and skill.

In addition to the freedom of medical practice, there are other features of the bill on which we welcome the testimony of such eminent practitioners as the Physicians Forum. They say "Several important features of the bill warrant emphasis because of the fallacious statements that have been made about it." They list these as follows:

1. A very adequate system of checks and balances in administration has been established.

2. 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.

3. The administrative costs as well as the total costs would be small considering the benefits.

As your committee appreciates, the testimony we are presenting will be made available to our members, and it is for that reason that we are doubly glad to be able to make the foregoing quotations from the Physicians Forum. We want our members to know that a group of leading physicians agree with us that this legislation is not only desirable in principle, but on the whole is well drafted to achieve its purposes.

We are also gratified to see that a group of America's leading lawyers think the bill is constitutional. We do not propose to argue the merits of its constitutionality. We think that is up to the Supreme Court.

It seems to us as laymen, however, that the constitutionality of social security legislation has already been decided favorably by the Supreme Court, and we have operated under that legislation for 11 years.

We are glad to see that this bill extends coverage for medical care beyond the groups now benefiting from the Social Security Act. We observe that it includes all persons in industry and commerce, agricultural and domestic workers, most seamen, most employees of non-profit institutions (except ministers and members of religious orders), and self-employed persons such as small businessmen, farmers, and professional persons. We regret that it does not include those employed by the United States Government or the States. The appropriate CIO union, the United Public Workers of America, will wish to submit their testimony on this matter.

PUBLIC DEMAND FOR HEALTH INSURANCE

We believe that all groups which it is proposed to cover under this bill are in favor of its passage. You recall that in 1944 the survey of public opinion conducted for the Physicians' Research Committee by the National Opinion Research Center at the University of Denver showed that eight-tenths of the public were dissatisfied with the present methods of paying for medical care, and two-thirds would be

willing to pay on an insurance basis for complete medical and hospital care for themselves and their families.

In the face of the general Nation-wide demand for passage of this bill, we cannot believe that efforts of certain entrenched individuals at the top of a few organizations can block its passage. The broadcasting of misrepresentations over the last several years has begun to boomerang and the groups these individuals influence are talking compromise. There should be no compromise short of an adequate Federal compulsory health insurance act.

A great effort has been made to confuse the public by emphasis on the word "compulsory." As used to apply to this bill, all Federal taxes are compulsory. Our support of this very limited measure of "compulsion" arises from our recognition that in 15 years' time the "voluntary" medical care plans have managed to persuade only 5 percent of all Americans to operate under their limited coverage. The turnover under these plans is rapid, the costs are high, and the benefits are restricted.

We believe in a Federal system because under it our members and all working people can obtain for themselves and their families complete medical and hospital care by small, regular contributions, supplemented by employer contributions, and, insofar as needed, by Government. It will spread the risk, keep down the cost, and eliminate "the financial barrier between the patient and doctor or hospital."

We believe that such a comprehensive, Nation-wide system will encourage preventive medicine by checking symptoms before they become serious.

We believe that this system will raise the quality of medical care. Our people will have greater access to the services of specialists and laboratories, and without excessive charge.

We believe that the medical profession will benefit. They will be financially more secure and better distributed relative to population and need for care.

We believe that the doctor-patient relationship will improve when people have a right to medical care. Charity will tend to disappear and so will the fear of doctor's bills.

SHORTCOMINGS OF VOLUNTARY INSURANCE

We do not propose to slam the door on voluntary insurance programs before Senate Bill 1606 is passed. Many of our members, even though a minority, have today the partial protection of voluntary plans. But for those opponents of S. 1606 who would like to persuade us to accept permanently the alternative of voluntary insurance plans, we have the following answers:

1. Coverage under the voluntary plans is today quite inadequate. Those persons who need protection most are outside.

2. Most plans discourage many would-be subscribers by limitations which exclude patients on account of age, type of disease, income limits, minimum number of persons who must enroll in a group.

3. Most plans are designed only for serious illness, many providing only hospital care.

4. Patients are discouraged from calling a doctor by extra charges.

5. Consumers of medical care rarely have a say in administration.

Most of these voluntary plans operate on a fee-for-service basis. Thus they do not foster the attainment of the benefits to be derived from either the capitation or the group-practice systems (both provided as possible choices under S. 1606).

It does not seem necessary for us to dwell further on the shortcomings of the voluntary plans. Under the chairmanship of Senator Pepper a subcommittee of your committee has prepared a comprehensive report on this subject which Senator Pepper has summarized in your hearings. He shows that they tend to insure or indemnify the surgeon and the hospital, but most of them give no adequate protection to the patient.

The opponents of S. 1606 have revealed an intention to take as their first line of defense the support of voluntary insurance programs. The CIO is gratified to see that the Nation-wide demand by a majority of the American people for adequate medical care and proper health protection has driven the opposition to retreat to this point. Ten years ago that much progress would have been unthinkable.

But it is interesting to note that some of the opposition are also preparing a second line of retreat. They are beginning to talk about State instead of Federal compulsory insurance programs.

The friends of S. 1606 can congratulate themselves on this further sign of yielding by the opposition.

But the shortcomings of State plans are as serious as those of the private voluntary plans. State plans would preserve inequities between States. A national plan gives coverage no matter where a family may move. It protects workers who live or work near State borders. It permits patients who need special care to secure treatment from the best doctor or in the best-equipped hospital. It provides doctors, nurses, and dentists with the chance to keep abreast of modern improvements in techniques. It costs less than State systems. It can be put into effect at once. And it raises the level of medical care in all the States simultaneously.

Just as the CIO has supported voluntary plans, so some of our State groups have advocated State plans, but we do so pending the passage of national legislation. We shall continue in some instances to take advantage of voluntary plans, as arranged with employers, but only where these voluntary plans offer protection in addition to the basic benefits of the health-insurance system.

Moreover, we understand that some voluntary plans can continue to operate as agents of the Government in the administration of the basic health benefits.

PROPOSED AMENDMENTS

There are two features of S. 1606 which we would like to see amended. The first is the provision in title I, section 137, paragraph (b), providing for money payments to needy individuals. This should be amended so that the proceeds of Federal grants are always used to insure relief cases under the National Health Insurance Fund.

The second section needing amendment is title II, section 210 (a), whereby the patient may be required to pay a fee for the first service or for each service in a period of sickness. There are other ways to

correct abuses by patients which will not foster abuses by physicians and which will not discourage the legitimate desire of patients to use the insurance funds. This requires the wise action of local committees on which the medical profession is adequately represented under the bill.

Much of the success of this legislation hinges on the evolution of the proposed administrative system. We believe that the administrative machinery is now well drafted in the bill.

Much will depend upon the wise choice of the 16 members for the National Advisory Medical Policy Council, including the choice of representatives of nonmedical groups, and on the relations developed by the Surgeon General as chairman.

We look forward with especial interest to the carrying out of the provision that similar advisory committees will be appointed at regional, State, and local levels. To succeed this legislation must in practice develop a careful balance between the centralization of policy-making responsibility and the decentralization of operating responsibility. We are sure this can be done. We do not want to take any responsibility away from the doctors, but this is a community problem.

For those who fear the effects of this bill in regimenting the medical profession attention should be called to the appeals machinery provided in the bill. Beneficiaries, physicians, and hospitals all may appeal to qualified appeal bodies. Provision is made that hearings on matters involving only professional practice or conduct shall be before hearing bodies made up exclusively of competent and disinterested professional persons.

In addition to title II (Prepaid Personal Health Service Benefits), with which our testimony has dealt at length so far, there are portions of title I upon which we wish to comment.

TITLE I OF S. 1606

We are in general agreement with the proposal for increased grants to States for public-health services. We have stated earlier our admiration for the achievements of the United States Public Health Service and for its effects on State public health systems.

The new frontier of public-health work lies in preventive medicine, and we favor the expansion of present programs and adequate funds to make expansion possible.

We support the amendments of S. 1606 proposed by Senator Pepper relating to the maternal and child health services, and intended to embody an agreement between the Secretary of Labor and the Administrator of the Federal Security Agency. We understand that these amendments are to aid grants to States for maternal and child health services, coordinate these with prepaid personal health service benefits, and to introduce into S. 1606 certain provisions of Senator Pepper's bill, S. 1318.

The CIO wants to see the widest development throughout this country of improved maternal and child care. We include in this community, programs which bring together doctors, dentists, nurses, educators, welfare workers, representatives of hospitals, clinics, and schools. We want to see State and local demonstration projects. We want to see the growth of new personnel in this expanding field,

and their extension to areas not now cared for, or inadequately covered.

We are eager that the Children's Bureau be sustained as an agency watching over the interests of children. We approve of Senator Pepper's proposal that its program supplement and complement the provision for families, including mothers and children, of general medical and dental care through personal health service benefits. And we want to be sure that mothers and children not covered by insurance because they are financially needy shall receive the same personal health services as if they were insured, and so long as there are such groups it seems appropriate that the Children's Bureau together with State health agencies should administer this part of the health program. As to the child welfare services included in S. 1318 and not in S. 1606, we hope that Congress will make early provision for those children who are in need of social services.

In addition to those matters in title I, I should like to comment in praise of section 213 in title II, grants-in-aid for medical education, research, and prevention of disease and disability. It seems important if we are to meet the expanding need for well-trained personnel to keep up with the rapid changes in modern medicine, that the Federal Government lend a hand with medical education and research. I am especially glad to see explicit preference and priority for projects to aid servicemen seeking postgraduate training in these fields.

As to veterans who are possible beneficiaries of medical care, this bill will greatly improve their coverage over anything provided in the GI bill of rights, and will also, of course, protect the other members of their families. It will especially assist veterans with the care of ailments which are not service connected.

FINANCING OF S. 1606

In closing, let me say a few words about financing. This does not strictly concern your committee. A revenue bill, of course, to provide for social insurance contributions or taxation will originate in the House Ways and Means Committee and be referred to the Senate Finance Committee. But I want to reiterate here the stand of the CIO that we favor the payment by employers and employees of payroll taxes, and the supplementation of these amounts by the Federal Government to provide for needy persons. If at some later date it becomes desirable to add to the Federal contribution, we are prepared to consider such appropriations and the consequent taxation as they become necessary.

We feel that it is imperative now to press for early passage of the benefit provisions of this legislation. The sums now spent annually for the medical care of the American people today would amply cover the benefits provided in this bill. We should act to protect our people by this plan for spreading the risks and we shall then be in a position to debate the most efficient and equitable manner of channelling the insurance payments to the personal health services account. We urge your committee to report this bill at your earliest opportunity so that Congress may act on it at this session.

The CHAIRMAN. Do you desire to submit any questions, Senator?

Senator DONNELL. Yes; I do, Mr. Chairman. Would the chairman prefer for me to proceed?

The CHAIRMAN. Yes.

Senator DONNELL. All right.

Mr. CAREY. I understand this testimony was originally expected to be submitted by Mr. Murray?

Mr. CAREY. Up until 10 o'clock this morning.

Senator DONNELL. This morning.

Mr. CAREY. And suddenly they arranged a meeting for 10:30 with the employers in the industry. It is a very serious situation, and we are anxious to see a solution of that problem.

Senator DONNELL. Were you personally acquainted with the contents of this testimony before coming here?

Mr. CAREY. Senator, I am also the chairman of the CIO committee on health, welfare, and safety, and that way I come in close contact with the policies of our organization containing the questions covered by this bill.

Senator DONNELL. Had you personally had anything to do with the preparation of this testimony to be given by Mr. Murray?

Mr. CAREY. Not in the actual writing, but in the policy determinations; yes. And I participated in the discussions that took place in the policy meetings.

Senator DONNELL. Who actually prepared this?

Mr. CAREY. Mr. Murray, with the assistance of Bob Lamb, who is beside me this morning.

Senator DONNELL. Mr. Lamb is an attorney, is he not?

Mr. LAMB. I am an economist.

Mr. CAREY. I do not think it would be any reflection on him if he was an attorney.

Senator DONNELL. No; I think it would be all right. Neither is it any reflection if he is an economist.

Now, Mr. Carey, have you personally given study to this matter of compulsory health insurance?

Mr. CAREY. Yes, sir.

Senator DONNELL. You have?

Mr. CAREY. I might say that I am a member of a group health hospitalization plan.

Senator DONNELL. Yes, sir.

Mr. CAREY. And the experiences I have had personally with my family in their health questions would confirm the testimony here given.

Senator DONNELL. You agree with the testimony as you have read it?

Mr. CAREY. Absolutely.

Senator DONNELL. Yes, sir.

You start in this testimony by saying that "The American people want better medical care and believe they can get it under S. 1606." What is the basis for your judgment as to what the American people believe with respect to obtaining medical care under S. 1606?

Mr. CAREY. The medical care the people receive at the present time would not nearly be as good as that that can be received under proper organized methods of compulsory health insurance.

Senator DONNELL. Perhaps I did not state my question clearly.

I wanted to know the basis on which you draw the conclusion that "The American people want better medical care and believe they can get it under S. 1606." Has the CIO taken any poll?

Mr. LAMB. Mr. Chairman, I would like to intervene—

Senator DONNELL. I would like to examine Mr. Carey.

Mr. LAMB. Since I wrote this—

Senator DONNELL. Pardon me, Mr. Chairman, I would like to examine Mr. Carey.

The CHAIRMAN. You may examine Mr. Carey. If Mr. Carey wishes to refer any technical question to his adviser, he may do so.

Mr. CAREY. Mr. Lamb is trying to help me understand your question.

Senator DONNELL. Mr. Carey, you understand my question, do you not? Namely, on what is it that you base the conclusion that the American people believe they can get better medical care under S. 1606?

Mr. CAREY. The contents of the bill.

Senator DONNELL. The contents of the bill.

Have you taken any poll of the American people on that subject?

ATTITUDE OF WORKERS TOWARD HEALTH INSURANCE

Mr. CAREY. Senator, we have an organization that, I suppose, provides a better opportunity to determine the thinking of the people than any other institution in this country, including Congress.

We have 6,000,000 members. We average about 4 members per family. That is 24,000,000 people. Those 24,000,000 people are concerned with the health problems of themselves and their families.

We have in these communities local unions. These locals discuss these questions.

And we have in the cities councils of the representatives of the local unions that discuss these questions.

We have in the States organizations that discuss these questions.

We have in the national organization, in addition to the national CIO convention, as I indicated in my testimony that this matter was a matter of discussion, we have 41 national organizations, and they discuss questions, and they have their district bodies, and in the course of that we are able to set forth before you, Senator, the opinions of the 6,000,000 members of the CIO and their families on this question of health.

This today is a very important question. And this today is one of the key questions of why our people are so anxious that the Senate understand that they all unanimously—and they are not unanimous on every question—are in support of Senate bill 1606.

They understand its purposes. They believe it is one of the best bills ever drafted by the Senate.

It is clear. It covers what could be made a very difficult problem, but it is understandable to them, because they deal with the children and other members of the family that are ill.

I do not think, Senator, you can confuse us on the question of what our people want.

As to the polls, I will say that the polls are far better than any ever taken in this country in determining the wishes of the people.

Senator DONNELL. Mr. Carey, you have not answered the question yet. You have made the question an observation of the opinion of the CIO and the members of the CIO families.

Mr. CAREY. I understood you—

Senator DONNELL. Will you let me ask the question, and then I will be glad to have you answer it.

In the opening of this article you have read, prepared by Mr. Murray and Mr. Lamb, as you stated, you make this statement: "The American people want better medical care and believe they can get it under S. 1606."

My question is: What is the basis on which you draw the conclusion for the American people, which, as I understand it, consist of about 140,000,000 people?

Mr. CAREY. Can we take it step by step?

Senator DONNELL. Yes, sir.

Mr. CAREY. I think you will agree with me that the people of this country do want better medical care.

Senator DONNELL. Go ahead. You are answering the question. I am not here under examination by you, Mr. Carey. Go ahead and take it step by step.

Mr. CAREY. Are you asking for clarification?

Senator DONNELL. I am seeking your answer.

Mr. CAREY. I think our difference, Senator, is that you question whether or not the people want better medical care. You won't even go so far as to agree that they do, and before I can touch the next question I will have to get from you an indication of where you stand on the proposition.

Do you say we are wrong in saying that the people want better medical care?

Senator DONNELL. Mr. Chairman, I will ask Mr. Carey, please, to answer the question rather than undertake to examine me as to the things I did not say and did not mean and he knows I did not mean.

You know very well I agree with everybody who has stated that the American people want better medical care. Of course they do. You understand that as well as I do.

What I am asking is: What is the basis of your conclusion—and I will ask it as clearly as I know—as stated, that "the American people want better medical care and believe they can get it under S. 1606?"

What is the basis of your statement to that effect?

Mr. CAREY. Because S. 1606, if enacted, will provide the list of services in the medical field that I have listed at the beginning of page 2.

Senator DONNELL. You have not taken a poll of the American people outside of the CIO, have you?

Mr. CAREY. Senator, we do. We have to.

Senator DONNELL. Have you taken a poll of the American people?

Mr. CAREY. May I first finish my answer?

Senator DONNELL. On the question of whether or not they believe they can get better medical care under S. 1606?

Mr. CAREY. Certainly.

Senator DONNELL. When did you take that poll?

Mr. CAREY. In our political-action work.

Senator DONNELL. That is the political action committee?

Mr. CAREY. That is our political action work, Senator.

Senator DONNELL. That is the Political Action Committee of the CIO?

Mr. CAREY. That is a small part of our political-action work, Senator.

Senator DONNELL. When did you ever take a poll on that question as to whether, "The American people want better medical care and believe they can get it under S. 1606."

Mr. CAREY. We have machinery for holding meetings throughout the country of our own members, and also people that are friendly to some of the issues that we seek enlightenment upon.

We have, as part of our political-action program, this very bill. That was brought about as the result of these many discussions that have taken place throughout the country, to discuss the kind of program that our political action committees and the CIO would seek enacted into legislation on behalf of the people of this country.

Our people, which I think is a fairly large section of American society, are a good cross section of the thinking of the American people.

And through all these mediums, Senator, we came to the conclusion that the people do want better medical care and that they can best get it under this type of system provided for in this bill.

Senator DONNELL. Mr. Carey—

Mr. CAREY. The people of this country are not nearly as ignorant of the contents of this bill as some of you opponents would indicate. They are not nearly as confused with some of these statements about no freedom of choice or socialization or violation of State rights, or something of that nature, as if there is such a thing as State rights. The people have the rights.

And I think under this bill the people will get medical care of an adequate nature that they do not secure today under the present situation.

Senator DONNELL. Mr. Carey, I will ask you a very simple question, as to whether or not the CIO has taken a poll of the people of the United States on the question as to whether they believe they can get better medical care under S. 1606?

You know what a poll is; do you not?

Mr. CAREY. What is a poll, Senator? Maybe you can help me. A poll is a method for determining the wishes of the people and opinions on a certain question.

You asked me if we do that, and I said, "Yes."

Are you thinking of the Gallup poll? Of the Crosley poll? If that is your narrow definition of the term "poll," I think, Senator, we have not.

Senator DONNELL. Mr. Carey, I think perhaps now the meaning of this question is at least permeating your brain.

The question I am asking you is, Have you taken a poll, p-o-l-l, poll? Have you taken a poll of the people of the United States on this question?

Mr. CAREY. Yes, sir.

Senator DONNELL. When did you take it?

Mr. CAREY. We take it constantly, day in and day out, through the channels of our organization.

Senator DONNELL. Have you sent out any questionnaire of any kind?

Mr. CAREY. Now you are getting down to something.

Senator DONNELL. You did not have any idea of what I meant? Is this the first time you had any idea of what I meant?

Mr. CAREY. Is that your definition of a poll, Senator?

Senator DONNELL. Mr. Carey——

Mr. CAREY. You asked me a question. I asked you to define what you said.

Senator DONNELL. I will put my question——

Mr. CAREY. You know that Gallup takes a poll and Crosley take a poll. The CIO has no poll of that type.

As to your questioning my credentials representing the CIO, I say we know the thinking of our people that authorized us to support this legislation.

Senator DONNELL. I want to say this, Mr. Carey: You may have credentials. I do not know what they are or what is their nature, but I want to say to you, you do not have any credential to act for me, and I am one of the members of the American people.

Mr. CAREY. Are you a member of the CIO?

Senator DONNELL. I am not.

Mr. CAREY. I will modify my testimony.

Senator DONNELL. Just a minute.

Mr. CAREY. And I will say that the American people, with the exception of one, single, solitary Senator, wants better medical care.

Senator DONNELL. That is not the question I asked you.

Of course, I want better medical care.

Mr. CAREY. Senator, you do not happen to be the American people.

Senator DONNELL. I think I am one of them.

Mr. CAREY. You are no more the American people than I am.

Senator DONNELL. I want to say to you, Mr. Carey, that my question is perfectly simple, and you have understood it all along. Have you sent out a questionnaire. If you cannot understand the meaning of the word "poll"; have you sent out a questionnaire to the American people, as such to ascertain whether or not they believe they can get better medical care under S. 1606?

Have you sent it out?

Mr. CAREY. May I——

Senator DONNELL. Have you sent out such a questionnaire? Just answer that question, please, sir.

Mr. CAREY. Are you trying to harrass me, Senator?

Senator DONNELL. I am asking a question.

Mr. CAREY. Are you trying to frighten me?

The CHAIRMAN. Gentlemen, I do not think we are making any progress here.

Senator DONNELL. Apparently not.

The CHAIRMAN. It seems to me that his statement that the American people want better medical care and believe they can get it under S. 1606 is an expression of opinion on his part, based upon these facts which he has stated here several times, that they have chapters all over the United States, and they discuss these matters. I think what he means is that that statement there is the result of his experience and study of the thinking, and is an expression of opinion.

Of course, I am sure he could not have taken a poll in the nature of a questionnaire being sent to 140,000,000 people, but I think he had a right to express his judgment on the thing.

Senator DONNELL. Yes, he has a perfect right to express it.

I think, also, Mr. Chairman, that he has a right, when he comes before this committee, to answer a question; and I undertake to say that any man with ordinary common intelligence would understand

the question I asked, and it could have been answered "yes" or "no" instead of all these speeches that this witness has made.

Mr. CAREY. Senator, perhaps your use of the term "poll" is quite different from the one I am accustomed to using.

Senator DONNELL. I mean a questionnaire.

Mr. CAREY. When we have a desire to poll our membership, we do it through the machinery of the organization, and we have occasion to poll our organization on questions, our State and our city bodies. So the system I described to you is our way of polling the membership.

Senator DONNELL. Very well.

Now, Mr. Carey, you have not, however, sent out any questionnaire to the people of the country as entity?

Mr. CAREY. You know we have not, Senator.

Senator DONNELL. And you know you have not.

Mr. CAREY. Certainly, you would not ask a question you know the answer to?

Senator DONNELL. Apparently you were unable to answer it.

Mr. CAREY. I said we do poll the membership. We do poll the American people. We do not send out a questionnaire.

Had you worded the question: do we send out post cards to every citizen?—the answer will be No."

Senator DONNELL. Very well. If you have had difficulty in understanding my questions, I will try to make them more clear in the future.

Mr. CAREY. I want to ask you this question: in that first paragraph there appears an opinion also; "I feel sure a majority of this committee"—that is, this committee here, this Senate committee—"needed no argument even at the start of these hearings."

Have you polled this committee in advance of the start of these hearings as to how it felt?

Mr. CAREY. Have we sent them a letter or a post card? No. Have we had our representative talk with members of the committee? Yes.

In my definition, we have polled the committee. In your definition of a poll, no.

Senator DONNELL. You have learned in advance of the beginning of these hearings, that "a majority of this committee needed no argument even at the start of these hearings." That is your judgment?

Mr. CAREY. Senator, there are Members of the Senate that we know from their past record that they will support certain good legislation, and they will oppose certain bad legislation.

Senator DONNELL. May I ask you this question, Mr. Carey: You state, on page 5 of your testimony:

* * * that in 15 years' time the "voluntary" medical care plans have managed to persuade only 5 percent of all Americans to operate under their limited coverage.

What is your meaning there in the term "limited coverage"?

Mr. CAREY. With your permission, Senator, I would like Mr. Lamb to answer that.

Senator DONNELL. Very well. Very well. I understood you concurred with the contents of this statement.

Do you know what is meant by that language there?

Mr. CAREY. Yes, Senator, but I think Mr. Lamb would be more desirable.

Senator DONNELL. As you know, I would like to have your knowledge. You are testifying as secretary-treasurer of the CIO.

Mr. CAREY. That is correct.

Senator DONNELL. Let me phrase that question this way: You say that you support this, and, as I quote: "very limited"—

The CHAIRMAN. Where is that, Senator?

Senator DONNELL. Page 5, the second full paragraph.

Our support of this very limited measure of "compulsion" arises from our recognition that in 15 years' time the "voluntary" medical plans have managed to persuade only 5 percent of all Americans to operate under their limited coverage.

Are you referring there to such organizations as the Blue Cross?

Mr. CAREY. That is correct.

Mr. LAMB. No, Senator. That is not correct.

May I answer that question?

Senator DONNELL. Mr. Carey says it is. Which is right?

Mr. CAREY. We are referring to all the plans.

Senator DONNELL. All the plans.

Mr. CAREY. That is right. The Blue Cross.

Senator DONNELL. And do you cover all the people, all the plans of voluntary coverage with respect to health?

Mr. CAREY. That is correct.

Senator DONNELL. And you say that only 5 percent of all Americans have been persuaded to operate under the limited coverage.

Do you not know, Mr. Carey, that over 20 millions of the American people are today under the Blue Cross itself?

Do you not know that to be a fact?

Mr. CAREY. I do not know that to be a fact, Senator.

Senator DONNELL. You do not. Well, I think that is the testimony of the gentleman who appeared here from the Blue Cross the other day.

The CHAIRMAN. That is not a complete coverage.

Senator DONNELL. He is not talking about complete coverage.

Mr. CAREY. Mr. Chairman, I cannot testify as to the coverage of the Blue Cross plan.

The Senator should know I am not here testifying in that behalf.

Senator DONNELL. Mr. Chairman, I undertake to say that this witness comes here with a statement which was prepared by Mr. Murray and Mr. Lamb, and which the witness says he concurs in, he being on a committee that he says studies these problems, and that statement says that—

in 15 years' time the voluntary medical care plans have managed to persuade only 5 percent of all Americans to operate under their limited coverage.

Now, do you not know whether that is correct or not, do you, Mr. Carey? That would be about 7,000,000.

Mr. CAREY. Senator, I ask you for the opportunity of having Mr. Lamb testify on that.

Senator DONNELL. That is perfectly all right, sir.

Mr. CAREY. He is familiar with that in detail.

Senator DONNELL. And you are not; is that right?

Mr. CAREY. In detail?

Senator DONNELL. Yes.

Mr. CAREY. You asked me if I understood the meaning of that sentence, and I say "yes."

Senator DONNELL. I am asking you, Do you know whether or not the statement of fact is true, that "only 5 percent of all Americans" have been persuaded "to operate under their limited coverage"?

Mr. CAREY. Did I count them, Senator?

Senator DONNELL. No.

Mr. CAREY. The answer is "no." Did I send out a poll?

Senator DONNELL. No.

Mr. CAREY. The answer is "no."

Senator DONNELL. I did not ask you that.

Mr. CAREY. You wanted a clarification of this sentence as to what it means?

Senator DONNELL. I want to know whether you know what it says.

Mr. CAREY. I said "yes." What is not clear to you, Senator?

Senator DONNELL. The statement is perfectly clear.

Mr. CAREY. Why do you ask questions on it if it is clear?

Senator DONNELL. Mr. Chairman, I think I have a right to ask questions.

Mr. CAREY. Not if it is clear.

Senator DONNELL. That was not the question.

The CHAIRMAN. It seems to me we are not making any headway here. I think Mr. Carey should have the right to have his adviser answer any technical question.

Senator DONNELL. That is all right. I am perfectly agreeable.

All right, Mr. Lamb.

May I ask you just a question or two? What are your initials or your full name.

Mr. LAMB. Robert K.

Senator DONNELL. Robert K. Lamb. And what is your connection with the CIO?

Mr. LAMB. I am legislative representative for the United Steel Workers of America, of which Mr. Philip Murray is president.

Senator DONNELL. You are an economist?

Mr. LAMB. I am an economist.

Senator DONNELL. Were you with a Government department before you worked for the CIO?

Mr. LAMB. I worked for the Senate and the House of Representatives, but I never worked for an executive agency of the Government.

Senator DONNELL. You worked for the Senate and the House of Representatives, and now you are a member of the CIO?

Mr. LAMB. That is right.

Senator DONNELL. Reference was made by Mr. Carey to Mr. Murray and yourself, who prepared this statement.

Mr. LAMB. That is right.

Senator DONNELL. What proportion of this statement did Mr. Murray prepare?

Mr. LAMB. I was instructed by Mr. Murray, and Mr. Van Bitner, the chairman of our social security committee; the committee on health and welfare and social security have some overlapping jurisdiction.

Senator DONNELL. Yes.

Mr. LAMB. To prepare this statement, which I did, and it was indicated to me that I should examine the previous actions of the CIO, dating back to 1943, which are here described.

Senator DONNELL. Yes.

Mr. LAMB. And conform my statement to their position.

They took the position in 1943, and have since then, that they are in favor of the provisions of this bill, or its predecessor, those sections of S. 1050.

Senator DONNELL. Yes.

Mr. LAMB. Which you are familiar with.

Senator DONNELL. Yes, sir.

Mr. LAMB. I prepared this statement and went over it in detail with President Murray, and he concurred in the statement, and as Mr. Carey told you, was prepared to come here this morning, but was unable to do so.

Senator DONNELL. The actual preparation was done by yourself?

Mr. LAMB. Yes, sir.

Senator DONNELL. 100 percent.

Mr. LAMB. That is right.

Senator DONNELL. And Mr. Murray concurred in the views expressed in this statement?

Mr. LAMB. That is right.

Senator DONNELL. And that is the only connection, so far as preparation is concerned, that Mr. Murray had with it?

Mr. LAMB. Yes, sir.

Senator DONNELL. Now, Mr. Lamb——

Mr. CAREY. Senator, may I clarify that?

Senator DONNELL. Yes, sir.

Mr. CAREY. In our activity, we have people assigned to carry out various portions of our work.

Senator DONNELL. Yes.

Mr. CAREY. I think, beyond what the answer that Mr. Lamb gave you to your question, takes in, he says the only connection Mr. Murray had with it, I might add that Mr. Murray is responsible for the statement. He supports it. He went over it. He endorsed it.

Likewise, myself, as an officer of the CIO, find it within the policy of the CIO, and we are responsible for it.

When Mr. Lamb says he is responsible for the statement, he is stating that as a representative that the whole CIO is responsible for it.

Senator DONNELL. I understand that. That is very clear.

VOLUNTARY INSURANCE PLAN

Mr. Lamb, you heard the question I asked Mr. Carey a while ago, which he has referred to you, with respect to this statement, quoting—

Our support of this very limited measure of "compulsion" arises from our recognition that in 15 years' time the "voluntary" medical care plans have managed to persuade only 5 percent of all Americans to operate under their limited coverage.

Would you please tell us just what is referred to there by the "5 percent of all Americans" operating "under their limited coverage"?

Mr. LAMB. I would be glad to try, Senator.

Senator DONNELL. Thank you.

Mr. LAMB. As you are aware, a campaign is now being made to persuade the American people that voluntary prepaid medical care plans are an adequate substitute and a more desirable substitute for the provisions of this bill.

Those plans are advanced, but the groups I have reference to are not the Blue Cross plans, because it is well understood by all those who

are even amateurs in this subject, that the Blue Cross plans afford coverage for hospitalization and surgical benefits.

This certainly is not voluntary prepaid medical care in the sense in which the opponents of this legislation are using it. It is no substitute in any sense of the word for this bill. It covers a very meager part of the problems of the average American family, as to the health needs in the course of a year or a lifetime.

Senator DONNELL. Now, Mr. Lamb, I think you are answering my question directly and very informatively, and I am glad to have your answer.

I would like to ask just a few more questions along the same line, as to voluntary medical care.

You are not referring to the type of service the Blue Cross affords?

Mr. LAMB. I did not. I will refer to that, if you please, but I did not in that paper, because I thought the CIO should address itself to the voluntary prepaid medical care plans comparable in their coverage to the coverage afforded by this bill.

Senator DONNELL. Very well.

As to those organizations, could you tell us the principal ones of those voluntary prepaid medical care plans to which you refer and which include 5 percent of the Americans at this time?

Mr. LAMB. Well, Senator, the two outstanding ones of which I have any knowledge are the California Physicians Service, and then one in Michigan, and I do not profess to know much about the one in Michigan.

As to the general coverage—that is to say, the 5,000,000 or so, and perhaps it is as high as 7,000,000—as I understand it, the State and local medical societies are responsible for about 1,000,000 and between 500,000 and 800,000 at the present time of the people covered.

Senator DONNELL. Yes.

Mr. LAMB. Under special plans, such as I am describing, and that includes, I believe, the California Physicians Service.

Senator DONNELL. Very well.

May I ask you this: Do you know whether or not the California Physicians Service recently entered into an arrangement, whether final or not I am not informed, with the Grange, whereby approximately 100,000 members of the Grange are to come in under the operation of that plan?

Do you know whether or not that has been tentatively or perhaps finally arranged?

Mr. LAMB. I do not know, sir.

Senator DONNELL. You do not know about that?

Mr. LAMB. My information on the California Physicians Service predates any such arrangement as that.

Senator DONNELL. So that in your opinion approximately 5 percent of our entire population has already come in under the limited coverage of voluntary medical-care plans, as you have described them, about some 5,000,000 to possibly 7,000,000 of our population?

Mr. LAMB. I would like to amend that statement—

Senator DONNELL. Very well.

Mr. LAMB. To say this—

Senator DONNELL. Yes, sir.

Mr. LAMB. If you took the number of people who had experienced the benefit of such plan, the number is far larger.

Senator DONNELL. Yes, sir.

Mr. LAMB. The turn-over under these plans is such that there are not more than 5,000,000 now.

We believe that this is one of the indexes of the shortcomings of this particular voluntary system.

Senator DONNELL. Yes. I get your point exactly.

By the way, you say 5,000,000. The statement says "only 5 percent of all Americans."

Mr. LAMB. I am assuming it may be as high as 7,000,000, but I do not know the exact figure, and I am using 5,000,000 as approximate.

Senator DONNELL. Of course, there is a substantial difference between 5,000,000 and 7,000,000. Two million persons is quite a substantial acquisition, and I just wanted it clear that you do say "5 percent of all Americans" have been persuaded to operate under their limited coverage, to which you referred.

Mr. LAMB. I have seen that figure used in two forms: one is 5 percent, and the other is less than 5 percent.

Senator DONNELL. That is all right. I have no objection at all.

I want to ask you also: Is it not true that in addition to the voluntary medical care to which you refer, and which has persuaded 5,000,000 or possibly a little over that of the Americans to operate under their limited care, that the Blue Cross has attracted within its hospitalization plans something in excess of 20,000,000 persons? That is correct, is it not?

Mr. LAMB. Sir, the figure I have seen is 19,000,000, but I will not argue it.

Senator DONNELL. That is close enough. My recollection is the testimony here from the gentleman of the Blue Cross was it runs about 21,000,000. I might be in error.

Mr. Lamb, there is nothing, legally at any rate, to prevent the Blue Cross, if people want the additional service, from enlarging their service from hospitalization to include the medical care to which you refer?

That is correct, is it not?

Mr. LAMB. I am not acquainted with the legal aspects of the Blue Cross operation. But I am prepared to take your word for it that there is not.

Senator DONNELL. Perhaps I should amend my statement. I do not want to go too far. I take it, if the Blue Cross would have to operate in a given State, it would operate under the laws of that State, and there may be limitations I am not informed of. The point I am making is, it would seem logical, and I ask you if it does not seem logical, that it is possible for voluntary agreements to be made with respect to provisions for hospital care? It would seem logical that there would be good, legal ability to make like arrangements with respect to general medical care. That would seem logical, would it not? You would agree to that?

Mr. LAMB. Yes; I would be prepared to agree to that.

Senator DONNELL. Now, Mr. Lamb, you know also, do you not, that the various groups of physicians, notably the American Medical Association, are today working along the lines of developing the voluntary insurance plans? You know that?

Mr. LAMB. Yes; I know that.

Senator DONNELL. You know of the organization in the State of Illinois, perhaps, within the past few months, a corporation, which I think was under the auspices of the American Medical Association, which has had that in mind as one of its fundamental purposes. You know that, do you not?

Mr. LAMB. I am not acquainted with that in any detail. I have simply heard that.

Senator DONNELL. You have heard that. All right. Thank you, Mr. Lamb, for the information.

Now, Mr. Carey, going back for a moment to your testimony: You refer on page 2 of your testimony, which you called to my attention a few moments ago, to the services that you say are obtainable under S. 1606; or, to put it a little more exactly, I quote from your testimony: "He," that is, the average worker, "knows that under S. 1606 he and his family are entitled to the following medical and hospital services."

Then you list on page 2 some of those services.

Now, you mention, for instance, at the outset:

1. All needed medical care for himself and family—from the doctor of his choice.

Now, Mr. Carey, have you read this bill yourself, personally?

Mr. CAREY. Yes, sir.

FREE CHOICE OF DOCTOR

Senator DONNELL. Have you read subdivision (j) on page 50 of the bill, section 205? I will read that section out loud for the record:

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

Mr. CAREY. Yes, sir.

Senator DONNELL. Now, that, I may say, and I think I should say this in fairness, applies only in the instances in which the so-called per capita basis of compensation is agreed upon by physicians in a given area.

Now, the illustration I wanted to call to your attention is this: Suppose that in a given community, we will say with a population of 10,000 persons, there are 10 physicians prescribed under this bill shall have said that each one of the doctors in that particular area, each one of the 10, may take 1,000 patients.

I am using that just for easy mathematics. Now, suppose that on the day of registration of the persons who desire to go to the different doctors, the most popular and best-known doctors' lists are promptly filled; and then you, Mr. Carey, and Mr. Lamb and I come along a week later than that to register, or a day later than that to register. And we find that we want one of those same doctors, each one of us does, but his list is filled.

Do you not concur that it would be necessary for each of us, then, under this bill, to take another doctor rather than the one that we would have preferred ourselves? You would agree to that, would you not?

Mr. CAREY. That operates today: If a dentist, let us say, has more work than he can handle, you either have to wait, or not have those services or go to another dentist.

Senator DONNELL. But is it not a fact that the dentist today decides, whether he can take you, under the present existing law?

Mr. CAREY. That is right.

Senator DONNELL. Whereas under this bill the Surgeon General as I have just read, may prescribe these maximum limits beyond which a practitioner may not go. That is correct, is it, under the terms of this section that I have just read to you?

Mr. CAREY. That is only on the basis of the limits. That is correct. That operates the same today if the dentist, whether he wants to or not, could not take you, if he had more work than he could handle.

Senator DONNELL. I am not arguing about the conditions today. I am undertaking to present the law here as it is proposed. You say in your statement that the average worker "knows that under S. 1606 he and his family are entitled to" these services, namely, "all needed medical care for himself and family—from the doctor of his choice."

We have agreed, have we not, Mr. Carey, that in the illustration used, you or Mr. Lamb or myself might not get the doctor that we choose under this bill? That is right, is it not?

Mr. CAREY. That is correct.

Senator DONNELL. You also say in the next line—

Mr. CAREY. You may not get him for two reasons: (1) that the doctor has more work than he can handle, or (2) the doctor does not want to accept you as a patient.

Senator DONNELL. Or it might be that the Surgeon General had prescribed that the maximum limit that he could take would be 1,000, and you and I are 1001, 2, and 3.

The CHAIRMAN. I think it would be proper to call attention to the other sections of the bill, Senator, which allow the patients to select the doctor from which they wish to receive service, and you might refer to subdivision (b) of section 205, on p. 45.

Senator DONNELL. Yes. I think that is perfectly proper.

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

That is in there. However, it is also prescribed, as I have indicated, in subdivision (j), that the Surgeon General prescribe these maximum limits to the number of persons that a physician may take.

Mr. LAMB. Excuse me, Senator. I wonder if I might speak on this?

Senator DONNELL. Certainly, sir.

Mr. LAMB. In the first place, I call the attention of the Senator to the word "may." And in the explanation I would like to suggest to the Senator the example of the game of musical chairs which some people call "going to Jerusalem."

If you have ever played the game, you know that there are a limited number of people in the room, and that you have one less chair than there are people in the room.

Now, obviously, somebody is going to stand up. The problem at the present time in this country is that there are far too few chairs and far too many people standing up.

But this is not due to the number of doctors. It is due to the distribution of patients relative to the doctors. Obviously if you are going to have a capitation system and a certain number of people in the community are going to be covered under the capitation system, there is going to be a limit which is placed by the relationship between the number of doctors and the number of patients in the community.

Consequently, for the Surgeon General to have some right to state, with the advice, as I understand it, of his advisory council, which is representative of the medical profession, an upper limit whereby one doctor is not permitted to have two-thirds of all the patients in the given community, leaving the rest of the doctors out under a capitation system, it seems to me is simply within the logic of the system, which would require some such provision as this.

It is an optional provision, however, on the part of the Surgeon General and not a compulsory one.

Senator DONNELL. Thank you, Mr. Lamb. I think Mr. Lamb has made a very clear statement of the reasons underlined in this section. I might say in response to that, however, that while this is not compulsory on the Surgeon General, I think all of us would agree that section (j) gives him that power and says he may prescribe maximum limits to the number of beneficiaries, and so forth.

I think we would also agree, as to the illustration I have mentioned, that when the three of us gentlemen come to the doctor of his choice and find that the Surgeon General has exercised this option that he has and that the doctor had taken all the patients he could, we cannot get his services.

I quite agree that under existing circumstances today it is possible that a doctor may have his maximum of patients, but at any rate the fact is that today the doctor can decide that question for himself, whereas under the law, S. 1606, as I understand it, the Surgeon General would have the right to decide that for the doctor.

Now, that is the point I make.

THE ADVISORY COUNCIL

The CHAIRMAN. Of course, Senator we must always keep in mind that the Surgeon General has the Advisory Council to advise him on all questions of general policy and administration in carrying out the provisions of the title in regard to—

- (1) Professional standards of quality to apply to personal health service benefits;
- (2) designation of specialists and consultants;
- (3) methods and arrangements to stimulate and encourage the attainment of high standards—

and so forth, a whole list of things on which he has advice from the Advisory Council; and it is assumed that he will not arbitrarily act on any of these matters on which he is going to consult with the Advisory Council.

Senator PEPPER. Is it not, after all, Mr. Chairman, a permissive authority that he has?

Senator DONNELL. Mr. Lamb just made that point, Senator Pepper, in pretty close to the same language that the distinguished Senator used. I would like to add, Mr. Lamb, that you referred to the Advisory Council. In the first place, I mention the fact that it is only an advisory council and that the council does not have power to put into effect its recommendations; and second, you also mentioned that the Advisory Council—I think I quote you substantially correctly—“is representative of the medical profession.”

Mr. LAMB. I said that members of the medical profession were represented on it. I did not limit my statement, Senator, with respect to the fact that others might be on it, because I am well aware that it permits the representation of groups other than professional people, either from the medical or hospital fields, and we welcome that; as a matter of fact, it is one of the things that we make a particular point of.

Senator DONNELL. I was quite sure that you did not want to leave that impression, Mr. Lamb, but I wanted to make it perfectly clear that under the provisions of section 204, it is provided as follows:

The membership of the Advisory Council shall include (1) medical and other professional representatives, and (2) public representatives, in such proportions as are likely to provide fair representation to the principal interested groups that furnish and receive personal health services, having regard for the functions of the Advisory Council.

I call attention further to the fact that the membership of the Advisory Council is 17, namely, the Surgeon General, as chairman, and 16 members to be appointed; also to the fact that it has already been testified before this committee that some groups, and I have no doubt your own group, would want to be considered for membership—maybe not appointed, but certainly considered for membership on that Advisory Council.

It has been testified, I was about to say, that some labor organization or organizations would like to have representation; and, indeed, we had a gentleman here the other day who was referring to racial recognition also.

So that the point I make is the one which Mr. Lamb readily realizes; that this Advisory Council of 16 people includes all of these various representations, and we find that the professional or medical representatives are in the minority upon the council.

That may be good or may be bad, but that is the fact under the statute.

Then, the third thing that I would like to call attention to, if I may mention it to Mr. Lamb and Mr. Carey, is that while the Surgeon General has these various powers that I have referred to, subdivision (j), power to prescribe maximum limits in number of potential beneficiaries, it is provided on pages 35 and 36 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.

Now, then, it proceeds with—

The Advisory Council * * * as to questions of general policy and administration, * * * et cetera.

The point I am making is that the ultimate power under this bill, as I read it, rests back up in the Federal Security Administrator, who,

as we have realized, under this bill or under any bill, is not required to be a physician and in fact today is not a physician.

I wanted the record to show those points in connection with this testimony.

Mr. LAMB. Mr. Chairman, I wonder whether the Senator wants to suggest that the CIO is opposed to having the Federal Security Administrator over the Surgeon General? It seems to us clear that in any administrative organization, such as the present one, such a division of functions is absolutely indispensable to the proper working government. It is hard to see how the Surgeon General could be set outside, in view of the fact that there are so many other matters which bear upon the question of public and individual or private health which are involved in the work of the Federal Security Administration.

Senator PEPPER. Excuse me, Doctor. May I interrupt right there?

Senator DONNELL. Certainly, Senator.

Senator PEPPER. At the present time the Public Health Service is in the Federal Security Agency and under the general supervision of the Federal Security Administrator, who is not a doctor.

Mr. LAMB. That is right, Senator.

Senator DONNELL. Mr. Lamb, in this connection, I observe that in the statement as read by Mr. Carey this morning it states that specialists practicing individually or in groups are entitled to special rates of payment and—

to be eligible they are to be chosen according to general standards prescribed after consultation with the National Advisory Medical Policy Council.

So I take it that under this statement, as set forth in what Mr. Carey has presented to us, specialists are to be chosen according to standards, prescribed after consultation with this council, which certainly is not obliged to have upon its membership a majority of professional men. That is correct, is it not, Mr. Lamb?

Mr. LAMB. That is correct, Senator; but I think you will observe if you read the bill carefully that every effort is made to consult the existing State medical and other professional societies, such as the Hospital Association, on all matters having to do with their jurisdiction, and that the standards as prescribed are those laid down in the laws of the States in question, and, consequently, I fail to see how this provision contravenes the best practices or would jeopardize the practice of good medicine.

Senator DONNELL. The point I am making, Mr. Lamb, is that the selection of these specialists—

Mr. LAMB. No, Senator; you mean the prescription of general standards for the selection of specialists.

Senator DONNELL. No; I am referring to just what I said, the selection: "To be eligible"—that is the statement Mr. Carey has made. The statement reads, page 4, line 2:

To be eligible they are to be chosen according to general standards.

That may be eligibility to special rates of payment?

Mr. LAMB. That is correct; that is what it means.

Senator DONNELL. They are to be chosen, then, according to general standards prescribed after consultation with the National Advisory Medical and Policy Council. The point I am making for our consideration—and I think it is worthy of consideration—is that the body with whom consultation must be had prior to the prescription

of general standards of eligibility of persons to payment as specialists is a body which may be constituted of persons, the great majority of whom are not either physicians or surgeons.

Mr. LAMB. Senator, as I read this bill, that matter is left to the decision of this committee.

Senator DONNELL. Of which committee?

Mr. LAMB. Of this committee and this Congress.

Senator DONNELL. Of our committee here?

Mr. LAMB. Yes, sir.

Senator DONNELL. Well, I do not think so, under the bill.

Mr. LAMB. I said I think it is left to the decision of this committee, because you are writing the bill.

Senator DONNELL. You have in mind, then, that we may change the bill. I am talking about the bill as it is.

Mr. LAMB. That is correct.

Senator DONNELL. You gentlemen have come here, and Mr. Carey here strongly advocates this bill with the particular suggestions that he has made, and he has not made any such suggestion as would require this policy council to be constituted in the majority of professional members. He has not made that as one of his suggestions.

Now, of course, if he desires to suggest that, I know the committee will consider it.

Now, I was addressing myself, however, when we began this discussion, which I think is in part, at any rate, a digression, to the statement made in Mr. Carey's statement on page 2, to the effect that the average worker knows—

that under S. 1606 he and his family are entitled to the following medical and hospital services:

One. All needed medical care for himself and family—from the doctor of his choice—from specialists, if he needs them.

Now, I would like to call the attention of either Mr. Carey or Mr. Lamb, whoever desires to answer the question, to the fact that subdivision (d) on page 46 says that 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, and then this sentence, which I think is quite significant, quoting:

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.

Mr. LAMB. Excuse me, Senator, I do not have this line reference, if you please.

Senator DONNELL. It is page 46, lines 15 to 22.

Mr. LAMB. Yes, sir.

Senator DONNELL. In other words, it states, as I understand it, that ordinarily the patient can obtain the services of a specialist or consultant only upon the advice of the general or family practitioner or of a specialist or consultant attending him. Then the further provision, which has a bearing upon the statement of Mr. Carey here, that the worker, the average worker, knows his family is entitled to medical services "from specialists if he needs them."

Suppose he thinks he needs them. What does he have to do to get them? Suppose the family practitioner or the specialist that he

already has under the operation of this bill says, "No, you don't need them." And then he says, "I want a specialist." That sometimes happens.

Then we come to this:

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.

Mr. LAMB. Senator, as I understand this point that you are driving at, the problem is this: Either you rely upon the judgment of a general practitioner as to whether the patient does or does not need further specialist care, or you allow the individual to seek a specialist's care with the understanding that the pay for it is either made by him privately, if it is not approved by this medical administrative officer, or the pay is authorized.

I see no way in which you can administer a system of this sort by permitting anyone who wants to consult all the specialists in the country to move from place to place consulting specialists at the expense of the system.

That is all I can see that is provided in this particular paragraph.

Senator DONNELL. I think, Mr. Lamb, that the sentence that I have read indicates that if the individual, after treatment by his general or family practitioner or a specialist attending him or consultant attending him, shall still desire a specialist or consultant, he can only obtain such a one in the event of approval by the medical administrative officer appointed by the Surgeon General.

Mr. LAMB. Not the way I understand it, Senator, unless this system ties up the individual physician so that he cannot take any patients outside of the system.

Senator DONNELL. Well, Mr. Lamb, of course, if he wanted to take a patient out, obviously, the patient would have to pay extra for that, would he not? He would not get it under what he had paid?

Mr. LAMB. No; quite right.

Senator DONNELL. Of course, I am not talking about what a man can do independently of the system. I am talking about S. 1606; and Mr. Carey says the average worker knows, "That under S. 1606 he and his family are entitled to the following medical and hospital services."

Mr. LAMB. He is entitled to them, Senator.

Senator DONNELL. My point is that he is only entitled to this additional specialist or consultant that he may himself think is needed in the event of approval by a medical officer appointed by the Surgeon General.

Mr. LAMB. That is right, Senator, he has to take his chances on whether or not he gets approval, and he also has the right through the appeals machinery to appeal whether the bill should be paid by the insurance fund or paid by him privately.

Senator PEPPER. Senator, if you will allow me, right there: Mr. Lamb, would you suppose that under the voluntary plans, where they exist in the country, an insured person can go at his own desire to any kind of a specialist he wants to, without anybody's approval?

Mr. LAMB. On the contrary, Senator, he is obviously a great deal more restricted under the voluntary plan. Because if a person were suffering from a rare disease, and if there were only a very few specialists in the country who could treat them, the chances that

the voluntary plan would make it possible to get treatment from those specialists would seem to me to be remote; whereas under this plan I can conceive of every opportunity for him to get to such specialists and to have his bills paid.

Senator DONNELL. The point that I am addressing myself to is the part here in this statement presented by Mr. Carey that the average worker knows that he is entitled to the following medical and hospital services; namely, all needed medical care for himself and family from a specialist if he needs one.

And I have undertaken to point out what I think is the limitation which the individual would find himself confronted with if he himself thinks he needs a specialist.

Mr. LAMB. Well, Senator, if this were pointed out to the members of our organization, they would not be surprised at that, but would tend to take it for granted.

Senator DONNELL. Very well, but the statement made by Mr. Carey here this morning does not tell us about anything such as that.

Mr. LAMB. You are saying, Senator, that this does not have all the qualifications necessary, and therefore you are saying that we should have presented a statement of the same length as the bill itself.

Senator DONNELL. Well, I do not think that follows.

Mr. LAMB. I think it does.

Senator DONNELL. I think when a statement is made we are entitled to understand that that is your understanding of those facts.

Mr. CAREY. May I point out that my statement does not say "if he thinks he needs them"?

Senator DONNELL. No; if he needs them.

Mr. CAREY. So the statement of fact would be correct.

Senator DONNELL. I do not know whether it is correct or not. It is provided here in the bill that these services shall be grantable provided they are approved, as I understand it, by a medical administrative officer appointed by the Surgeon General.

ESTIMATES ON COSTS OF HEALTH INSURANCE

Now, you say also, Mr. Carey, in your statement here this morning, that the CIO heartily supports the Wagner-Murray-Dingell social-security bill, S. 1050. Have you examined into the question of the cost of the entire system to be carried out by S. 1050, including the expenses under S. 1606?

Mr. CAREY. We have inquired into it. We have had our representatives check those matters in detail.

Senator DONNELL. Could you tell us about that?

Or could Mr. Lamb tell us as to the total cost annually of the administration of S. 1050, including the provisions of S. 1606?

Mr. CAREY. We did indicate in our statement that S. 1606 would be less than the present cost of medical and hospital services now rendered.

Senator DONNELL. Of course, I am wondering, Mr. Carey, if you have made any investigation which you would regard as thorough in determining either what the present costs are or what, in the second place, the total costs would be under the bill? Have you made such an investigation? If so, who made it?

Mr. CAREY. We have considered it. Mr. Lamb was one of those who did. We have reviewed the estimates made by the agencies of government. We also reviewed the testimony given of medical authorities on the subject.

As to telling you the exact amount, I would hesitate to do that.

Senator DONNELL. I understood you to say that Mr. Lamb—

Mr. CAREY. Mr. Lamb was one of the ones who assisted in that.

Mr. LAMB. Senator, you are familiar with the estimates presented by Mr. Arthur Altmeyer of the Social Security Board in his testimony before this committee earlier this year. He presented as his statement, as you will remember, the "total dollar cost of the system for the compulsory-coverage group, if per capita costs are around \$27 and if 110,000,000 persons on the average are eligible, thus would be about \$3,000,000,000 annually, in the early years of the system."

Senator DONNELL. That is S. 1606?

Mr. LAMB. Yes, sir.

Senator DONNELL. I wanted to include that, but the actual question I asked was: What would be the expense of the operation of S. 1050, including the provisions of S. 1606, which bill, S. 1050, is stated in Mr. Carey's statement to be favored by the CIO.

I wanted to know if you had that aggregate figure and estimate on the total expenses of the program of S. 1050.

Mr. LAMB. That figure has to do with temporary and permanent disability benefits, does it not?

Senator DONNELL. Yes; it does.

Mr. LAMB. And in order to arrive at that, you would have to know what the figures allowed for total temporary and permanent disability benefits would be and how many people would probably be covered by them, and I do not have those figures.

Senator DONNELL. You do not have those figures. Well, we have had in evidence here from a book that is gotten out by the American Enterprise Association, Inc., the author of the book being Earle E. Muntz, New York University, various figures, which we will not present unless you would like to have them given at this time.

Mr. LAMB. We can examine those.

Senator DONNELL. The figures suggested by Dr. Muntz are:

(1) Based on Senator Wagner's figures and remarks, \$11,625,000,-000; (2) Based on Tax Foundation study, \$11,737,000,000; (3) Based on author's estimate, \$13,405,000,000; (4) Based on Gerhard's study, \$14,625,000,000.

Now, I understand that you are not at the moment, at any rate, prepared to testify as to your views with respect to the correctness of those figures?

Mr. LAMB. No; except to point this out to the Senator, which I am sure he already knows: That the money to pay for this comes out of the pockets of the workers and their employers under the total permanent and temporary disability benefits.

Senator DONNELL. You do not mean to say that the entire expense of the program would be paid out of that, do you, Mr. Lamb?

Mr. LAMB. Well, that depends upon the number of uncovered people who were also taken care of, does it not?

Senator DONNELL. Well, I quote this language: "The Social Security program as set up in this bill would require a Federal subsidy,

based on the most conservative estimates, in excess of 50 percent of the total annual expenditures."

So if the total were \$12,000,000,000, there would have to be a Federal subsidy, as distinguished from the moneys raised from pay-roll contributions, of over \$6,000,000,000, under his views.

Now, I am not undertaking to say whether that is correct or not, but that is the opinion of the gentleman who has made this study.

Mr. LAMB. Senator, I am sure that in previous testimony before the House Ways and Means Committee and the Senate Finance Committee, you can find testimony by the Social Security Board which would be more accurate, at least I presume it would, than outside information of this sort.

Senator DONNELL. I think as to Mr. Altmeyer's testimony, was it not that this S. 1606 cost in the neighborhood of \$4,000,000,000.

Mr. LAMB. The total dollar-cost of the system for the compulsory coverage group is something over three.

ATTITUDE OF MEDICAL ORGANIZATIONS

Senator DONNELL. Over three. Very well. Now, Mr. Carey, you referred in your testimony, here, to your pleasure at seeing that a group of this country's outstanding doctors in the Physicians Forum supports this.

Do you know how large an organization the Physicians Forum is?

Mr. CAREY. Not exactly.

Senator DONNELL. Do you have an idea of approximately how many members it has?

Mr. CAREY. Oh, it is over 6,000.

Senator DONNELL. The officer of it who was here testified 1,000, and testified that 600 of them were in New York City, or approximately that.

Mr. CAREY. I am sure his testimony would be better than my own.

Senator DONNELL. Yes, I think it would be on that matter. Dr. Boas is the president of it and he testified it is a thousand, or approximately that.

Now, I am not casting any insinuations because of the number.

Mr. CAREY. There might be a question of time. How long ago was that?

Senator DONNELL. That was just a few days ago that he testified here.

Mr. CAREY. He would be able to give much better testimony than I on the subject. We go more by the content of their program, and we find it excellent. I certainly would suggest that they enlarge the group.

Senator DONNELL. I will not ask you to give all the names, but do you personally know anyone who is in the Physicians Forum except Dr. Boas, the president of it.

Mr. CAREY. Only by reputation, sir.

Senator DONNELL. Could you give us the name of any other doctor?

Mr. CAREY. I suppose Dr. Boas gave you that?

Senator DONNELL. Well, I am wondering if you know. You say here that you are glad to see that a group of this country's outstanding doctors, in the Physicians Forum—do you know personally yourself?

Mr. CAREY. I know Dr. Boas.

Senator DONNELL. Do you know any other except Dr. Boas?

Mr. CAREY. Mainly by reputation.

Senator DONNELL. Which doctor do you think of at the moment that you know of, other than Dr. Boas?

Mr. CAREY. I think it is a very reputable organization.

The CHAIRMAN. Could you give him a list of the doctors? That might refresh your memory.

Senator DONNELL. I want to get who it is they are when you refer to them as outstanding doctors.

Mr. CAREY. All of them.

The CHAIRMAN. I think it would be fair to submit him a list of the doctors to refresh his memory.

Mr. CAREY. I am just saying that perhaps you may have the opportunity to ask Dr. Boas as to that.

Senator DONNELL. We can get that, yes; but what I want to know is what you meant when you read out the words "outstanding doctors"; which particular individuals you meant?

Thus far you have not been able to give us the name of anybody except Dr. Boas, whose name I gave to you myself a few moments ago. Is there anyone else you can think of at the moment in this Physicians Forum that you know of as an outstanding doctor in this country?

Mr. CAREY. All of them, Senator.

Senator DONNELL. But I wonder if you know the name of anyone?

Mr. CAREY. I would not consent to testify in behalf of that organization. I do cite what they have said in behalf of this bill. I think it is an excellent statement. I suppose because it agrees with our point of view; that is the reason they are considered outstanding.

In our opinion they are certainly outstanding physicians.

Senator DONNELL. Thus far you have not been able to give us the name of anyone.

Mr. CAREY. Senator, I could not even give this committee your name. I am not questioning your right to sit there. I would say that you are an outstanding citizen of your State.

Senator DONNELL. Now, you also refer, Mr. Carey, down on the bottom of page 3 of your statement to a matter which I want to discuss.

This is a matter of the patient's freedom of choice. You say, "This is of course ridiculous." You also mention earlier, and here is what I would like to call your attention to on page 3: You say:

We believe that when the average doctor knows of the benefits to him under S. 1606, he will want it too.

You referred earlier in your testimony, as I recall it, to the fact that you thought that the provisions of S. 1606 are widely understood throughout the country among the general public.

You think that is true, do you not?

Mr. CAREY. Yes, sir.

Well, do you not think the average doctor knows considerably about S. 1606 also?

Mr. CAREY. I think the average doctors, part of the American Medical Association, have been victims of a barrage of propaganda misrepresenting the contents of this bill.

And I do state as to those doctors I have talked with—and I have addressed the meetings of doctors regarding the Wagner-Dingell

bill—that they are perhaps the least able to give objective consideration to this bill in the face of the Medical Association's campaign. I have reason to believe, as a result of the experiences I have had in talking with doctors, that time will make the doctors the champions of the principles contained in this legislation, and I believe that is already taking place, Senator.

Senator DONNELL. Has not the same information been available to the members of the American Medical Association as has been available to the members of the Physicians Forum?

Mr. CAREY. I would suppose members of the Physicians Forum are more interested in the objective question that we are considering in this bill. I would even go so far, Senator, as to say that perhaps the CIO members have more information regarding the bill than other people that do not have channels that are sympathetic to better medical care, and I would say that the officers and members of the CIO unions would know a great deal about this, more than the general public.

The CHAIRMAN. Right there, could I ask the witness a question?

Senator DONNELL. Certainly.

The CHAIRMAN. Are you acquainted with an organization known as the National Physicians Committee, which is operating under the American Medical Association in sending out literature on this proposed bill?

Mr. CAREY. My only contact is that my own family physician happens to be part of it, and we discussed it at some length.

The CHAIRMAN. Have you seen any of the literature that was sent to the medical profession by the National Physicians Committee which charges this legislation as being socialistic?

Mr. CAREY. My own doctor had the literature on his desk when I saw him last.

The CHAIRMAN. You'd you think, then, that the medical profession may be deceived by this literature which has been sent to them by the National Physicians Committee?

Mr. CAREY. Definitely; and deliberately so.

Senator DONNELL. You say that your own doctor is a member of the National Physicians Committee, to which reference is made?

Mr. CAREY. He receives the literature from them?

Senator DONNELL. I thought you said he was a member of it?

Mr. CAREY. He is a member of the group that finances it.

Senator DONNELL. He helps finance it?

Mr. CAREY. I help finance it too.

Senator DONNELL. That is because you pay your bills to your doctor. Do you make any independent contributions to the National Physicians Committee?

Mr. CAREY. Certainly not.

Senator DONNELL. And your doctor helps finance it?

Mr. CAREY. Up to now. I do not know the results of our conversation, but as I say, my own experience in that field will indicate that my own doctor I believe will be a champion of this bill.

Senator DONNELL. He is not as yet?

Mr. CAREY. I will not know until next week.

Senator DONNELL. Mr. Carey, you do know that the membership of the American Medical Association consists of over 125,000 of the physicians and surgeons of this country? You know that, do you not?

Mr. CAREY. I will accept those figures.

Senator DONNELL. You mention, by the way, in this statement, page 4, certain language used in the testimony, I believe, of Dr. Boas, from the Physicians Forum. You quote by saying that

Only financing and over-all policy are formulated on a strictly national basis.

You observe that, do you? That is number 2 on page 4.

Mr. CAREY. Yes, sir; the second sentence.

Senator DONNELL. Now, it is a fact, is it not, Mr. Carey, that under the bill regulations and rules are to be prescribed for the operation of this system? That is correct, is it not?

The CHAIRMAN. Where is that statement?

Senator DONNELL. That is on page 4, number 2.

For the moment, I do not find the express statement except that on page 38 it states:

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

At any rate, you realize that that provision on page 38 does exist, do you not, Mr. Carey?

Mr. CAREY. Yes, sir.

Senator DONNELL. And you realize also that rules and regulations will be essential in carrying out the details of this proposal, do you not?

Mr. CAREY. Certainly.

Senator DONNELL. Are you familiar with this volume?

Mr. CAREY. No, sir.

Senator DONNELL. The Law of National Health Insurance, which is the British law on the National Health Insurance Acts, 1936 and 1938, with explanatory notes, reported cases, decisions of the Administrator of Health, and statutory rules and orders.

Mr. CAREY. I am not personally familiar with that, no.

Senator DONNELL. Do you know of such a book, even if you are not personally familiar with it? You see the book here entitled "The Law of National Health Insurance." I call your attention to the fact that that consists of some 1,200 and over pages; in fact, including the index, some 1,282 pages. That is in the British law at this time.

I call your attention also to this book on medical insurance practice, issued by the British Medical Association, which itself contains, including its indexes, and so forth, some 223 pages.

Senator PEPPER. Senator, are those duly authenticated copies? [Laughter.]

Senator DONNELL. No; this last one, however, is issued by the British Medical Association.

You say, Mr. Carey, in your testimony, that the United Public Workers of America will wish to submit testimony also. Am I right on that?

Mr. CAREY. Yes, sir; with regard to the coverage of employees of the Government.

Senator DONNELL. May I ask you this: This is a matter of curiosity, which perhaps has no bearing on the bill. Does the CIO have not only organizations among Government workers, Federal Government workers, but does it also have them among State government workers?

Mr. CAREY. Yes, sir.

Senator DONNELL. And does it also have them in some of the banks of the country?

Mr. CAREY. Yes, sir.

Senator DONNELL. You have local CIO organizations in banks?

Mr. CAREY. We have now an international union covering public employees, Federal, State, city, county, and so forth. We have the organization of the United Office and Professional Workers, which covers white-collar workers in that particular field. That includes bank clerks, et cetera.

Senator DONNELL. You conclude your statement with a paragraph, the second sentence of which reads:

The sums now spent annually for the medical care of the American people today would amply cover the benefits provided in this bill.

Who is it that has made the requisite computations on which that statement was based in your organization?

Mr. CAREY. We sought information regarding the present health bill of the system, and the services rendered and the payment of that amount of money.

We also compared with that the cost of the operations under the principles contained in this bill, if enacted, the estimated costs; and we find that the people of this country will be eligible for greater benefits with less money than they are at the present time.

Senator DONNELL. Who is it that has the custody of your computations and figures on that?

Mr. CAREY. The compilation of figures? Bob Lamb is one. In addition to Bob Lamb, we have a research department likewise engaged in that field.

Senator DONNELL. Mr. Lamb, have you made a computation as to the amounts now spent annually for the medical care of the American people?

Mr. LAMB. I believe, Senator, there has already been put into testimony before this committee such evidence, not on one but on several occasions. The Social Security Administrator, Mr. Altmeyer, is one of those who has testified to this effect, and I believe that his figures were based upon calculations made with the assistance of the United States Bureau of Labor Statistics and the United States Public Health Service.

Senator DONNELL. Has your organization, the CIO, itself made an independent study?

Mr. CAREY. No, sir.

Senator DONNELL. It has not. You are relying in your statement here upon the testimony and views of Mr. Altmeyer and the statistical information which you think exists in various other governmental agencies; is that right?

Mr. CAREY. Which is the basis on which his testimony was made; yes, sir.

Senator DONNELL. Very well. But there has been made no separate statistical study by the CIO with respect either to the sums now spent annually for the medical care of the American people or as to the amount which would amply cover the benefits provided for in S. 1606?

Mr. LAMB. No; except that, as Mr. Carey has said, we have a research department, and the assistant director of that department is

a person with a good deal of background in the subject of social security, and she has made this investigation.

Senator DONNELL. Is that Mrs. Katherine Pollok Ellickson?

Mr. LAMB. Yes, sir.

Mr. CAREY. Senator, I might add: Where that comes up, we do make our own independent studies and surveys of the expenditures of our families.

In that way we have a very wide sample of the medical expenditures of the families of the CIO.

Senator DONNELL. But as I understand from Mr. Lamb, there has been no separate study?

Mr. LAMB. No Nation-wide study for the people of the United States; no.

Mr. CAREY. We are interested in the cost to the society by not having adequate medical care. That would be to us an extremely significant figure.

Senator SMITH. Mr. Chairman, I would like to ask the witness one or two more questions. I have no disagreement whatever as to the issue of a public-health bill. It is my objection that this contemplates a very complete Federal control.

The other thought is as to whether the experience of the American people in the 48 States, in dealing with these matters in the trial and error method, is not a better approach to an over-all Federal plan, and whether we should not develop a plan with Federal grants to the health departments of the States.

What I am getting at is that the issue is between using the decentralization principle, following the different views of different States in different parts of the country, thereby encouraging inventive genius to experiment; or do you want to have a blueprint here that everybody has to follow?

Mr. CAREY. I think we have had a wealth of experience in this field of government, speaking now of the American people.

We recognize there are some services that can best be rendered in an international way, by international organizations of government; some can best be rendered federally; others by States and counties; and as to others, you can go so far as to say the best service can be rendered through the family.

We gave consideration to that question. We are not slaves to any particular system operating within a framework of democracy.

We would like to find the best way of handling it. We are not wedded to a State-rights proposition.

Senator SMITH. Do not talk about State rights. Talk about the experimental proposition. It is not a question of rights but of the best administration.

Mr. CAREY. But we think that the people are denied certain services by the use of these statements as to "States' rights," and "socialism," and things of that type, and we think that this bill represents what democracy needs. I regret that we do not have an officer of Cabinet rank concerned with the health of the Nation, whereas in other countries they recognize that there is nothing more important.

Senator SMITH. Do you think there is any country that provides medical service comparable to the medical service that we give to the people in this country?

Mr. CAREY. There is no country in the world that can compare with this country in any of these questions, whether it be housing or clothing or medical care, or whether it be education or production or any of those other features.

But I do not think any other country in the world makes expenditures in this field of health to the extent of our own country, and no other country, to my knowledge, wastes so much in failing to bring about a better relationship between doctor and patient.

Senator SMITH. That, of course, is a matter of opinion. We can be dogmatic in drawing such a conclusion.

Mr. CAREY. I would think that the experiences we have had in these important fields, such as education and health, could well be used, and that is where we get our experience, and that is why we so vigorously support this bill.

We recognize it as a present step in the right direction. There can be no question anywhere in the world but that under our system of government and the flexibility we have in meeting the problems of the people, we can do this job. I would have liked to use in the testimony some of the information that was brought about as a result of our participation in the last war, the great number of rejects, the tremendous costs.

I would not attempt to measure what the price was in terms of life or even in dollars, but certainly there is indication here that we do not have as good a balance as we could have. Some areas are more depressed than others in terms of having medical care available to the people.

Senator SMITH. Your conclusion is that you think we can do it better by centralized experiments than by continuing our State experiments, as we have during the years, and decentralize our operations.

Mr. CAREY. I would say the system suggested here as to the over-all policies is the only thing that is actually determined by the Federal Government.

Senator SMITH. And you do not take cognizance of the experiment in Minnesota, which I am told has made great progress, and the experiment in California; a system whereby we are getting combined judgment of different areas trying different things, to move toward perfection as fast as we can. Is that not the best way to do it?

Mr. CAREY. That is the best way to gain experience, and as a result of that experience in the systems we have had operating, such as that in St. Louis operating under the direction of the labor organizations, the people have better medical services now than they had before.

But still we think that experience itself is good argument in support of Senate bill 1606.

Senator SMITH. So you think we have gotten to the end of the experimental stage. We have gotten to perfection now, and we can write the blueprint here in the central Government, rather than encourage these different States and medical societies and boards of health to go on trying to perfect it in their own areas?

Mr. CAREY. The enactment of this bill would in no way put a stop on experimentation and further development.

Senator SMITH. That is where I disagree with you.

Mr. CAREY. Senator, I would say if we refused to enact this legislation, that in itself would be an indication that we believe the present situation is a perfect one.

Senator SMITH. Let me correct you on that. As to my thinking along that line of grants-in-aid to your States, I am for that. I think the first part of this bill contemplating grants-in-aid proceeds along the right line. I would like to see it perfected in certain respects.

But when you get into part 2 you are in a totally different philosophy, and that is where I have difficulty in following you. But I am glad to hear you say that that is your opinion. We want to get the opinion of the CIO.

Mr. CAREY. The American Medical Association and others operate on that central basis, as we do. Because they find in many cases you can best render service in that way.

Senator SMITH. It is a matter of degree how far you can decentralize administrative powers. To my mind that is the issue we have here; that of determining the right kind of a bill to report out.

The CHAIRMAN. Do you have anything further, Mr. Lamb?

Mr. LAMB. I would like to refer Senator Smith to the letter which your chairman put into the record, because I recognize it as being a copy of one I have here which came to us a day or so ago from the secretary-treasurer of the California CIO Council in which he has reference to the California Physicians Service, and he has this to say with respect to their experience. And our California CIO, as you know, has been among the pioneers in the CIO in its interest in medical care; our California CIO and the American Federation of Labor out there have worked together in the recent past on this.

He says:

The CIO in California has had considerable experience with voluntary plans. We have studied with particular care the State-wide plan of the doctors, California Physicians Service. We are completely convinced that this type of plan can never bring good medical care to those who need it most, the middle and lower income groups. I am listing below the principal reasons which have led us to this conclusion. Many of these faults are inherent in all voluntary plans.

Of course, this does not have reference to the State plans, but to the California Physicians Service, which I believe you mentioned a moment ago, which has been in force for some time.

Senator SMITH. I mentioned it, Mr. Lamb, as one of the experiments which is going on today. I would have no objection if some State wanted to try a compulsory plan to see whether it would work better than the voluntary plan.

Mr. LAMB. I would like to list these points first, Senator:

(1) CPS costs too much for the service given. Administrative and acquisition costs are very high and are not subject to control by the membership or any public body. The tremendous turnover in voluntary membership destroys the actuarial integrity of the plan. The cost of selling the plan is tremendous. These two factors negate the advantage of the insurance principle of spreading the risk. According to CIO'S figures, in the months of October and November a total of 27,489 new members were acquired. The net gain in membership, however, was only 2,349.

(2) The coverage is too limited. CPS offers only surgical and hospital coverage to the majority of members. Medical care is not offered to families. The day-to-day medical and dental expenses of the average family are not met. Many members of CPS report annual medical expenses of hundreds of dollars despite their CPS coverage. Preventive medicine has not any part in the CPS plan.

(3) The quality of care is poor. CPS physicians tend to treat CPS patients with less care than private ones. CPS is totally unable to control professional standards and practices of its physicians. In the CPS housing projects program, completely controlled by the doctors, the average quality of care was so poor as to be scandalous. The large turnover in membership is largely due to dissatisfaction with the service.

(4) CPS cannot control overcharges by member physicians. These doctors are not satisfied with CPS fees and attempt to collect additional fees from the patient. Hundreds of complaints on this score have reached us from members of CPS.

(5) CPS does not encourage the growth of group practice. The benefits of pooling skills, reducing costs, and so forth, which make a group practice desirable, are lost to CPS members.

(6) CPS does not seek bona fide consumer representation on its controlling board. The plan is completely dominated by physicians. Members have nothing to say about dues, medical coverage or administration. CPS seeks to perform a vital public function, while controlled by a very small minority, the physicians. Unlike a government body, CPS has no responsibility to the people and cannot be controlled by them.

(7) CPS has not shown good faith in an honest attempt to devise means to make medical care available to all. It is openly admitted by the California Medical Association that CPS was created and is maintained in an attempt to prevent the enactment of health insurance legislation. This very attempt is proof that the physicians are aware of the need for health insurance and the desire of the people to have it.

(8) CPS failed utterly to prove its soundness in the largest mass attempt to provide care on a prepaid basis. In the housing project program CPS demonstrated that voluntary enrollments are doomed to failure. CPS and the California Medical Association officially demanded of the Government that membership of public housing tenants in CPS be made compulsory. Their contention was that only thus would the plan succeed.

Senator SMITH. If I may just suggest this, at that point: I see those defects, but I am not convinced that the plan which you are advocating here S. 1606, would cure those defects better than if we did try to experiment with those things as we met them in different parts of the country.

Mr. LAMB. If I may address myself to the point that you are particularly on, in the first place I think the CIO bases its observations here on two things: (1) That we have had considerable experience with respect to various Federal versus State operations, and that we think we can learn from this some of the shortcomings of State operation in the field of social security; that in this particular field you have, however, certain peculiar problems. In the first place, this is a problem of insurance primarily, and as an insurance problem you are dealing with 140 million people and their coverage.

It ought to be clear that if you cut them up into segments, as, for example, one State which might have three hundred and fifty or five hundred thousand people, and another State which has some 13 or 14 million, you are going to have different experiences but to a considerable extent predictable experiences in the cases of those different States. The smaller State will not be able to provide the kind of insurance, as any actuary could tell us, that the larger State could give, just because of the group who are covered.

Senator SMITH. The smaller State might very readily be able to handle it on a voluntary plan. I mean, you have different conditions in States with larger or smaller populations, rural or urban, and that is what I am suggesting here: That we ought not to get away from the experimental value of our 48 States.

Mr. LAMB. In the second place, Senator, we know that with respect to health the problem of State lines is a particularly troublesome one

and one which would cause you many administrative difficulties; I mean, to be consistent in backing the State as against the Federal program.

Finally, the problem with which we are here concerned is that, as I tried to say a moment ago, of the insurance principle, which must be Nation-wide, and the administrative principle, which I believe—and I am not sure that Senator Donnell agrees with us, but the CIO believes that the principle which is provided in this bill permits a considerable amount of local autonomy.

With respect to general practitioners, for example, it is pretty clear that if the medical society in that area wants to go on with what it wants in its own program, it is at liberty to do so.

With respect to the conditions in which the specialists operate, that is determined on the State level and within the requirements of the State laws.

Consequently, I fail to see the argument which is continuously advanced here that this is a highly centralized program. The thing that is centralized is the insurance principle. The thing that is decentralized is the carrying out of the rules and regulations as laid down in the center, and those rules and regulations are subject, I believe, under this, to considerable interpretation.

I see no reason why if this committee is genuinely interested in advancing a Federal plan they cannot perfect it if they feel there are shortcomings in the bill as now written. It ought to be possible to improve with experience the rules and regulations, and their centralization versus their decentralization, depending upon the type of program.

To turn aside from that, when the insurance program is such an overriding consideration, in order to have experiments, locally, which I feel are fully provided for under this bill, with local autonomy, just seems to me to be dodging the issue.

Senator DONNELL. Mr. Lamb referred to the rules and regulations. I was unable, a few moments ago, to put my finger on the exact section. I would like to have the record show that in the subdivision immediately after the one which I quoted is the specific provision for the prescription and publication of rules and regulations. I am referring to subdivision 203 (g) appearing on page 38 of the bill, which distinctly provides that:

The Surgeon General, after consultation with the Board, and after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, shall prescribe and publish such rules and regulations and require such records and reports, not inconsistent with other provisions of this act, as may be necessary to the efficient administration of this title.

May I say further that without undertaking to inject into this procedure any question of States' rights in this matter, I would like to say that, particularly in view of some remark that Mr. Carey made which I cannot quote quite accurately, and also the colloquy between him and Senator Smith, I should like to call attention to the fact that the States still do have some rights; that the Tenth Amendment of the Constitution reserves not only to the people but to the States those rights which are not delegated to the Federal Government.

I am not undertaking to say that we have no right to pass this bill, but I would like not to have by any silence on my part any thought that I am in any sense taking the view that there is no longer States' rights.

Mr. CAREY. I do not think the Senator and I disagree, except that I think people that are in a State have certain rights, but the State has no rights.

Senator DONNELL. I do not agree with that. That is exactly the basis on which we differ. The tenth amendment not only refers to people but specifically states that the rights are reserved to the States as well; and we differ very much indeed, and I think the remark that Mr. Carey made quite early in his testimony is in direct contradiction to the view which I take, and I want the record to indicate that.

Mr. CAREY. I think the same thing would apply to property rights: As if property has any rights. People that own them, of course, have rights. But I do not think there is any fine difference of opinion that pertains to this bill on the subject.

The CHAIRMAN. We may concede that the States have rights, and will continue to have them, but I think, too, that a program of this kind can be more effectively administered under a national law. We find often that while States have rights, they do not always exercise them in the interest and welfare of the people.

For instance, States have rights to set up utility commissions to control utilities in various States of the Union, and yet, because of the power and influence of the interests in those States, those rights are not honestly and fairly administered in the welfare of the people.

So it seems to me that we should not brag too much about States' rights because they have not always been administered in the interests of the welfare of the people.

Senator DONNELL. I want to place myself on record as recognizing and thoroughly rejoicing in the fact that we do have States' rights under the Constitution of the United States and the tenth amendment thereto.

Senator SMITH. Mr. Chairman, I think we have expressed a difference in philosophy here that is legitimate as a part of this whole question: Can this best be done through Federal control or through decentralization to the States?

If we differ on that, I want to say that I appreciate Mr. Carey's testimony and that of Mr. Lamb. I have had contact with Mr. Lamb before, and I have the highest regard for him in the work he is doing for his cause. I disagree with him, but respect his judgment.

The CHAIRMAN. I think such discussions will be helpful in studying this question when we go into executive sessions.

THE MEANING OF "COMPULSORY"

Senator PEPPER. I just wanted to ask the question: Mr. Carey, you are here representing an organization of workers who will be subject to the pay-roll taxes which are contemplated if this bill and other necessary legislation should become effective, are you not?

Mr. CAREY. Yes, sir.

Senator PEPPER. Now, when you get right down to the bottom of what this bill is, is it not simply and essentially a national insurance plan which will make membership in the plan as respecting the wage earners and employers of wage earners compulsory, so as to provide a

national health fund through which medical care and services may be rendered to the people?

Mr. CAREY. That is our understanding of the bill; yes, sir.

Senator PEPPER. And you are here representing the people who have to pay the payroll taxes as employees?

Mr. CAREY. That is correct; yes, sir.

Senator SMITH. Might I ask the Senator a question?

Senator PEPPER. Yes.

Senator SMITH. I read this bill very carefully the other night, and I could not find any place where it provided for a pay-roll tax.

Senator PEPPER. This bill, due to the fact that the Senate cannot initiate tax measures, contemplates the plan assuming the existence of the money; but I think everybody has contemplated that a pay-roll tax is the basic method by which the funds that will provide this in an insurance shall be provided.

Senator SMITH. It is your theory, then, that there would be such legislation?

Senator PEPPER. Yes, I have always understood that this bill is generally predicated upon there being a pay-roll tax of $1\frac{1}{2}$ percent required to be paid by the employees, and $1\frac{1}{2}$ percent being required to be paid by the employer, which would be analogous to the pay-roll tax which is today collected of employer and employee, to provide for a national fund.

Senator SMITH. That is the contemplation in S. 1050?

Senator PEPPER. Yes.

Senator DONNELL. Does the Senator understand that it is contemplated that this $1\frac{1}{2}$ percent upon the employer and employee would pay all the expenses of the fund, or that there would be a Federal subsidy in addition?

Senator PEPPER. Senator, the only way we could answer that would be by experience. It might be that with this fund, the preventive health services, the general health care that might become available, the clinical diagnosis that might become possible for people so that illness might be nipped at its beginning or may be prevented from beginning, might so reduce the medical bill of the country that that $1\frac{1}{2}$ percent by employer and employee would prove to be enough.

If it were not enough, we in the Congress would have to decide whether we would wish to raise the amount of the pay-roll tax or make up the difference by a Federal subsidy. That is just a mere matter of policy. But what I wanted to emphasize is this: We all have good doctor friends whom we highly respect and admire, whose professional skill we esteem. Some people seem to take this bill and our advocacy of it as a personal affront on them, as a sort of trespass upon their prerogatives, an invasion of their sacred precincts.

Now, what I have been trying to get into my mind is the essential and basic character of this bill. What I am asking you is: Do you people not regard what it will do if it is financed as I have said, by the sort of pay-roll tax I have described, as a national compulsory insurance program whereby the people may, with one another, provide funds through which they may procure medical services.

And it is not essentially a tax and compulsory insurance program?

Mr. CAREY. I stated that in my testimony, Senator.

Senator PEPPER. Let us take the way it will affect the masses of people as compared to the way it will affect the doctors.

If your organization has some 6 million members and they are wage earners, they will be covered by the pay-roll tax if there is one. They will be required compulsorily to come under this bill, will they not?

Mr. CAREY. That is correct.

Senator PEPPER. They would not have any choice in the matter. Their representatives would be making them come under this insurance plan, because they deem it in the public interest, and you were saying you want to come under it.

Now let us see whether it would make any doctors come under it. A doctor is a self-employed person most of the time, is he not?

Mr. CAREY. That is correct.

Senator PEPPER. And the self-employed, under this bill, do not have to come under it unless they elect to come under it, do they?

Mr. CAREY. That is right.

Senator PEPPER. So all except the doctors of this country who are employed by somebody else and have the status of an employee, working for a salary, up to say \$3,500 or \$3,600 a year, where they came under this plan, that would be entirely voluntarily, whereas your people would have to come under it would they not?

Mr. CAREY. That is right.

Senator PEPPER. Now, it is not suggested that the doctor must render the service, any medical service, to anybody, unless he elects to associate himself with the plan?

Mr. CAREY. That is correct.

Senator PEPPER. And then all that he is required to do is to agree that he will accept the schedule of fees which are provided by the authorities that have had to do with it. If he wants to render service to the people who are covered by the plan for the schedule of fees that those who have the authority to prescribe the schedule provide, then he may do so.

If he does not want to do so, he does not have to?

Mr. CAREY. He can withdraw it at any time, even if he starts.

Senator PEPPER. So he does not have to take a single patient by the compulsion of law. He does not have to accept the fees provided by any compulsion of law. Whether he renders his professional services to the fund or not, and to the people covered, or in most cases, whether he pays the taxes, are matters of purely voluntary character.

Now, in view of that fact that a mere handful of the doctors of the country would be compulsorily brought under the plan, whereas millions of citizens would be brought under the plan, do you think that the mere fact that the doctors might not favor this should deter either the masses of the people, your 6 million, from insisting that the Congress pass it, or us in the Congress from passing it if we believe it to be in the public interest?

Mr. CAREY. I think if it is in the public's interest, and, of course, we testify that it is, the bill should be passed. In fact, we regret the long delay in the passage of this bill. But that is why we recommend and urge this committee to immediately, as soon as possible, recommend it for its adoption by the Senate.

Senator PEPPER. Now, the last thing: It has been suggested here that because there is authority in the Surgeon General to fix a limit to the number of patients that a doctor may take under his tutelage and care that imposes a legal prohibition against the free choice of physician by the patient.

Now, is that intended for anything except with respect to a few doctors who might be overambitious to make money or might be disposed to yield to the pressure of too many people to try to take care of them—is that intended for anything except to provide a higher standard of medical care to the people it will cover?

Mr. CAREY. Senator, it is intended to prevent possibility of abuses. There are other statement's in the bill which do likewise regarding the abuses by the patients.

Senator PEPPER. Well, even if we were to knock out that provision—

Mr. CAREY. Senator, may I interrupt and say I hope you do not, because even if you knocked out that provision, the same people who oppose the bill will oppose it because it lacks that provision.

Senator PEPPER. Well, if it would make it acceptable to other Senators, if my able friend the Senator from Missouri would say, "I want to see people get this coverage, but I do think that is a form of compulsion upon the doctor," and he would say he would support this bill if you amend it, so that it would be up to the patients and would leave it up to trial and error for them to learn by painful experience that they had better see how many patients a doctor had before they signed up with him, I do not know but what in the balance of interest I would yield to my friend, and we would change that. And later on the people might find that a few doctors were taking advantage of them in trying to take care of too many patients and they would perhaps come back to us and say, "Look here, we can't go to every doctor and examine his books and determine how many patients he can take care of, but I am signed up here with Dr. Jones, and I never can see him. He is as busy as a Senator and as hard to see as a Senator. And I am wondering if we could not do something toward limiting the numbers of patients, so that I can get to see my doctor when signed up with him." Then, perhaps, we would be convinced it would be a mistake to leave it exclusively up to the doctor. And there ought to be the authority in the people running this thing to say, "All experience has proven that you cannot take care reasonably of but a thousand patients. We are letting them take care of 1,500 out in the rural districts, but in the towns we think a thousand is the maximum, and we are going to lay that down as a standard."

But my friend here has seemed to feel that because that balance of interest was, in this bill, decided in favor of the authority—not making it mandatory to put those prohibitions in, but giving authority in case it should be found necessary to do that—that this bill was going to have the character of compulsion about it; which I am afraid has led him to indicate he may not be altogether for it.

Senator SMITH. May I ask you a question there with relation to your observation?

Supposing you put through the compulsory plan and then are short on doctors, what is your solution? How are we going to handle that?

Senator PEPPER. There are two answers, Senator. One is that this bill encourages the training of more doctors.

Senator SMITH. That is very worthy.

Senator PEPPER. Right, that is very worthy. In the second place, do you not think that if doctors have an opportunity for a fair fee under favorable surroundings, such as adequate equipment and assist-

ance, and that sort of thing, and to render a good quality of medical care; do you not think, with regard to the law of demand and the desire to make money as well as to render humanitarian service, that is going to provide the doctors needed?

Senator SMITH. I think so, but I think that comes back to the point you made: I think unless you have the profession with you, you will not get the cooperation you need.

Senator PEPPER. I am only asking the question, Senator, as to whether when the burden of this thing is to be paid for by the people, and the people are the ones whose lives and whose health and whose dear ones are involved, and when the people feel that they want to pay this money: Whether we ought to let a little handful of doctors who are not directly affected deter us from serving the people or permitting them to save and to serve themselves?

Senator SMITH. This is where I disagree with you on your thesis. Assuming you are going to have the doctors available to handle this matter that you have persuaded the people to pay for?

Senator PEPPER. Well, is it the case that these doctors are going to refuse to render medical service to the people when they are paid for it; that they are going to strike?

Senator SMITH. I think they are going to suggest it can be worked out through your State boards more effectively than through a Federal plan. That comes back to the basic philosophy. I am just raising some of the difficulties I see, and I think you will agree there are difficulties.

The CHAIRMAN. There is one organization of doctors who had a representative here before the hearing a short time ago, who had as one of their objectives the idea of organizing the doctors not to enter this system. In other words, they are proposing a sit-down strike on the part of the medical profession against enforcement of this law in case it becomes a law. I do not know whether they will abandon that idea or not, but they have sent out literature to that effect, and the doctors that are joining that organization are joining it with the understanding that that is one of the objects that they have in view.

Senator PEPPER. Mr. Chairman, lest someone might misunderstand my attitude, I want to say that I do not have the slightest idea that a handful of doctors in this country would ever think of doing such a thing as that. There may be a few people that are excited now, whose emotions are stirred up now, who are deeply moved by this matter, largely because they misunderstand it.

The CHAIRMAN. I think it is largely misunderstanding.

Senator PEPPER. Right. They have been made to misunderstand it, most of them. I do not have the slightest misgiving about the doctors giving hearty cooperation, and what will happen is that once we get this thing under way administratively, there will be difficulties that we will develop, and when we pass this bill we may find there are things which should not have been put in there. But experience will teach us how we can perfect the bill. You need have no worry about what will happen. As we go along, we will learn, and the doctors will become our counselors; they will become the counsel of the administrative agencies that are running it.

In a little while you could not any more repeal it, once it becomes law, than you could repeal the unemployment compensation law or the social-security law or any other.

The CHAIRMAN. I think that is a correct statement. Mr. William Green of the American Federation of Labor testified a short while ago, and he called attention to the workmen's compensation laws, which were bitterly fought by the medical profession at the time they were proposed, and they argued then that that would destroy the medical profession. But since that time they have come to recognize the value of that law and now would not think of recommending its repeal.

Senator DONNELL. Mr. Chairman, it was mentioned by Senator Pepper that this bill does not require physicians to come in under it. I think that is quite true. I want to mention this, however: That obviously in order that this plan may succeed it would be essential that the great majority of the physicians in our country did come under it. Therefore, we are going to be, as a practical matter, confronted with the situation that if the people that pay in these taxes are to get their money's worth out of it, the great majority of the doctors must come in—I do not mean legally; they are not compelled to legally—and then we are going to be confronted with the economic question which worries many people: As to the great majority of the profession that will come in under this system will discourage personal advancement and initiative or whether it will bring about deterioration of service.

I think all of those problems are involved. I take it this is not the time and place to argue those questions, but that is involved.

The CHAIRMAN. I think Dr. Eliot testified yesterday to some extent with respect to the question of deterioration of services in the medical profession, and pointed out that under the operation of the system of which she is in charge, the professional services have been improved.

Senator DONNELL. Those were instances of grants-in-aid by the Federal Government to State-operated plans that she was referring to, Mr. Chairman, I think; at least in the main.

Senator PEPPER. In other words, under that, Dr. Eliot pointed out that no doctor—and of course, it is said to their credit—no doctor declined to aid a mother and child or to attend a little child simply because the money was being provided by a public source instead of out of the private savings of the mother of that little child. The important thing, it seems, is where the doctor is going to get his money from. All of us know doctors who work for big corporations, and so on, railroads, that furnish services. The fact that they are paid by the railroad or the corporation does not mean they are not willing to attend the man who gets sick.

Senator DONNELL. I do not concur that all that is involved here is where the doctor is to get his pay from. I think there are many other far more fundamental questions than that.

The CHAIRMAN. I do not think any Senator would be bound by anything that I may say or Senator Pepper may say, or you may say.

Senator PEPPER. You know, Mr. Chairman, I am persuaded that, if we could just make a few minor changes in this, our friend from Missouri is going to support us in this thing. [Laughter.]

The CHAIRMAN. I am afraid it is too late to start the other witness now.

Mr. LAMB. Mr. Chairman, before we close I would like to make an observation on something Mr. Carey said a few moments ago. The Senator is concerned with the capitation question of the limitations on numbers of patients.

The CHAIRMAN. Yes.

Mr. LAMB. I am informed that Dr. Morris Fishbein has recently objected, as to the New Zealand law, that one of the shortcomings of the law is that it does not include a limitation on the number of patients whom a doctor operating under the law is permitted to have, and I thought Senator Donnell would be interested to know that and might be able to check the statement, which I believe appeared in the American Medical Association Journal.

The CHAIRMAN. All right. Thank you.

We have two other witnesses, Edward Poss and Martin Miller.
(Discussion off the record.)

The CHAIRMAN. We will recess until 2 o'clock.

(Whereupon at 12:45 p. m., the committee recessed until 2 o'clock same day.)

AFTERNOON SESSION

(The committee convened at 2 p. m., pursuant to recess.)

The CHAIRMAN. Gentlemen, we will resume the hearing.

Mr. Martin Miller will be the first witness. Mr. Miller, will you state your full name, the organization you represent, and where you reside.

STATEMENT OF MARTIN H. MILLER, NATIONAL LEGISLATIVE REPRESENTATIVE, BROTHERHOOD OF RAILROAD TRAINMEN

Mr. MILLER. Mr. Chairman and members of the committee, I am Martin H. Miller, national legislative representative of the Brotherhood of Railroad Trainmen. Our Washington office is located at 10 Independence Avenue SW., the general offices are located in the Standard Building, Cleveland, Ohio. Mr. A. F. Whitney is president of the brotherhood.

The Brotherhood of Railroad Trainmen is the largest of the railroad train service labor organizations and represents conductors and brakemen, road, passenger, freight and yard—train baggagemen, yardmasters, dining-car stewards, switchtenders, car-retarder operators, and operators of intercity busses.

Senator DONNELL. What is a car-retarder operator?

Mr. MILLER. A car-retarder operator is a man that works in a station, usually an elevated tower that operates a retarding device on the inclusion yards that retards the cars in their movement to the classification yards down the incline. It is called a mechanical yard.

Senator DONNELL. Thank you.

HEALTH AND SAFETY PROGRAM OF THE RAILROAD TRAINMEN

Mr. MILLER. As a representative of the brotherhood, I appreciate the opportunity to briefly state our position on S. 1606, to provide a national health program. The Brotherhood of Railroad Trainmen has long recognized the need of a health and safety program. We have found such programs to be very beneficial in affording proper and adequate protection for the welfare of our members. One of the first and most important items to be discussed in the conferences of 1882-83, which resulted in the organization of the Brotherhood of Railroad Brakemen, was that of making provision to care for the sick and

disabled trainmen. The name of the Brotherhood of Railroad Brakemen, was later changed to the Brotherhood of Railroad Trainmen, our present name.

At the very beginning of the original organization there was established a beneficiary department, financed through assessments upon the members, and commonly referred to as the assessment beneficiary plan of insurance protection. Provision was made to care for those not participating in the beneficiary department through direct allowances under our benevolent provisions.

The chief reason for our organization giving early consideration to the creation of the beneficiary department was due to the hazardous conditions under which the railroad train-service employees were compelled to work and the extremely low wages, also that it was almost impossible to obtain reasonable insurance protection. The insurance companies refused to write policies on switchmen and head brakemen due to the hazard of these occupations, and those who wrote policies on other classes of train-service employees added so much loading for the employment hazard that the premiums were beyond the reach of the average train-service employee.

Several years ago we changed our assessment beneficiary plan to that of individual reserve insurance, where the member could, if physically qualified, participate in several forms of reserve insurance in any amounts suitable to his insurance requirements. I am sure you will recognize that we were able to effectively and successfully serve our members adequate insurance on a cooperative basis.

We also devoted considerable time and effort in reducing the hazard of the employment, through urging the enactment of State and Federal laws, such as full-crew laws, clearance laws, safety-appliance acts—which required installation of air brakes, automatic couplers, properly secured and proportioned grab-irons, brake steps, and so forth—Hours of Service Act and the Federal Employers' Liability Act.

Improvement and development in railroad equipment has brought more than its share of hazards, which we are now attempting to correct through negotiation and, if unsuccessful, will again urge corrective measures through proper legislative enactments.

Many years ago we found that large numbers of our members who were subjected to the severe elements of the weather were victims of the dreaded tuberculosis. In 1922 we established a TB fund for the purpose of providing proper medical care and treatment of our afflicted members. A special assessment is levied upon all members, who are eligible to participate in the benefits. Our TB fund has provided the needed care and treatment for thousands of our afflicted members. The overwhelming majority of those furnished treatment have been able to again resume their places on the railroads and provide for themselves and their families.

In addition to the aforementioned, we have now made provision for health, accident, and hospital insurance, which is available to our members who pass the qualifying examination. Thus, you can see that we have gained considerable experience in attempting to care for our members, so that they can keep physically fit and financially able to meet the economic problems for themselves and those dependent upon them.

We recognize that our safety and health program reaches chiefly to our members, and we realize full well the need of a national health

program to cover all persons not otherwise provided for. Section 317 (b) (6) of the bill excludes from its provisions the members of the brotherhood employed by carriers by railroad, or officers and employees of the brotherhood; however such exclusion does not apply to our members employed by bus companies and by the transportation departments of industrial enterprises.

Senator DONNELL. Pardon me. There is not a 317 (b) (6). I wonder if that is an error in your statement?

Mr. MILLER. No; I do not think so.

Senator DONNELL. Maybe it would be 217 (b) (6)?

Mr. MILLER. That is right, it is 217.

Senator DONNELL. Which has the language:

Service performed by an individual as an employee or employee representative as defined in section 1532 of the Internal Revenue Code.

Mr. MILLER. That is right.

Senator DONNELL. Thank you.

Mr. MILLER. You see, I had faith in my secretary.

Senator DONNELL. Yes.

Mr. MILLER. Thank you very much, Senator.

Senator DONNELL. That is all right.

Mr. MILLER. S. 293, now in the Interstate Commerce Committee, providing for amendments to the Railroad Retirement and Railroad Unemployment Insurance Acts, makes provision for payment of sickness benefits under the latter named act. The House will act this month on H. R. 1362, companion bill to S. 293.

THE NEED FOR S. 1606

There is great and urgent need for development of an adequate national health program. Experiences in recent years have been such as to demonstrate the need of such a program years ago instead of now. The program provided for in S. 1606, if carried forward successfully, will be a great contribution to the public welfare and can easily prove to be one of the surest means of developing a strong and reliable program of national defense.

President Truman, in his State of the Union message to Congress, called attention to the disgraceful conditions revealed through the military physical examinations during the recent war. Quoting from the President's message:

During the war, nearly 5,000,000 men were rejected for military service because of physical or mental defects which in many cases might have been prevented or corrected. This is shocking evidence that large sections of the population are at substandard levels of health. The need for a program that will give everyone opportunity for medical care is obvious. Nor can there be any serious doubt of the Government's responsibility for helping in this human and social problem.

The President has called attention to what amounts to, in my opinion, a national disgrace. It is shocking and terrible that so many young men would be rejected on military examinations due to preventable physical disabilities, in this, the most prosperous nation on earth. It would be an interesting study to investigate all of those young men who were rejected on account of preventable physical disabilities to ascertain the number whose rejections were traceable to insufficient food, medical, and dental care.

It can be recalled that in the early thirties there were millions of American workers who were unemployed and millions of others on only part-time employment. Such a study should have a two-fold effect upon the Members of the Congress. It should make the majority of the Members realize the extent of their failure to correct any such future conditions in the feeble way they answered the President's request for a full employment program; and it should have the effect of making them recognize their responsibilities to all of the people, as national lawmakers. Then there should be no question as to whether we need and should have an adequate program of national health.

It is unfortunate that we have some specialized groups organized to assail and oppose any semblance of a beneficial national health program. I say it is unfortunate; unfortunate for the professional groups who place their own selfish interests above the common good and the public welfare, under the assumption that they are protecting their professional ethics.

Judging from the experiences of recent years, and especially with the knowledge of so many young men rejected from military duty on account of preventable physical disabilities, we simply cannot hope to improve our national health by leaving this all-important matter to the individual.

We hear loud cries about disturbing the professional-patient relation. No one wants to disturb any such relations. A check-up will reveal that many millions of such relations were disturbed and definitely broken up by economic factors, just as economic factors broke into the physical well-being of our young men. So now, as we plan for the postwar years, as a Nation—yes, a big, powerful, and influential Nation—it just seems to be good common sense that we plan carefully, to make sure that our national health, the health of all of our people, is equal to our influence among the nations.

Thank you very much.

The CHAIRMAN. How long have you been in the railroad business, Mr. Miller?

Mr. MILLER. I hold employment rights with one railroad 30 years the 6th day of this month.

The CHAIRMAN. When did you start railroading?

Mr. MILLER. Well, I really began my first railroading prior to that time. I worked for about 8 years prior to that time. In 1910.

The CHAIRMAN. And how old were you then?

Mr. MILLER. About 18.

The CHAIRMAN, I see. And you have followed railroading since that time?

Mr. MILLER. Well, except the times that I was dismissed from the several railroads. I went into other fields. I worked in a glass factory one time and in a steel mill another time; and, of course, each time I would come back to the railroad.

The CHAIRMAN. Railroading, of course, is a very hazardous occupation.

Mr. MILLER. Particularly train service itself.

The CHAIRMAN. They have a great many accidents that occur on railroads, and also it has some bad effects on the health, sometimes, in some parts of the work; is that right?

Mr. MILLER. It does.

The CHAIRMAN. I notice that you say in your statement here that your brotherhood now have—

made provision for health, accident, and hospital insurance, which is available to our members who pass the qualifying examination.

What are the qualifications for membership? Does it apply to all that belong to the union?

Mr. MILLER. It applies only to those that belong to the brotherhood.

The qualifying examinations for accident and health insurance are the same examination as is required by an insurance company doing the same kind of business.

The CHAIRMAN. An insurance company usually has very strict restrictions against people in hazardous occupations, do they not?

Mr. MILLER. That is right.

The CHAIRMAN. And it is impossible for people working in hazardous occupations to get voluntary insurance at a reasonable rate?

Mr. MILLER. It is.

The CHAIRMAN. Now, you will notice that under this bill, if it is enacted, that your system of insurance could be taken over under this act and made a part of the national insurance system?

Mr. MILLER. It could insofar as the members who are not employed on railroads.

Section 217 excludes those who are taxed under section 1532 of the Internal Revenue Code.

The CHAIRMAN. I see. Well, what is the reason for that situation? Is it under the provisions of this bill that you are excluded from membership, or is it that your membership does not desire to be brought into the system?

Mr. MILLER. Well, no. The bill provides for an exclusion.

On page 75, it says at paragraph (6) :

Service performed by an individual as an employee or employee representative as defined in section 1532 of the Internal Revenue Code.

That is the taxing provision to provide taxes for the Railroad Retirement Act.

The CHAIRMAN. Oh, I see.

Well, have you studied this bill carefully and gone over all of the provisions of it, Mr. Miller, or are you just testifying with reference to the general proposition of the legislation?

Mr. MILLER. I have not made a study of the bill. I read it, but I have prepared to discuss it when I meet with the officers of the brotherhood in connection with H. R. 1362 and 293.

You see, those companion bills provide for sickness and disability provisions in addition to the unemployment benefits under the Railroad Unemployment Insurance Act. And I imagine that is why this prohibition in paragraph (6) on page 75 was put in.

The CHAIRMAN. I see; and you are prepared to discuss the bill in those respects?

Mr. MILLER. I am preparing to discuss it with them; yes.

The CHAIRMAN. I see.

Mr. MILLER. As a matter of fact, as soon as I leave here I am going to a conference with other officers of other labor unions with respect to those two bills.

The CHAIRMAN. Well, now, you will notice that this is a very extensive piece of legislation, and has many provisions in it.

Are you able to analyze these and discuss them, or do you wish merely to confine your testimony to the over-all problem of the need of the national health system to provide better care, better medical care for the people of this country on a reasonable cost?

Mr. MILLER. Senator, I am not prepared to go into detailed discussion as to the several provisions in the bill.

In preparing my statement I prepared it generally.

The CHAIRMAN. I see.

Mr. MILLER. It is just my general comments, that we recognize the need of an over-all program.

The CHAIRMAN. And you are leaving to the committee the problem of working out the provisions that will properly carry the program into effect?

Mr. MILLER. That is correct.

The CHAIRMAN. That is all.

Any testimony, Senator?

Senator DONNELL. Yes, sir. I would like to ask Mr. Miller a few questions.

Mr. Miller, on page 4 of your testimony appears the language:

The program provided for in S. 1606, if carried forward successfully, will be a great contribution to the public welfare and can easily prove to be one of the surest means of developing a strong and reliable program of national defense.

Do you not think, Mr. Miller, that before undertaking to be able to express an opinion as to the practicability of this program, that it would require quite a good deal of detailed analysis of this bill, before you could really pass on that and tell us whether or not that program will work successfully?

Mr. MILLER. That, Senator, is true. The educational research department of the brotherhood at Cleveland has made a very careful study of the bill. That is why we are supporting the bill.

Senator DONNELL. Mr. Miller, this is not said in any criticism at all, but did you personally prepare this statement?

Mr. MILLER. I certainly did.

Senator DONNELL. You prepared it?

Mr. MILLER. That is right.

Senator DONNELL. And you are giving us your own conclusion that the program provided for in S. 1606 "if carried forward successfully, will be a great contribution to the public welfare"?

Mr. MILLER. I just said, Senator, that our educational research department, in Cleveland, had made a study of it, and that is why we are supporting the bill. I base that statement on page 4 upon the conclusion found by the Cleveland office.

Senator DONNELL. You are giving their conclusions rather than your own conclusions as to whether or not the detailed provisions of this bill will operate successfully?

Mr. MILLER. Oh, yes. That is correct.

Senator DONNELL. Yes.

Mr. MILLER. I do not think there is anybody that can say definitely now that every detail or provision of S. 1606 will work out. It is just a matter, just like the Railroad Retirement Act, when it was first passed.

It is a program in the right direction, and it must be developed, and as conditions warrant it, the bugs, if any, can be removed.

I do not think it is a perfect piece of legislation, and do not hold it to be such.

Senator DONNELL. This bill is divided into three different titles, is it not?

Mr. MILLER. That is right.

Senator DONNELL. Do you recall the general theory of the first title of the bill?

Mr. MILLER. That is grants-in-aid to the States.

Senator DONNELL. To carry out State plans.

Mr. MILLER. That is right.

Senator DONNELL. Approved by the Federal Government.

Mr. MILLER. That is right.

Senator DONNELL. And then the second title is the compulsory health insurance?

Mr. MILLER. That is right.

Senator DONNELL. Have you investigated, Mr. Miller, as to the cost of carrying out the provisions of the compulsory health insurance part of this bill?

Mr. MILLER. No; I have not.

Senator DONNELL. Have you looked into the question as to whether or not there is a freedom of choice by the patient of his physician under the terms of title II of the act?

Mr. MILLER. Well, as I remember it, and I am not entirely clear, but as I recall it, the patient was given an opportunity to his choice of the professional men who had accepted or who were in the set-up.

Senator DONNELL. Is it your recollection that he could wait until he was a patient in order to do that, or does he have to do it under the terms of the bill, as you understand it, at the time that the list of doctors is decided upon and the public notified that they are to make that choice?

Mr. MILLER. Well, I do not recall that just right now.

Senator DONNELL. You do not recall that; very well.

Mr. MILLER. I think it would be a good idea, though, to practice the system I would practice with my own family and have practiced in Indianapolis.

I arranged with a doctor to keep my family well, not to treat them when they were sick.

Senator DONNELL. To keep them well.

Mr. MILLER. That is right.

Senator DONNELL. That is a rather unusual type of engagement under our present practice in this country, is it not?

Mr. MILLER. Well, it is unusual, but it seemed to me, at the time, and since, very sensible.

Senator DONNELL. That is the plan you adopted personally?

Mr. MILLER. That is right.

Senator DONNELL. Mr. Miller, I believe, in your experience, you said you started railroading in 1910?

Mr. MILLER. That is right.

Senator DONNELL. When you were 18 years of age?

Mr. MILLER. That is right.

Senator DONNELL. What had been your schooling before that?

Mr. MILLER. I rather hate to admit that it was eighth grade, common school.

Senator DONNELL. That is nothing to be ashamed of in the slightest. The eighth grade.

Mr. MILLER. That is right.

Senator DONNELL. Did you go on further in high school, any specialization?

Did you have anything, whether or not you specialized, in the study of economics, actuarial matters, or insurance matters or health?

Mr. MILLER. I think I have made a pretty thorough study in economics from the working man's viewpoint.

Senator DONNELL. Yes.

Mr. MILLER. I have not had any post-school work other than the eighth grade.

Senator DONNELL. And you were in the railroad business from the time your were 18 until—when was it you first dropped out, temporarily?

Mr. MILLER. Well, the early part of 1911, my first time.

Senator DONNELL. 1911. That is, you were in a little less than a year the first time?

Mr. MILLER. If I remember correctly, it was 5 months.

Senator DONNELL. Five months.

Mr. MILLER. That is right.

Senator DONNELL. And what were you doing at that time? A brakeman?

Mr. MILLER. I worked on a section.

Senator DONNELL. Worked on a section.

Mr. MILLER. That is right.

Senator DONNELL. How long was it until you returned to railroad work?

Mr. MILLER. The latter part of 1911.

Senator DONNELL. The latter part of 1911. And did you continue in the same type of work or over in some other department?

Mr. MILLER. I became what we call a yard checker.

Senator DONNELL. Yes.

Mr. MILLER. I checked the railroad yards at a coal mine. That is the cars, loads, and empties.

Senator DONNELL. And from that time on, without going into the detail of it, did you successively perform other duties along railroading lines?

Mr. MILLER. Oh, yes.

Senator DONNELL. Were they along the lines of operating of trains?

Mr. MILLER. Yes. Later. I worked in the freight house and then in the car department in several capacities, in the car department.

Senator DONNELL. Yes.

Mr. MILLER. And then in 1917, April 1917, I became a brakeman in the operating department.

Senator DONNELL. Yes.

Mr. MILLER. And I hold employment rights since that date, as a brakeman and conductor.

Senator DONNELL. I see. And have you served as a conductor on trains?

Mr. MILLER. No; I have not. I have been promoted. Since being promoted, before accepting a position as conductor, I became an officer of the brotherhood.

Senator DONNELL. When did you become an officer of the brotherhood?

Mr. MILLER. September 1926.

Senator DONNELL. And so for almost 20 years consecutively, you have been with the brotherhood as an officer?

Mr. MILLER. That is right. Of course, with the exception, I work under an agreement whereby I go back and perform service each 9 months.

Senator DONNELL. I see. So that you have been either performing service on the railroad or acting as an officer in the brotherhood ever since September of 1926; is that right?

Mr. MILLER. Yes. I have been in the service of the brotherhood with the exception of the 1-day requirement to perform service.

Senator DONNELL. That is just a requirement for 1 day's service, so that technically you are an operating employee of the railroad; is that right.

Mr. MILLER. That is right.

Senator DONNELL. To all intents and purposes, except for that 1 day each year, you have devoted your time exclusively to the brotherhood?

Mr. MILLER. That is right.

Senator DONNELL. You have been acting as national legislative representative most of that time?

Mr. MILLER. In 1926, I became State legislative representative in Indiana.

Senator DONNELL. Indiana. Yes.

Mr. MILLER. And I came to Washington as national representative in July 1941.

Senator DONNELL. So your work has been that you were either State or National legislative representative with the exception of your 1 day a year ever since 1926?

Mr. MILLER. That is right.

Senator DONNELL. Yes, sir.

Now, Mr. Miller, you appeared before our committee just a few weeks ago?

Mr. MILLER. That is right.

Senator DONNELL. In connection with a labor bill, I think it was?

Mr. MILLER. A couple of times.

Senator DONNELL. A couple of times.

Mr. MILLER. Yes, sir.

Senator DONNELL. I recall your being here.

You quoted from the President's message in regard to the nearly 5,000,000 men rejected for military service.

Have you had occasion to check that figure, to find whether that includes a good many persons who were afflicted with one kind or another of physical afflictions which would not be susceptible to cure by medical services?

Mr. MILLER. No, I have not checked it, but I assume that it does include all physical rejections.

Senator DONNELL. Yes, sir. And we have evidence here before the committee somewhat in detail along that line, but you do assume that that is correct?

Mr. MILLER. Yes, sir.

Senator DONNELL. Mr. Miller, I judge that you favor a full employment bill. You indicate that in your statement here.

Mr. MILLER. I so testified before the committees to that effect.

MOTIVES OF THE OPPOSITION

Senator DONNELL. Yes, sir. And you feel that some of the "professional groups who place their own selfish interests above the common good and the public welfare under the assumption that they are protecting their professional ethics," you feel that way with respect to S. 1606?

Mr. MILLER. I do.

Senator DONNELL. Would you mind telling us which professional groups you classify in that category?

Mr. MILLER. The doctors, surgeons, and dentists.

Senator DONNELL. Doctors, surgeons, and dentists.

Anyone else?

Mr. MILLER. That is all I can think of at the present. They are the most common ones.

Senator DONNELL. And by the doctors, are you referring to those in any particular association?

Mr. MILLER. No. The American Medical Association is, I think, predominant in their opposition.

Senator DONNELL. And you judge that they, to quote your generalization, have "placed their own selfish interests above the common good and public welfare" with respect to this bill?

Mr. MILLER. I do not think there is any question about that, in my conversations, had with several members of the association, and reading some of their articles by Dr. Fishbein and others.

Senator DONNELL. Yes.

You feel that undoubtedly the American Medical Association has placed the selfish interests of its members above the common good and public welfare; is that right?

Mr. MILLER. If not the entire association, the leaders of the association have.

Senator DONNELL. The leaders?

Mr. MILLER. That is right.

Senator DONNELL. Have you looked into the question, Mr. Miller, as to whether the house of delegates of the American Medical Association has passed resolutions on this subject of compulsory health insurance?

Mr. MILLER. Well, now, I am not in a position to answer that. It seems a little hazy to my mind, as to whether I read something about it or not.

I am not certain.

Senator DONNELL. Yes.

I notice you also refer here to the fact, as you put it, that "it would be an interesting study to investigate all of those young men who were rejected on account of preventable physical disabilities to ascertain the number whose rejections were traceable to insufficient food, medical and dental care."

I judge that you favor the Government, through some plan, furnishing the medical and dental care that would have been requisite

to giving them the best health treatment that they could receive; is that right?

Mr. MILLER. Well, that the Government should, in some way, provide. I do not think that should be left to the individual. I think the Government should require the individual to go through certain things in regard to health, just the same as they require the individual with respect to education.

I think it is just foolish to require a child to go to school with rotten teeth that will injure health throughout the life, or with deformities, or malnutrition, or other conditions.

I had experience with that in school in Terre Haute, Ind., in 1930 and 1931, where children were in school hungry. Mrs. Miller and I, through the Parent-Teachers Association, provided free meals for them at our own expense, and later others came in.

RESPONSIBILITIES OF THE FEDERAL GOVERNMENT

Senator DONNELL. And you favor the idea of the Federal Government adopting some plan under which medical and dental care would be provided some way?

Mr. MILLER. Yes. I think the Federal Government should see to it.

Senator DONNELL. Yes.

Mr. MILLER. That is, if it can be provided for the States, O. K. But I think the Federal Government should either go beyond, where the State fails to do it, as we know they have in several States.

Senator DONNELL. Your sentence here includes, and I quote: "Not only medical and dental care, but also food."

Would you advocate that the Government should provide food also to all those who did not have sufficient food?

Mr. MILLER. I think that a Government that would require the compulsory education of a child should first have that child's stomach filled with nutritious food.

Senator DONNELL. You would regard that as a Government function?

Mr. MILLER. I think that is a governmental obligation.

Senator DONNELL. And you favor the Government also providing the full employment contemplated by the full-employment program which you mention here in the next paragraph; is that right?

Mr. MILLER. I favor the Government making provisions and directing a full-employment program, where all who are employable, desiring employment, can obtain the same at cultural wages.

Senator DONNELL. And you feel that the Congress is subject to some criticism for the feeble way they accepted the President's request for a full employment program?

Mr. MILLER. Definitely so.

Senator DONNELL. You feel a full employment program should have been enacted under which the Government would guarantee opportunity to every individual to have employment. Is that your thought?

Mr. MILLER. That is right. I do.

Senator DONNELL. That is all, Mr. Miller.

The CHAIRMAN. Well, with reference to this problem of full employment you do not mean, of course, that the Government should put everybody on the Government pay roll, but you believe that they should

so operate our system of free enterprise in this country that it would make it possible for jobs to be available for people?

Mr. MILLER. That is right. A job opportunity for all who are willing to work.

The CHAIRMAN. And in times when there is no opportunity for work for men who seek work and who are willing to work, in order to take care of their families, there should be some provision to take care of them during the time they are unable to find work, such as a system of unemployment compensation, when they are out of work?

They may be able to draw unemployment compensation, to care for their families during that period?

Mr. MILLER. That is right.

The CHAIRMAN. Now, with reference to this problem of food: You do not mean that the obligation is on the Government to furnish everybody directly with food, but your idea is that with reference to the children who are unable, or whose parents are unable to properly feed them in the tender years when they are going to school, the Government should provide some plan for additional feeding for them in the schools?

Mr. MILLER. That is right. Certainly.

The CHAIRMAN. And you would refer to that in the program you mentioned a little while ago that you and your wife were interested in?

Mr. MILLER. That is right.

The CHAIRMAN. In reference to this health program, you believe also that people should be required to pay for medical care and hospitalization when they are able to do it, but it should be supplied to them at reasonable cost so that they may be able to avail themselves of it without too much hardship?

Mr. MILLER. That is correct. Certainly.

The CHAIRMAN. And that is what this bill provides?

Mr. MILLER. That is the way I understand it.

The CHAIRMAN. It is a national insurance system which would enable and provide wide coverage to a great many people contributing to it, and in that manner bring down the cost of medical care, and you favor that kind of a system, a national health insurance system?

Mr. MILLER. I do.

The CHAIRMAN. As distinguished from voluntary systems. Voluntary systems are hard to join. They have so many restrictions. Is that not right?

Mr. MILLER. That is right.

The CHAIRMAN. And they do not give complete coverage. You might belong to two or three voluntary systems and get sick and have something happen to you and you would find that none of your policies would enable you to get adequate care?

Mr. MILLER. That is right.

The CHAIRMAN. For that reason you want to see one complete Federal program of national health?

Mr. MILLER. That is correct.

The CHAIRMAN. Which would give the public full coverage, full protection, in case of illness?

Mr. MILLER. That is right.

The CHAIRMAN. I think that is all.

Senator DONNELL. Mr. Miller, so that I understand just your theory in view of the examination by the chairman, this matter of full em-

ployment: It was the President's program with respect to full employment that you feel Congress responded to in a very feeble way?

Mr. MILLER. That is right.

Senator DONNELL. Do you personally favor the Government guaranteeing to each person in the country that if that person desires to work he shall have a job or failing a job shall be paid some type of unemployment compensation by the Government? Is that your position?

Mr. MILLER. Yes. Definitely. I think that each individual has a right to live.

Senator DONNELL. And you feel that that is a governmental obligation, as I have outlined, either to furnish the person with a job or give him unemployment compensation if the job is not at hand?

Mr. MILLER. I would say it just a little differently.

That it would so direct the economy of the country that work would be available, either private or Government work would be available, or in the absence of both, then unemployment compensation to tide them over.

Senator DONNELL. And you think that should be a national function emanating from the National Government?

Mr. MILLER. Well, naturally, I would think it should be a national function.

We found out on the railroads that you just could not operate the State unemployment laws to adequately take care of railroad employees.

You see, members of the Brotherhood of Railroad Trainmen often times run into and through four States.

Senator DONNELL. Yes.

Mr. MILLER. In the course of their tour of duty, so you see, you just cannot recognize those imaginary State lines, because they cross them. The same thing is true of highway workers. It is true of operators of airplanes; and we just have some places that we cannot recognize State lines.

Senator DONNELL. So you feel that this is a Federal governmental function?

Mr. MILLER. Yes; I think it is a Federal responsibility.

Senator DONNELL. Yes.

And in this matter of insufficient food, the chairman, Chairman Murray, mentioned food in the schools.

Now, if a child should not have sufficient food in his home, as distinguished from the school, because he does not do nearly all of his eating at school, if he did not have sufficient food in his home, would you advocate that the Government should see that food should be provided to him in his home?

Mr. MILLER. I think it is an obligation of the Government to see that that child grows up to be a normal human being, just as mentioned in the President's State of the Union message, and as we all know, the many rejections, after all, it proved to be costly to the Federal Government to have so many millions of young men rejected, and it certainly becomes an obligation of the Federal Government, because, after all, the Federal Government, when it leans back upon the people in national defense, if they do not have healthy people, they have not got much to lean back on.

Senator DONNELL. So you regard it as an obligation of the Federal Government to see that the child be sufficiently fed to grow up to be a useful citizen of the country?

Mr. MILLER. That is right.

Senator DONNELL. And if that food is not furnished at home or in school or wherever it may be, you feel it is the obligation of the Federal Government to see that the food is furnished?

Mr. MILLER. That the child grows up to be a normal, healthy human being.

Senator DONNELL. And food is required, of course.

Mr. MILLER. That is absolutely necessary.

Senator DONNELL. And so the Government should provide the food that is not provided otherwise?

Mr. MILLER. Yes, sir. I think so.

Senator DONNELL. That is all.

The CHAIRMAN. When you say the "Government" you do not mean the National Government. Already in this country, where people are without food, there are programs by which they may be provided for under various communities of the country; is that not true?

Mr. MILLER. That is true, but we found out in the depression that a lot of townships and counties and, in some instances, States, did not take very good care of the people.

The CHAIRMAN. Yes.

Mr. MILLER. I say to you that it becomes an obligation of the Federal Government to see to it, if the State, if the township, of the county; if the State does not take care of them, it is the obligation of the Federal Government to see to that child.

The CHAIRMAN. That is right. That was recognized by the National Government in the late depression, when the economic system broke down, and threw men out of employment, and we had 16,000,000 men in the country tramping the streets looking for jobs, the Federal Government came along and recognized that situation as presenting a national problem, and they undertook to take care of it and provide for it at that time; and you think that is a continuing obligation on the part of the Government?

Mr. MILLER. I do.

The CHAIRMAN. To see to it that our economic system is operated in such a manner as to supply opportunities for jobs.

That is what the full employment bill does. It provides that there should be opportunities for jobs for workers seeking employment and willing to work?

Senator DONNELL. Pardon me, Mr. Chairman. You mean the full employment bill as it passed the Senate?

The CHAIRMAN. Yes, as it passed the Senate.

Senator DONNELL. I understand Mr. Miller feels that Congress responded very feebly to the President's program.

The CHAIRMAN. Of course, a lot of people who would like to see the bill fail are still continuing to criticize it, but the bill, with any weaknesses which it may have, can be made to operate, and can successfully tackle the problem. But a lot of literature has been put out in the country belittling the bill, and claiming that it will never succeed.

I differ with that theory, and I believe that if that bill is given an opportunity, it will succeed in a very large measure in meeting the problem of unemployment in this country.

It provides that the Government will so act as to see to it that our economic system operates in such a fashion that it is going to keep job opportunities for the workers of the country open.

Well, Mr. Miller, you did not have an opportunity to go to colleges and universities. Your education has been in practical life; is that not true?

Mr. MILLER. Yes. It has been as a worker. My first employmnt for wages was when I was 9 years old at 25 cents a day.

The CHAIRMAN. Twenty-five cents a day, and you have worked along through your life until you got into this position that you occupy now with the Brotherhood of Railroad Trainmen?

Mr. MILLER. That is right.

The CHAIRMAN. And you feel that this bill, if given an opportunity and enacted into law, will be of great benefit to the country.

Mr. MILLER, I definitely do. I think it is a step in the right direction. We can then correct any insufficiencies or mistakes that may be in there, and with our experience, we can build, and we can have a better place for our fellow Americans to grow up into, if we start this kind of a program now?

It should have been started years ago. We are just late on it.

The CHAIRMAN. That you very much for your statement.

Senator DONNELL. That you, Mr. Miller.

The CHAIRMAN. The next witness is Mr. Edward Poss.

Will you first state your full name and residence, Mr. Poss.

STATEMENT OF EDWARD F. POSS, GRAND WORTHY PRESIDENT, FRATERNAL ORDER OF EAGLES

Mr. Poss. Edward F. Poss, the grand worthy president of the Fraternal Order of Eagles, Toledo, Ohio.

The CHAIRMAN. Is that your home city?

Mr. Poss. That is right.

The CHAIRMAN. Where do you live?

Mr. Poss. And I am still employed there. I am secretary and manager of the local aerie there.

WELFARE WORK OF THE EAGLES

It is a privilege to appear before your committee to present the views of the Fraternal Order of Eagles on national health insurance and related subjects. I do not claim to be an attorney or actuary, an expert or specialist on public-welfare problems. But I represent as national president and speak for an organization of 1,100,000 Americans and Canadians—over 90 percent of them workingmen—that has long been interested in security legislation.

May I digress for a moment?

The CHAIRMAN. I believe your organization was the first organization of the country to propose a program of this kind?

Mr. Poss. That is right.

The CHAIRMAN. I am very glad to have your testimony about that.

Mr. Poss. I think it is included. May I say that I do not appear in an arbitrary mood, nor do I have any new bill, but I am here simply to give you the attitude and expression of our members as

expressed not on this bill but in our late convention held 2 years ago on the Murray-Wagner-Dingell bill, that has provisions that parallel this particular bill.

The CHAIRMAN. And your ideas on this subject are not something new that have occurred to you just since the start of this program?

Mr. Poss. This is the breath of our organization. This is the foundation of our philosophy.

The Director of the Social Security Board, Mr. Arthur Altmeyer, was kind enough to say of the early Eagle campaign for pension legislation—

In those early days few were the voices that cried out against the neglect of children, the plight of the aged poor and the jobless, the sorry makeshifts of emergency relief hand-outs. Among those few were the leaders of the Eagles, who, for no reason except that of humanity, preached from the housetops that our rich Republic owed its unfortunates, particularly its needy old people, something better than the almshouse.

The Eagle campaign to spread the risks and distribute the burdens so that no American family would be overwhelmed by an economic catastrophe beyond its control and beyond its financial ability to provide against began when the Eagles in Kansas City, Mo., sponsored America's first mothers' pension law. The idea that society should provide a pension to keep a widow and her orphaned children together gained increasing acceptance. Today this recognition of our common obligation to those stricken by the death of the breadwinner of the family is everywhere accepted.

The CHAIRMAN. I think it will be accepted by the Senator from Missouri here if we keep on bringing in people from Missouri.

Senator DONNELL. I was interested to note it was from Kansas City, Mo. Was that the local organization or the national organization from Kansas City?

Mr. Poss. The idea was promulgated by a member from that area.

Senator DONNELL. From that area. Thank you.

Mr. Poss. During the years when State mothers' pension laws became a reality, the members of our then very young fraternal order also campaigned for what have become known as workmen's compensation acts. The first law, the Wisconsin act, was drafted by an Eagle member and supported by the Eagle lodges in that State. It was based on the realization that an average worker's family could not weather the storm of interrupted income and expenses involved in disability arising out of an industrial accident. Today few would challenge the soundness of insuring workers, on a compulsory basis, against the risk of industrial accidents.

In the summer of 1921 the Fraternal Order of Eagles took up the crusade for old-age pension laws. To those who wanted to provide for the needy aged through providing food and shelter in a poorhouse, the Eagles answered that the American way was to help our senior citizens provide for themselves through cash pension laws—starting with the Montana and Nevada bills, drafted and introduced by Eagle members—is now history—

Senator DONNELL. Pardon me.

Mr. Chairman, I observe another of our excellent States mentioned there, too.

The CHAIRMAN. That is right. I have recognized the Eagles for all my life as being one of the most worthy and advanced organizations in the country.

We are very proud of our Eagle organizations out in Montana. They have contributed so much toward the progress of our State.

Mr. Poss. Even though much remains to be done in adjusting old-age allotments to changed conditions and higher living costs.

Even in those earlier days the Eagles envisioned the time when a contributory system of social insurance would replace a noncontributory system of public assistance as the average man's minimum protection against the major economic hazards of life. So the Fraternal Order of Eagles joined the groups that sought the enactment of a Nation-wide Social Security Act. It happens that the bill was introduced in the Senate by a member of our order, Senator Robert Wagner, in the House by an Eagle member, Representative David Lewis; and was signed by a life member of our order, the late President Franklin D. Roosevelt.

President Roosevelt gave the pen with which he signed the Social Security Act to the Fraternal Order of Eagles, saying, "I have long observed with satisfaction the sponsorship by the FOE of social justice legislation both in the States and in the Nation. The records for more than a quarter of a century bear witness to the campaigns of education conducted, the literature distributed, and the addresses delivered by your socially minded order. The pen I am presenting to the order is a symbol of my approval of the fraternity's vision and courage."

So, while we were but one of the groups that paved the way and fought for a National Social Security Act, we can lay claim to over 40 years of interest and work in the field of security legislation. And we feel that more than 10 years of experience in administering the social-security law has demonstrated the soundness of its approach to security problems—through Federal grants to States to provide for the public assistance of needy persons and through social insurance on a contributory basis to continue family income during periods of crisis. Certainly sickness is such a crisis, an economic catastrophe against which an average family cannot defend itself. The threat of decreased income and increased expenses during periods of ill health is as great a source of fear as is the danger of industrial accidents, unemployment, or poverty in old age.

Recognizing this, the delegates at the 1942 national convention of the Fraternal Order of Eagles adopted a report of the order's old age and social security committee, endorsing and quoting with approval this excerpt from a report of the Federal Social Security Board:

The absence of a systematic provision for compensating wage losses due to disability and for meeting the larger costs of medical care is a major shortcoming of Social Security. Sickness, disability, and the death of the breadwinner constitute by far the most important causes of poverty and dependency.

At our most recent national convention, held in the summer of the year 1945, the order's old age and social security commission considered the matter of the Wagner-Murray-Dingell bill, then pending before Congress, an omnibus bill that included many features of Senate bill 1606 now being considered by your committee. The Eagles' commission recommended and the convention went on record as endorsing and approving "the general aims and objects of the Wagner-Murray-Dingell bill."

As a matter of fact, certain provisions of the Wagner-Murray-Dingell bill were in line with the long-time fundamental policies and program of the Eagles. The same can be said of certain provisions of the Senate bill 1606 and companion measures pending in the United States Senate and House of Representatives.

SUPPORT OF TITLE I OF S. 1606

The providing of Federal help to State programs for maternal and child care, for services to crippled children, and for assistance to the needy were an important feature of the Social Security Act. The acceptance of Federal responsibility for promoting services of this kind has accelerated progress in these fields. The need for expanding Federal assistance in this direction seems apparent. Now, as in 1944, when the Eagles gave the matter convention attention, this seems to be an almost noncontroversial feature of the proposed changes in our national health and security laws. People may disagree as to the extent and form of such liberalization of grants, but the need for some relaxing of limitations on coverage and some expanding of the program is clear.

So, the provisions of Senate bill 1606, based on similar provisions in the original Wagner-Murray-Dingell bill, suggesting:

Grants-in-aid for State public health work;

Grants-in-aid for stamping out venereal diseases and tuberculosis;

Grants to States for maternal and child health services;

Grants providing medical care for those receiving public assistance:

Financing services to crippled children, as well as the proposed grants-in-aid of medical education, research, and prevention of disease, are based upon a fundamentally sound philosophy of stimulating and assisting States and community action in important fields of child and medical welfare. They deserve consideration and support.

Features of the original Wagner-Murray-Dingell bill, not contained in newer measures pending in the Senate, and endorsed by the Fraternal Order of Eagles, relate to the providing of cash benefits for temporary and permanent disability. There is at least as much reason for using social insurance to protect workers against sickness as there is in using it to provide replacement income during periods of unemployment. The need for providing wage earners insurance against wage loss when they are sick or disabled is an apparent one. Certainly the Eagles, who fought for workmen's compensation laws to protect against work-connected disabilities, could be expected to enthusiastically support a plan to provide cash benefits for disability identical with those given workers during times of unemployment. The loss of income during periods of sickness—enforced idleness—is as great a menace to those who work for a living as are the costs of medical care involved in such sicknesses.

Permanent disability, meaning a disability that lasts more than 6 months, is an equally menacing and equally insurable hazard. And old-age and survivors benefits system that provides for retirement at age 65 certainly should protect the man who becomes incapacitated at an earlier age. That man's children are certain to be younger and the expense of keeping his home together likely to be greater than in the case of the 65-year-old. The young or middle-aged head of a family stricken by a permanent disability deserves consideration at

least as much as the man who has grown too old to work. Contributions from employers and employees should be collected and cash benefits paid to protect workers from income loss during periods of temporary and permanent disability.

Obviously, a system of temporary and permanent disability benefits that made no provision for at least partial reimbursement of medical and surgical expenses would have serious shortcomings. If all Americans are to be given some minimum insurance against all common economic hazards, the crushing burden of unexpected medical and hospital expenses incident to illness must be redistributed through some form of social insurance. Particularly in lower-income and many-children families, doctor and hospital bills can eat away a family's lifetime savings.

OPPOSITION TO TITLE II OF S. 1606

Senate bill 1606—like the original Wagner-Murray-Dingell bill before it—proposes to meet this problem by setting up a system for prepaying doctors, dentists, nurses, and hospitals so that people could utilize their services or facilities on a "paid in advance by the Federal Government" basis. Under the plan, broad powers would be given to the Surgeon General "to take all necessary and practical steps * * * to arrange for the availability" of such prepaid services. Payments to general medical practitioners would be made on a fee basis, the method of payment quite completely left within the authority of the Surgeon General.

Considering an almost identical proposal in the original Wagner-Dingell-Murray bill, the 1944 national convention of the Fraternal Order of Eagles voted not to approve "the plan set up for administration of the medical and hospital benefits, whereby the appointed head of the United States Health Service would have complete power to set and establish rules and regulations for the physicians of the United States who render professional services to the people of the United States."

MEDICAL PROFESSION SHOULD BE INDEPENDENT

In the opinion of our Old Age and Social Security Commission, endorsed by vote of the delegates at the FOE 1944 convention, the bill should be amended "to guarantee the independence of the medical profession." For, as the committee report pointed out—

The bill cannot function effectively without the full and complete cooperation of a majority of the physicians and surgeons who are our family doctors.

Our organization represents a cross section of America. Undoubtedly there are thousands of our members who might think this statement of policy a very conservative and somewhat negative one. I believe that the average Eagle, who is an average American, favors the redistribution of some part of medical and hospital expenses so that all of us will help foot the Nation's doctors' bills instead of letting the unlucky or sickly ones take the brunt of the burden.

But I doubt that the average Eagle or average American is equally enthusiastic about having doctors and nurses become direct or indirect Federal employees, paid by the Government. He wants free choice of a physician, but not necessarily free choice of Government-

employed physicians. To put it differently, I'd venture the opinion that he wants insurance against medical expenses provided—but not necessarily the medical care itself provided.

When I take out a private company's health-and-accident policy, I am promised, subject to the limitations in the fine-print part of the policy, reimbursement for certain medical and hospital expenses, in addition to compensation for wage loss or periods of disability involved. My doctor doesn't go to work for my insurance company. I choose him, and I pay him. The insurance policy guarantees to me my ability to do so. In my opinion this is the American way.

That's postpaid medical care. It leaves untouched the relationship of doctor and patient, and creates no new relationship of insurer and medical practitioner. Plans vary—the Blue Cross and some factory group plans handle the matter differently—but a typical private health-insurance policy protects and pays the insured without hiring doctors and nurses to provide the services required.

Reimbursing wage earners for major medical, surgical, and hospital expenses on a schedule basis may not be the only alternative to Government prepayment of medical practitioners. It would involve considerable record keeping and report filing—but perhaps that is not too high a price to pay for an independent medical profession, completely removed from political control or Federal employment.

In making an alternative suggestion to federalized prepayment of medical care, I am not labeling the method proposed in Senate bill 1606 as "socialized medicine." For years local lodges of the Fraternal Order of Eagles have provided free medical services to members and their families, just as many industrial establishments now do.

Some Eagle aerie have maintained a panel of prepaid physicians for over 40 years. Many Eagles have received medical attention for themselves, their wives, and youngsters, that otherwise they might not have had or been able to afford. But we would have to admit that, even when there is a panel of several outstanding medical men in the community serving the local aerie, a majority of our members in any lodge seemed to prefer to have their own family doctor. They may be the better-off members, from a financial or income standpoint, but the idea of selecting their own doctor and paying themselves for his services appeals to them.

Insurance, social or private, to an average American, still means reimbursement for a loss or expense, protection against an uneven and unpredictable risk.

In asking amendment of Senate bill 1606 to provide some alternative method of cushioning the economic shock of paying for needed preventative and curative services and hospital care, we are not placing our reliance on voluntary systems. They are fine. But those who need them least are most likely to take out the policies. Those who need the protection most, the least likely to have it.

When the fight for old-age pensions started, opponents of the measure pointed to employers-staff pension plans, public employee systems, group set-ups, and the growing resort to annuity purchases. But voluntary plans would never have provided for the needy aged of our land. Neither will voluntary health insurance systems. However, the establishment of a national social insurance program for at least a minimum of benefit protection, will popularize and publicize

the health insurance idea so that private companies will sell more policies to a health insurance conscious nation.

Members of the committee, may I say again that I have welcomed this opportunity to present the views of the Fraternal Order of Eagles to this committee. Out of the many expressions of opinion and suggestions made by witnesses and groups they represent, there is certain to come a national health program that will have and deserve the support of an overwhelming majority of our citizens. After all—life, liberty, and the pursuit of happiness—all require and are made more meaningful by good health. Certainly our Government will help our people to help themselves to being well.

Thank you very much, gentlemen.

The CHAIRMAN. Any questions, Senator?

Senator DONNELL. Yes. I would like to ask a few questions, Mr. Senator.

Mr. Poss, as I understand it, you are the National Grand Worthy President of the Fraternal Order of Eagles?

Mr. Poss. That is correct, sir.

Senator DONNELL. Do you pursue an independent profession or business, or does that position take all of the time you have, your position with the organization?

Mr. Poss. All my time is devoted to the organization. I am the secretary and manager of the Toledo Aerie 197, that has a membership of 9,600 members.

Senator DONNELL. But you do devote all of your time to the organization?

Mr. Poss. That is correct.

Senator DONNELL. How long have you been the chief officer of the organization?

Mr. Poss. Elected the thirteenth day of last August.

Senator DONNELL. What was your business before that?

Mr. Poss. Prior to becoming actively identified with the Eagles?

Senator DONNELL. Yes, sir.

Mr. Poss. I was born and raised on a farm in central Ohio. I spent about 3 years in a bank, until my eyes went bad.

Then I worked for a few months in a filling station. I traveled on the road about 15 years, selling cigars. Then I went in business for myself in a wholesale tobacco and candy business.

Unfortunately, in 1931, I went the route of many industrious young men and lost my business and home.

I was then appointed deputy in the United States marshal's office and served for 4 years.

Senator DONNELL. Where was that?

Mr. Poss. Toledo, Ohio, the northern district.

Senator DONNELL. In what capacity?

Mr. Poss. Federal deputy marshal.

Senator DONNELL. Federal deputy marshal, yes, sir.

Mr. Poss. And then I resigned and accepted the appointment as secretary of the Toledo aerie.

Senator DONNELL. Of the Eagles?

Mr. Poss. That is right.

Senator DONNELL. That was in what year?

Mr. Poss. In 1939.

Senator DONNELL. So, for approximately 7 years, you have been connected officially with the Order of Eagles?

Mr. Poss. Well, I was connected officially prior to that time. I had gone through the State chair in the State of Ohio, but it was not my life's work and only income.

Senator DONNELL. I see.

Prior to 1939, however, you had not been upon a salary with the Eagles?

Mr. Ross. That is correct.

Senator DONNELL. But since 1939, you have been?

Mr. Poss. That is correct.

Senator DONNELL. Now, Mr. Poss, this statement which is exceedingly interesting, I am sure, and we are all glad to have it, was it prepared by you solely or in conjunction with others?

Mr. Poss. I wrote that thing out myself. I started about 1 o'clock and got through about 6:45 this morning.

Senator DONNELL. Yes, sir. I can see it has taken a great deal of work.

You spoke about the Eagles in Kansas City, Mo., sponsoring the first mothers' pension laws.

I happen to be from Missouri, and I am interested to know why it was you suggested that.

Mr. Poss. I do not have that name.

Senator DONNELL. I used to know Mr. Conrad Mann.

Mr. Poss. It was not him. I can furnish that information if you want it.

Senator DONNELL. That is all right. That was more of a matter of information.

The CHAIRMAN. Mr. Conrad Mann was pretty widely known. I think he was known in every State of the Union. He visited Montana many times.

Senator DONNELL. Mr. Mann was of great distinction in the city of Kansas City and rendered fine service.

The CHAIRMAN. He had a very attractive personality.

Senator DONNELL. Yes, indeed. I thoroughly concur in that.

Mr. Poss, you referred, at the bottom of page 4 of this statement:

Senate bill 1606—like the original Wagner-Murray-Dingell bill before it—proposes to meet this problem by setting up a system for prepaying doctors, dentists, nurses, and hospitals, et cetera, so that people could utilize their services or facilities on a "paid in advance by the Federal Government" basis.

Where do you get that quotation of "paid in advance by the Federal Government"? Is that out of the bill?

Mr. Poss. No.

Senator DONNELL. That is out of your own mind?

Mr. Poss. That is right.

Senator DONNELL. Do you understand that that bill provides a system for prepaying doctors, before they render their services?

The CHAIRMAN. Not before they render their services.

Senator DONNELL. Well, it says "prepaying" doctors.

Mr. Poss. We may change that word, but what I mean is that the men who become sick work under the assumption that if he becomes ill, it will be paid by the Federal Government. That, in essence, is prepayment. I do not mean the money is advanced prior to the time a man becomes ill.

Senator DONNELL. I just wanted to understand. The language here, as I understand it, would mean that—

system for prepaying doctors, dentists, nurses, and hospitals so that people could utilize their services or facilities on a "paid in advance by the Federal Government" basis.

I take it what you mean, and if I am incorrect, please check me, is the people would understand, by reason of the deduction from the pay roll or otherwise, that there would be a payment for him, and he can get the services without having to pay for it.

Mr. Poss. Otherwise the contribution he makes the way the thing is ultimately set up.

Senator DONNELL. You do not understand that this bill provides that a doctor is going to be paid in advance?

Mr. Poss. No. No, by no stretch of the imagination.

Senator DONNELL. I just wanted to be sure what that language meant.

Now, you also make several observations, Mr. Poss, on page 5, and I am not quite clear as to just exactly what is meant by portion of your observation.

You say that:

In the opinion of our Old Age and Social Security Commission, endorsed by vote of the delegates at the FOE 1944 convention, the bill should be amended "to guarantee the independence of the medical profession.

Are you speaking about S. 1606 as the bill which should be amended in order to accomplish that result of guaranteeing the independence of the medical profession?

Mr. Poss. Yes, that is correct.

Senator DONNELL. In what respects do you think that this bill, S. 1606, should be amended so as to guarantee the independence of the medical profession?

Mr. Poss. Well, in the opinion of the Fraternal Order of Eagles, and mine, I feel that the average independence of the man is in knowing that he can pay his own bill. In other words, that the money should be paid to the insured policy holder.

For instance, if I carry a sickness and accident insurance policy, the check is sent to me. It is not sent to the doctor. Then I pay the doctor.

Senator DONNELL. I think you are coming to a part later on. I was referring to the second full paragraph on page 5, where you state, as I indicated that:

In the opinion of our Old Age and Social Security Commission—

I take it you mean the Eagles?

Mr. Poss. That is right.

Senator DONNELL (reading):

Endorsed by vote of the delegates at the FOE 1944 convention, the bill should be amended "to guarantee the independence of the medical profession."

Just what amendments do you have in mind there that should be incorporated in the bill to guarantee the independence of the medical profession?

Mr. Poss. We feel that in order to make any bill work, especially this particular type of bill, you must have a cooperative feeling, and

a spirit on the part of the doctors, and by placing him directly or indirectly on the Federal pay roll, you eliminate his independence.

Senator DONNELL. You think the bill should be amended?

Mr. Poss. That is right. In the opinion of the Eagles, we feel that the money should be paid to the man who is sick, and he, in turn, pay the doctor.

Senator DONNELL. I see. And that is what you are referring to in regard to "guarantee the independence of the medical profession"?

Mr. Poss. That is right.

PROPOSAL FOR CASH BENEFITS UNDER TITLE II

Senator DONNELL. So you do not favor the plan of this bill insofar as it provides services? You favor the bill being so amended, as I understand it, to provide that the Federal Government shall give to the sick person a check, and then the sick person uses that check or the proceeds of it to pay the doctor?

Mr. Poss. That is correct.

Senator DONNELL. So you favor the amendment of the bill to change it in that respect?

Mr. Poss. That is right. We favor the bill and the principle of it, and everything, but we feel that would guarantee the independence of the medical profession, and likewise more or less guarantee the independence of the individual.

The CHAIRMAN. Well, let me ask you there: How would that have the effect of guaranteeing the independence of the physician?

Mr. Poss. Well, Senator Murray, in that case the man who is ill is going to receive the check, and he could choose any doctor out of the 5,000 or 6,000 we have in Toledo.

The CHAIRMAN. That is the system.

Mr. Poss. I have learned, down through the years, that when we have doctors in our home, it is a pretty sacred thing, with a child and a wife. We have pretty close association with the family doctor.

The CHAIRMAN. But this bill provides, in every community where it is put into operation, a panel of the physicians and surgeons who agree to come under the plan will have their names listed, and then the people in the community would have the right to elect to go under the care of many member of that panel.

Mr. Poss. That is right.

The CHAIRMAN. And when he becomes sick, it provides that that doctor that he selects will take care of him and he will be paid out of the fund.

A fund will be created and set aside out of the wages of the workers, and sent in to a separate fund, and out of that fund the doctor will be paid.

Now, if you require that fund to pay it to the individual, and then the individual to pay it to the doctor, you are going to create a lot more bookkeeping, which does not serve any purpose, as far as I am able to see.

Mr. Poss. Well, of course, that is a debatable question.

The CHAIRMAN. Do you think that would be of any advantage to the doctor? Would the doctor prefer to have the money from the person he treats?

As soon as he gets the money, he knows that the individual he has cared for is responsible for the fund.

Mr. Poss. No.

The CHAIRMAN. He has advanced that money, and out of that fund the doctor is paid for the care and services he has rendered.

Mr. Poss. I follow you, but I think we have a different thought in the thing.

Leaving the doctor out of it for the moment, the point I am attempting to make, it has been our experience, where we have provided it, and we have in many instances, doctor service to our members.

The CHAIRMAN. Yes.

Mr. Poss. Perhaps 85 or 90 percent, and I would not want to be held to that figure, but I know in our own aerie a very small percentage of our members avail themselves of that panel.

I am assuming that the difference would be that the individual could choose from any doctor in the community.

I do not know. This is an idea we are studying, and we hope to get some constructive work done. I am wondering whether or not the situation to the mother with a little baby, who wants Dr. Brown, who has not qualified on the panel, would be sufficient to incur the additional expense of the function.

I want it understood, gentlemen, I am not here arbitrarily. I am merely here for a statement of opinion.

The CHAIRMAN. I understand, and you do not want to encumber the bill with unnecessary provisions or make it overloaded with provisions that would require excessive bookkeeping or anything like that. You want to see us work out a system in this country whereby the cost of medical care can be brought down for the average ordinary person.

At the present time, modern medical care is so expensive that a person on a \$1,200 or \$1,500 a year income is unable to pay for it when he has a serious illness in his family.

You want to make it possible, is that right, to take care of a family, to give modern medical care at a reasonable cost; and the way you would do it is by a national insurance system where a huge fund is collected out of the wages of everybody, whether he is sick or not sick?

Mr. Poss. That is right.

The CHAIRMAN. Contributing just the same every month.

That fund is set aside, and is the source for the payments of the doctors who are selected by the sick person to perform the service.

I cannot understand how that would be depriving the physician of any independence, because he gets the money in a check from the national Government for the services that he has rendered, and to which the patient has contributed.

Mr. Poss. Well, of course, in the other instance, the Federal Government and the physician would not have any connection at all, because the money would be just as it is done in an insurance company.

If I have a sickness and accident insurance policy, I get the check and I take it over to the doctor and pay him.

The CHAIRMAN. I want to get your judgment. You think it would be better if this bill would provide that out of that fund the Federal Goverment should give a check payable to the individual who had been

sick, and the individual who had been sick will turn that check over to the doctor.

Mr. Poss. I think so.

The CHAIRMAN. All right. That is all I want to know.

Senator DONNELL. And you think, as I understand it, just to quote your statement here at page 5:

I would venture the opinion that he—

referring, I note from the previous sentence or two, to the average Eagle or the average American. I will start again.

I would venture the opinion that he wants insurance against medical expenses provided, but not necessarily the medical care itself provided.

Mr. Poss. That is the point I am trying to make. Give him the independence of calling any doctor in the city, and not having a panel.

The CHAIRMAN. Well, of course, you could not get the low-cost medical service if you did not have some plan whereby the physicians are organized and brought into it by a system of this kind, because the physician would have a right to charge anything he pleased.

I have paid as high as \$3,500 to a single doctor for an operation in my family.

Doctors have the right, under our free system of enterprise, to charge anything they wish. They have the judgment on it.

Now, if what you are proposing here were to be the situation, then any person under this system could go to any doctor whether he was on the panel or not?

Mr. Poss. I think your law could be amended even in that case, that there would be a flat rate for an appendectomy or a tonsillectomy. I think there could be a rate established.

The CHAIRMAN. But the only way you could get the rate down and make it possible for the ordinary person to get the services at a low cost is to have a situation of this kind where the physicians join a panel, and when they join a panel they agree to accept certain compensation. It is either on a per capita basis, which is paid for by the number of people they take care of, or it is paid on a fee system, where a fee system is fixed.

Mr. Poss. Is it not a fact that some of the insurance companies have a definite fee system established, and they do not have any difficulty?

The CHAIRMAN. Yes. That is all right. And if you do not want a national system of insurance, you can continue that system of going to private insurance companies, of course, but you cannot get under the private insurance system the low rates of medical care that this bill proposes to provide, you see, and the only way you can make it cheap for people that only make \$100 a month to get this low rate of service is by a national system of this kind, and if you do not want this kind of a system, why, there, of course, you can continue to take it under the system we have, the voluntary system and the private-insurance-company systems, and all that.

Mr. Poss. I am wondering, Senator. I do not know, but I am wondering if we couldn't drive—let us not call it drive, but reduce materially the cost of medical care when this thing gets functioning.

The CHAIRMAN. Well, of course, we will. Of course, we will reduce the occasion for medical care if this bill functions over a period of years. I have no doubt but what, as the result of this plan being in

operation for a number of years, it will make this country a more healthy Nation.

People will be taken care of from their infancy up, and can go to a doctor without fear that the cost is going to embarrass himself or his family, and he will avoid the danger of developing diseases which will afterward incapacitate him and make him die at an early age.

Now, the only way you can accomplish this is through a national system, and not under a private insurance system such as you mention. You have got to take a stand on it either for the national system or for the private system.

Senator DONNELL. Mr. Poss, you referred to a mother and baby—that a mother would like to have Dr. Brown, which I think you used as an illustration.

I take it that you recognize that mothers, and fathers, for that matter, as well, sometimes want to select the particular physician he or she wants. Is that true?

Mr. Poss. That is my opinion.

Senator DONNELL. And that is what you had in mind. The mother may think that a given doctor is better for her baby than another doctor, even though some other mother may not think so. That is correct, is it not?

Mr. Poss. I think we generally agree on that—that is, those of us who have had youngsters.

Senator DONNELL. You say, on page 5:

But I doubt that the average Eagle and average American is equally enthusiastic about having doctors and nurses become direct or indirect Federal employees, paid by the Government.

I understand from that that your interpretation, whether it is correct or not, your interpretation of this bill as it is now written is that, inasmuch as the money is collected and the person goes to the panel and gets the doctor and the Government pays the doctor, your interpretation is, either directly or indirectly, that these doctors and nurses are Federal employees.

Mr. Poss. That is correct.

Senator DONNELL. And you think the bill, S. 1606, should be remedied and amended so that the payments should be made direct to the patient, and then the patient go and select whatever doctor he or she may want. That is your thought?

Mr. Poss. That is my thought.

The CHAIRMAN. Regardless of what his fees would be?

Mr. Poss. I am wondering if we can place a price on our responsibility to our fellow men.

The CHAIRMAN. You think the doctors should be permitted to judge themselves the value of their services?

Mr. Poss. Well, Senator, again, if it will be put that way, of course, you are much more familiar with the facts than I am.

But I am wondering if you would not have an influx of doctors that would be willing to accept a set schedule, especially for a surgical case?

The CHAIRMAN. That is exactly what they will do under this bill. This bill will provide an opportunity for the doctors to avail themselves of practice under this bill.

Mr. Poss. Yes; but you still have the panel and you still have the Federal Government paying them.

I contend—and I may be wrong—

The CHAIRMAN. If you can work out something, I would like to hear it. Your organization, of course, we have a great respect for it.

I wish you would take this up, when you go back, with your counsel, and ask them to suggest a proposed amendment which would carry into effect your suggestions here.

Mr. Poss. Thank you.

The CHAIRMAN. I think that will be very valuable.

Mr. Poss. We will do the best we can. We have approached this thing open-minded.

The CHAIRMAN. I am sure of that. I know it.

Mr. Poss. Thank you.

The CHAIRMAN. Now, in your organization, do you have a physician employed to take care of the members of your different lodges?

Mr. Poss. Senator Murray, in some we do and some we do not.

The CHAIRMAN. In those you do, how does that operate? Is the doctor paid on a monthly or annual basis?

Mr. Poss. He is paid on a per capita, membership.

The CHAIRMAN. Per capita.

Mr. Poss. Yes.

The CHAIRMAN. And the fraternity pays him?

Mr. Poss. He is paid out of a general fund.

The CHAIRMAN. That is exactly what I expected it would be.

That does not injure the pride or independence or the freedom of that physician. He is entirely satisfied. In fact, there is a spirited contest, sometimes, among the medical profession to get that position; is that not true?

Mr. Poss. Sometimes.

The CHAIRMAN. Yes. Young doctors are delighted to get that employment with the Eagles whereby they are guaranteed a fixed income, and they perform services on the per capita basis for the members of the fraternity?

Mr. Poss. Yes.

Senator DONNELL. I think you said, Mr. Poss, in substance, that the experience has been that when a panel of physicians is set up, that the people will not go. They will go off and get some other physician.

Mr. Poss. Let us say that perhaps only 15 percent of our membership avail themselves of that service.

Senator DONNELL. In other words, the service is there. They could get it; but 85 percent of them do not accept it, because they would rather go out and get a doctor of their own choice. Is that right, sir?

Mr. Poss. Yes.

The CHAIRMAN. You live in Toledo?

Mr. Poss. That is right.

The CHAIRMAN. You have some very fine hospitals and clinics there, have you not?

Mr. Poss. That is right.

The CHAIRMAN. Are you familiar with this modern system of group medical practice?

Mr. Poss. I know about it. I am not too familiar with it; no.

The CHAIRMAN. Well, under that practice, a person that goes to a clinic does not have an opportunity to select each particular specialist or expert that studies his case; is that not true?

Mr. Poss. I think it is. You mean if a man goes into the hospital he will take the regular routine examinations?

The CHAIRMAN. Yes. And people go to those institutions with great confidence.

Mr. Poss. I think that is true.

The CHAIRMAN. You have heard of the Mayo Institution in Rochester, Minn., have you not?

Mr. Poss. Yes.

The CHAIRMAN. People flock to that institution from all over the United States, and go there and get service from medical men and surgeons they have never seen before.

Is that not true?

Mr. Poss. That is true.

The CHAIRMAN. And that is true in many sections of the country, not merely the large cities of the country.

You could take Johns Hopkins of Baltimore, Md. People come from every section of the United States and are operated on and treated and examined by physicians they never saw before.

And in the country sections, many sections in the rural districts of the United States, there is only one physician in an entire county; is that not true?

Mr. Poss. Yes.

The CHAIRMAN. They have no freedom of choice. They have to take the physician there or take none, or leave the county.

Mr. Poss. I imagine there are communities where they have only one doctor.

The CHAIRMAN. This idea of freedom of choice under modern medical practice is gradually getting to be a thing of the past. Is that not true?

Mr. Poss. It may be in the rural communities. Of course, I am living in a city. We get the doctors.

The CHAIRMAN. Is that not true in the large cities? For instance, if you had a condition which required an operation, you would not go to an ordinary physician who just has an office and is not connected with a hospital, even though you knew him well.

Mr. Poss. In my own personal experience, our family doctor recommends a surgeon.

The CHAIRMAN. He recommends a surgeon.

Mr. Poss. Yes.

The CHAIRMAN. Yes.

But you would take his recommendation on that? You would accept his recommendation?

Mr. Poss. I have. I have paid for several operations.

The CHAIRMAN. Yes. Surely. That is generally the situation around the country. If a person has some special condition to care for, he goes to a specialist or is directed to a specialist.

Mr. Poss. Well, yes. I do not think the majority of the sickness, however, is taken care of by the specialist. I think it is taken care of by the family practitioner, the family doctor, let us call him.

The CHAIRMAN. After a person gets to be 40 years of age, he is pretty much his own doctor, for ordinary conditions, such as a little indigestion, or a cold, or something like that. If a man is not able to doctor himself, he is up against it, with the high cost of medical care in the country today; is that not true?

Mr. Poss. I imagine that is true.

The CHAIRMAN. Thank you.

Senator DONNELL. Mr. Poss, with reference to the Senator's question there as to whether or not this matter of the freedom of choice of doctors is getting to be pretty much a thing of the past, you do not favor, as I understand it, from the experience of your organization, you find that mothers that have babies do not favor the system, if they want to go to Dr. Brown, they do not feel it ought to be a thing of the past. They still want to choose the doctor they want; is that not your observation?

Mr. Poss. I think that is true.

Senator DONNELL. And, as you have indicated, in these panels where they have service waiting free of charge, 85 percent of the people in your organization do not avail themselves of it?

Mr. Poss. Let us correct that.

We do not pay for maternity cases or any surgery.

Senator DONNELL. Well, you can leave that out.

Mr. Poss. The provisions of our organization provide that the services of the physician are free. Any surgery or medicine must be collected for.

Senator DONNELL. But what I have reference to is that the service that is available and free of charge that your members can get free of charge from members of the panel, as I understand it, only about 15 percent of your members avail themselves of that service; is that right?

Mr. Poss. I think that is a fair estimate.

Senator DONNELL. Now, in regard to Mayo and Johns Hopkins over in Baltimore, if you know, is it not a fact that largely what happens there is that the home physicians, way back home where you or I live, if he is confronted with a situation where he thinks we ought to go to Mayo or Johns Hopkins he will send us there, largely either for diagnosis or perhaps for an operation, and then after we have recuperated sufficiently to come on back home and resume treatment under the family physician, we do so.

That is what normally happens in the case of Mayo's and Johns Hopkins, is it not?

Mr. Poss. I presume that is true. They have an enviable reputation for their ability, and I imagine, when you have a serious ailment, you would seek the people best reputed.

Senator DONNELL. But after you had the operation and convalesced and you came on back home, you would resume treatment from your family physician?

Mr. Poss. If you did not establish a residence in Rochester.

Senator DONNELL. If you came home?

Mr. Poss. Yes.

Senator DONNELL. And then your local physician takes up again?

Mr. Poss. Yes.

Senator DONNELL. All right.

The CHAIRMAN. You do not want us to understand that that is a perpetual operation? You expect, when they go up to Mayo or Johns Hopkins, that they will get cured, and when they come back they are well.

Mr. Poss, I certainly do not believe that when you go to Mayo's you are coming back sick. You go there to get well.

The CHAIRMAN. You will furnish us with that information I requested?

Mr. Poss. I will.

The CHAIRMAN. I want to thank you for coming here and congratulate you for your wonderful talk here today.

Mr. Poss. Thank you, sir.

The CHAIRMAN. The hearing will adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 3:45 p. m., Thursday, May 2, 1946, the committee recessed to resume Friday, May 3, 1946, at 10 a. m.)

NATIONAL HEALTH PROGRAM

FRIDAY, MAY 3, 1946

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

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

Present: Senators Murray, Ellender, and Donnell.

The CHAIRMAN. Gentlemen, we will resume the hearing.

This morning we have Gen. Omar N. Bradley, the Administrator of Veterans' Affairs.

General Bradley, you may proceed with your statement.

STATEMENT OF GEN. OMAR N. BRADLEY, ADMINISTRATOR, VETERANS' AFFAIRS

General BRADLEY. All right, sir.

Mr. Chairman, I am pleased to accept the invitation of the chairman to testify on S. 1606, Seventy-ninth Congress, as I believe with the President that the health of all Americans is one of the prime responsibilities of the Government.

The Veterans' Administration was requested to report on S. 1606, Seventy-ninth Congress, and at this point I desire to insert in the record a copy of this report.

(The report referred to is as follows:)

VETERANS' ADMINISTRATION,
Washington 25, D. C., May 3, 1946.

Hon. JAMES E. MURRAY,

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

MY DEAR SENATOR MURRAY: Further reference is made to your request dated December 27, 1945, for a report on S. 1606, Seventy-ninth Congress, a bill to provide for a national health program.

Inasmuch as the bill is an involved and comprehensive proposal which does not impose any duties on the Veterans' Administration, a detailed analysis of the bill will not be given in this report. Briefly the bill contains two titles. Title I comprises three parts. Part A proposes grants to States for public-health services. Part B proposes grants to States for maternal and child-health services, and Part C proposes grants to States for medical care of needy persons. These grants would all be on the basis of matching contributions from the States. Title II of the bill proposes to establish a system of prepaid personal health service benefits. No taxes are imposed by the bill and the program, it is contemplated, may be financed by appropriations from the general fund.

Reference is specifically made, however, to certain sections of the bill which may possibly affect functions of the Veterans' Administration or existing rights of veterans. Title I, part C, section 132, subsection 8, provides that the State agency administering the bill shall "in determining need for medical care, take into consideration (a) the requirements of individuals claiming medical care

under the plan, and (b) any income and resources of an individual claiming medical care under the plan, which must be taken into consideration with regard to an individual claiming assistance under a State plan approved under the Social Security Act, as amended." It may be advisable to clarify the terms "income" and "resources" so as to indicate more plainly whether compensation and pension paid by the Government to veterans or to dependents of veterans as such are included within such language.

Title II, which would create a system of prepaid personal health service benefits, provides in section 208 that in the event an individual is eligible to medical treatment under a workmen's compensation plan of the United States or of any State, such individual would not be entitled to benefits under said title II, and should such individual receive any personal health service under title II, the Surgeon General shall be subrogated to the rights of such individual and to reimbursement to the extent of the estimated cost incurred in furnishing such service. It is further provided in section 209 (a) that reimbursement may be required in certain cases, and section 209 (b) further provides:

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

It would appear that veterans are a group "of persons for whom the Congress of the United States makes provision," as under existing law the Veterans' Administration is authorized to furnish hospitalization to veterans otherwise eligible for service-connected disabilities and to furnish hospitalization under certain conditions when space is available for war veterans for non-service-connected disabilities. It is considered that reimbursement should not be expected in the event a veteran eligible for hospitalization by the Veterans' Administration is hospitalized under the provisions of this bill. It may be advisable to modify the language of section 209 (b) to specifically exclude benefits under laws administered by the Veterans' Administration.

Title II, section 213, contains provision for grants-in-aid for medical education, research, and prevention of disease and disability and includes the following provision:

"* * * During the 5-year period beginning January 1, 1946, the Surgeon General and the Advisory Council shall give preference and priority to grants-in-aid with respect to projects to aid servicemen (as defined in section 217 (g)) seeking postgraduate education as medical or dental practitioners or training for administration of personal health services, disability benefits, rehabilitation services, and related services. * * *

Section 217 (g) defines the term "serviceman" as follows:

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

It is noted from the foregoing that the bill would give a preference and priority to persons who served in the armed forces of the United States after September 7, 1939, the day before the proclamation of a national emergency by the President, Executive Order No. 2352. For purposes of laws administered by the Veterans' Administration the period September 7, 1939, to December 7, 1941, was peacetime and service in the armed forces during that period was peacetime service. For purposes of hospitalization, domiciliary care, and burial benefits under laws administered by the Veterans' Administration, a World War II veteran is defined by Public Law 10, Seventy-eighth Congress, as—

"Any person who served in the active military or naval service of the United States on or after December 7, 1941, and before the termination of hostilities in the present war as determined by proclamation of the President or by concurrent resolution of the Congress: *Provided*, That the term 'active military or naval service', as used herein, shall include active duty as a member of the Women's Army Auxiliary Corps, Women's Reserve of the Navy and Marine Corps, and the Women's Reserve of the Coast Guard."

The Veterans' Preference Act of 1944, Public Law 359, Seventy-eighth Congress, gives preference to "(1) those ex-service men and women who have served

on active duty in any branch of the armed forces of the United States and have been separated therefrom under honorable conditions and who have established the present existence of a service-connected disability or who are receiving compensation, disability retirement benefits, or pension by reason of public laws administered by the Veterans' Administration, the War Department, or the Navy Department; (2) the wives of such service-connected disabled ex-servicemen as have themselves been unable to qualify for any civil-service appointment; (3) the unmarried widows of deceased ex-servicemen who served on active duty in any branch of the armed forces of the United States during any war, or in any campaign or expedition (for which a campaign badge has been authorized), and who were separated therefrom under honorable conditions; and (4) those ex-service men and women who have served on active duty in any branch of the armed forces of the United States, during any war, or in any campaign or expedition (for which a campaign badge has been authorized), and have been separated therefrom under honorable conditions."

It is suggested that uniformity in preference provisions and in definitions of such terms as "veteran" or "serviceman" is desirable insofar as may be possible. It is also suggested that a discharge or release under conditions other than dishonorable be made a prerequisite to the proposed preference and priority. This is the criterion established by section 1503 of the Servicemen's Readjustment Act of 1944, Public Law 346, Seventy-eighth Congress, for benefits provided by that act or Public Law 2, Seventy-third Congress, as amended.

It may be helpful to the committee to briefly outline the system of medical and hospital care furnished veterans under laws administered by the Veterans' Administration. Within the limits of the Veterans' Administration hospitals and homes, hospital treatment, or domiciliary care may be furnished the veteran applicants generally in the specified order of preference:

(1) Persons who served during a period of war discharged under other than dishonorable conditions from a period of war service and when suffering from an injury or disease incurred or aggravated in line of duty in that period of active military or naval service and for which they are medically determined to be in need of hospital treatment;

(2) Retired officers and retired enlisted men of the Army, Navy, Marine Corps, and Coast Guard, including members of the Fleet Naval Reserve or Marine Corps Reserve on retainer pay who had honorable service in a war period and are medically determined to need hospital treatment for an injury or disease that was incurred in line of duty in active service;

(3) Persons discharged from the Regular Establishment for disability incurred in line of duty or who are in receipt of pension for service-connected disability when suffering from injury or disease incurred or aggravated in line of duty in the active Federal service and for which they are medically determined to be in need of hospital treatment;

(4) Hospital treatment or domiciliary care may be authorized for veterans who served, regardless of length of service, during a period of war and who were discharged under other than dishonorable conditions, who swear that they are unable to defray the expense of hospital or domiciliary care, including the expense of transportation to and from a Veterans' Administration facility, who are suffering from a disability, disease, or defect which indicates their need for hospital care.

There have been omitted from the foregoing outline certain smaller groups included in hospitalization benefits, such as members of the Women's Army Auxiliary Corps and persons who suffered an injury or aggravation of a pre-existing disability when provisionally accepted and ordered to report to a place for final acceptance into the military or naval service, and certain peacetime veterans.

The Veterans' Administration in extending hospitalization and medical care to veterans in the United States, has constructed and organized the largest single system of hospitals in the world. As of January 31, 1946, the Veterans' Administration hospitals and homes had a hospital bed capacity of 83,927 in 98 hospitals distributed throughout the United States. The Veterans' Administration has a hospital construction program that will greatly increase the bed capacity of the Veterans' Administration within the next 2 years. It is planned to construct 77 new hospitals and to enlarge and increase the capacity of the 98 existing Veterans' Administration institutions. The Veterans' Administration has a large staff of highly trained professional personnel and is greatly expanding its personnel and program of treatment and medical care.

In addition to hospitalization the Veterans' Administration extends out-patient treatment for disabilities incurred or aggravated in service. In the fiscal year ending June 30, 1945, out-patient units made a total of 1,771,760 physical examinations. Out-patient treatments furnished during the same period totaled 828,620.

Other than the suggestions for clarification of the proposed legislation, the Veterans' Administration makes no comments on the merits of S. 1606. The proposals of the bill relate to a basic policy of the Government which is within the discretion of the Congress to determine.

Hospitalization and medical treatment benefits are presently regarded by veterans as one of the most valuable benefits that have been extended to them by a grateful people. The need for some care for veterans was recognized in the early days by the establishment of institutions such as the soldiers' homes. The present system of hospitalization and medical treatment, however, had its origin following World War I.

Upon request the Veterans' Administration will be pleased to furnish more detailed statistical information and information relative to cost of administration of its system of medical and hospital benefits which is, as heretofore stated, the largest and most extensive such system in existence.

This report has not as yet received clearance from the Bureau of the Budget.

Very truly yours,

OMAR N. BRADLEY.
General, United States Army, Administrator.

General BRADLEY. The report deals with certain technical aspects of the bill as to which I will make no further comment.

MEDICAL PROGRAM OF THE VETERANS' ADMINISTRATION

The bill imposes no duties on the Veterans' Administration. Therefore, I think I can be more helpful to the committee by outlining the program and experience of the Veterans' Administration in the field of medical care.

As the committee knows, the Administrator of Veterans' Affairs is concerned with and responsible for an extensive program of hospital and medical care to which some 20,000,000 veterans potentially will be eligible. The most valuable benefit afforded veterans is that of hospitalization. Since the enlargement of the program in 1924, thousands of veterans who might otherwise have died or become totally disabled have been given timely hospital care which restored them to employability. By assisting veterans in this manner the veteran is benefited by restored capacity for productive employment and probable enhanced longevity. Further, this program reduces the load of disability claims both as to insurance and pensions.

As will appear from the review of our program which follows, veterans have reason to take pride in the hospital program established for them. While the proposals presently contained in S. 1606 would not appear to be designed to impair in any way the hospitalization benefits now administered by the Veterans' Administration, I wish to state clearly that in my opinion it is important that nothing be done which will impair it. I also believe that this veterans' benefit should continue to be under the exclusive jurisdiction of the Veterans' Administration.

The bill does not specify any particular method of financing the program. By use of the term "Prepaid Personal Health Service Benefits," it would appear that contribution by the employed person is anticipated. This would require the veteran to contribute toward a benefit to which he is already entitled, without charge, under existing law, in that he is entitled without cost to himself to hospital or out-patient treatment of service-connected disability and to hospital

treatment of non-service-connected disability when bed is available. This effect, bearing in mind possible impairment of the existing program, should be considered carefully at such time as the financing procedures are worked out. In passing it is noted also that the bill would limit the period of hospitalization, whereas under the laws administered by the Veterans' Administration there is no such limitation. The period of hospitalization is determined by application of medical principles.

Existing hospitalization benefits for veterans arise from section 6 of Public Law 2, Seventy-third Congress, approved March 20, 1933, as amended. The present law provides that all veterans with service-connected disabilities, otherwise eligible, shall be furnished complete medical care for such disabilities. This authorization includes medical care for other disabilities which may adversely affect the service-connected disability. The law further provides that war veterans and a limited class of peacetime veterans otherwise eligible with disabilities which are not service-connected are entitled to hospitalization provided beds are available and also provided the veteran is unable to defray the necessary expense of hospitalization, including transportation.

The right to hospital care for service-connected disability is an absolute grant, and the Administrator of the Veterans' Administration has plenary authority to contract for hospitals deemed necessary to afford such hospitalization.

With the foregoing statement of the basic legal entitlement to hospitalization by veterans in mind, the vast extent of the medical program of the Veterans' Administration will be more clearly revealed by a glance at certain statistical facts relating to this program.

GROWTH OF THE PROGRAM

Since March 3, 1919, when the acquisition of Government hospitals was first authorized for the treatment of veterans of World War I, to December 31, 1945, there have been 3,315,780 admissions to hospitals of United States veterans. Patient turn-over indicates the extent to which hospital beds are used. The average period of hospitalization for a general-medical and surgical patient was 38.6 days, for a tuberculosis patient, 173.9 days, for a neuro-psychiatric patient 54.7 days, for a psychiatric or mental patient 370.4 days.

The patient turn-over in all types of hospitals administered by the Veterans' Administration in the last complete fiscal year was approximately once every 3 months and 24 days.

With the increase in number of veterans, increases in all parts of the medical program are anticipated during the current year. During March 1946, 54,464 applications for hospital or domiciliary care were received. The total number of patients remaining in all hospitals the last Thursday of March was 84,730. As of March 31, 1946, the Veterans' Administration had 101 hospitals. There is a Veterans' Administration hospital in every State in the union except three—New Hampshire, Rhode Island, and Delaware. The construction of hospitals in each of these three States has been authorized.

By the enactment of Public Law 293, Seventy-Ninth Congress, approved January 3, 1946, the Congress authorized the establishment of

a Department of Medicine and Surgery in the Veterans' Administration. With the authority of this law we have made a complete and drastic reorganization of the Veterans' Administration Medical Service. The selection of personnel to staff Veterans' Administration hospitals has been greatly expedited and the medical service is attracting outstanding specialists and medical personnel of the highest quality.

The Veterans' Administration is currently authorized to spend over 400 million dollars in the next 2 years in hospital construction. The vastness of this program is understood more readily when it is stated that more money will be spent for veterans' hospital construction in the next 2 years than was spent in the entire preceding 26 years.

In connection with the hospital construction program of the Veterans' Administration I wish to refer to the problem of staffing our hospitals. A hospital without a staff obviously is utterly worthless. In order to secure suitable professional personnel to staff a hospital, a general medical hospital must present a sufficient variety of problems in medical treatment to attract the best quality of medical personnel and to interest younger medical personnel. For this, among other reasons, the program of medical care for non-service-connected disabilities is an important factor in the Veterans' Administration hospital program. Furthermore, a medical staff must be maintained at the highest efficiency and in the maintenance of high professional efficiency the variety of disabilities among the patients is again an essential factor.

The Department of Medicine and Surgery in the Veterans' Administration is initiating new and greatly expanded programs. Arrangements have been made with medical and research centers to provide the Veterans' Administration with consultants, Visiting staffs and residents in hospitals located near these centers.

A staff of nationally known specialists has been appointed to serve as Veterans' Administration consultants. A special program has been instituted for the rehabilitation of blind veterans and for those with impaired hearing. An extensive program of research in prosthetic appliances is under way. A committee of outstanding citizens has been appointed to advise the staff personnel in charge of this program and it is expected that the Veterans' Administration will soon assume leadership in this highly important field.

The Veterans' Administration is giving serious thought to the care and rehabilitation of veterans with neuropsychiatric and mental disabilities. It is planned to bring nationally and internationally known psychiatrists into Veterans' Administration neuropsychiatric hospitals on temporary duty. As most of the Veterans' Administration neuropsychiatric hospitals are remote from medical schools, it is proposed to obtain outstanding psychiatrists for a few days or a week at a time who will lecture to the hospital staff and bring members of the staff up to date in the latest developments in the field. As an extension of the Veterans' Administration program of out-patient care, mental clinics are being established throughout the country; 16 have already been organized, 32 have been authorized, and plans are under way for the eventual establishment of 200 mental hygiene clinics.

It is noted that S. 1606 makes provision for medical research. The Veterans' Administration is also interested in developing an extensive research program. As an agency which has access to the health records

of millions of veterans over a long period of years, it should be able to render great service in the field of medical research. The Tumor Research Unit at the Edward Hines Junior Memorial Hospital, Hines, Ill., has made elaborate studies in this field and has some of the finest equipment in the world. In view of the large number of troops stationed in tropical areas, special research is being done in tropical diseases. Centers for this purpose have been established in the Bronx, New York; Biloxi, Miss.; San Francisco, Calif.; and Washington, D. C. A system of resident training is being instituted, which, together with plans for graduate work and special training for members of the staff, will greatly increase the proficiency of the staff.

In passing I may say that the program of education and vocational rehabilitation authorized by Public Laws 16 and 346, Seventy-eighth Congress, will enable veterans who desire to enter the medical profession to take such training at Government expense.

Another part of the Veterans' Administration medical program has to do with out-patient treatment. The law provides that veterans with service-connected disabilities shall be given out-patient treatment for such disabilities. During February 1946, out-patient medical care was provided 152,381 persons. Of this number 62,107 received treatment and 90,274 were examined. It became clear that new measures must be resorted to if the demand for out-patient treatment and examination was to be handled adequately. The Veterans' Administration, therefore, has developed a plan whereby contractual agreements may be entered into through the cooperation of State medical societies for services of physician members to furnish medical care on a fee basis.

I will refer only briefly to the domiciliary care afforded by the Veterans' Administration. To be eligible for admission to a home, in addition to other requirements unnecessary to mention here, a veteran must be suffering with a permanent disability, tuberculosis, or neuropsychiatric ailment, be incapacitated from earning a living, and have no adequate means of support. This benefit will become more important as veterans become older and undoubtedly it will be in the future, as it has been in the past, a refuge for many veterans in periods of economic distress. On June 30, 1945, there were 8,779 veterans in domiciliary status. Of this number 4.10 percent were veterans of World War II. As of March 28, 1946 there were 11,682 veterans receiving domiciliary care.

The program of medical care administered by the Veterans' Administration is designed for a special group of citizens and is subject to certain specific limitations. I feel that it is a program in which the country takes great pride and one that has been beneficial to all the people of the country as veterans form a considerable portion of the population. Great progress is being made in improving medical service extended to veterans and the American people can well take satisfaction in this program.

The CHAIRMAN. Thank you, General Bradley.

I believe that you know that the President recently sent a letter to me in connection with this matter.

It was introduced in the record the other morning, but I think it would be appropriate for me to read it at this time; it is as follows:

DEAR SENATOR MURRAY:

It has been most gratifying to observe the deep interest displayed and the progress made by the Senate Education and Labor Committee under your

chairmanship in the conduct of the hearings on S. 1606, the bill designed to give legislative effect to a large part of the national health message which I submitted to the Congress on November 9, 1945.

In providing generally for medical and hospital services under S. 1606, it is intended that these most essential and valuable benefits be within the reach of those persons who are not eligible for medical and hospital services under existing laws and be afforded to some persons already eligible therefor, in whole or in part, who for various practical reasons do not have such services made readily available. The latter aspect of the program is deserving of special attention to remove any doubts as to the real effects intended by the proposed legislation.

It is not intended that existing programs of medical and hospital services are to be supplanted. For example, it is not intended that our obligations to veterans for medical and hospital care shall be changed or impaired in either service-connected or non-service-connected cases. The special provisions for veterans under laws administered by the Veterans' Administration reflect our Nation's gratitude for their services, and I urge that when the bill emerges from your committee it provide in explicit terms for the preservation of medical and hospital services under laws administered by the Veterans' Administration.

A national health program such as I have recommended, and as envisaged in S. 1606, would make it possible for persons to get complete medical and hospital services locally. As to veterans, the program would merely provide additional means of securing medical and hospital care. Veterans with non-service-connected disability, in common with others, would become entitled to outpatient treatment. As to persons eligible under other laws, particularly veterans, the program under S. 1606 would include the families of such persons for complete medical and hospital services which benefit is not now available to them.

I have conferred with the Administrator of Veterans' Affairs and the Federal Security Administrator and they share in my convictions.

Sincerely yours,

HARRY S. TRUMAN,
President of the United States.

Now, in view of that recommendation on the part of the President, could you propose to us some amendment which would make it possible to achieve the purpose that the President has in mind there in protecting the veterans' program?

General BRADLEY. We have not one prepared at this time. We will work on it.

The CHAIRMAN. You will undertake to study that matter and propose some amendment?

General BRADLEY. Yes, sir. If that is your desire, we will be glad to do that.

LIMITATION OF THE VETERANS' PROGRAM

The CHAIRMAN. Now, under the existing conditions, it is not possible for the Veterans' Administration to adequately provide medical care for the veterans all over the country, is it?

General BRADLEY. We are able to take care of all service-connected cases and a limited number of non-service-connected cases.

At the present time, about 85 percent of those in general medical and surgical hospitals are non-service-connected, and about 15 percent are service-connected.

We have a waiting list at the present time of approximately 26,000, I believe.

The CHAIRMAN. So that a national program of health care in the country, which would be open to the veterans and to their families, would be a great help?

General BRADLEY. It would certainly furnish an additional means of veterans getting medical service.

The CHAIRMAN. Yes. And the important matter would be to prevent it from supplanting or in any manner interfering with the existing veterans' program?

General BRADLEY. Yes, sir.

The point we are trying to make here is, at the present time disabled veterans are entitled to hospital care without contribution.

The CHAIRMAN. Yes.

General BRADLEY. And we feel that while a contributory system, such as outlined here, although it is not outlined as to how he will pay, while it would provide medical care for his family, he himself would not be getting any additional services by contributing to the system.

The CHAIRMAN. In other words, he is already entitled to the care that the bill would provide?

General BRADLEY. Yes. And to unlimited hospitalization for whatever length of period his sickness requires.

The CHAIRMAN. Yes. So that you believe that it would be appropriate to provide some amendment which might protect the veteran in that right and not in any manner undermine the veterans' program?

General BRADLEY. I do not know enough about it to know whether or not an amendment to this bill is necessary, but when it comes down to setting up the machinery for these people to pay, then is the time, I think, you must be careful you do not charge, particularly a service-disabled veteran, for something he is entitled to.

In fact, for all veterans with non-service-connected disabilities, beds are available in a very large number of instances.

The CHAIRMAN. I see.

Then some program outside of the veterans' program would be a great help to the family of the veterans in the way of providing medical care and hospitalization for them?

General BRADLEY. Well, I should think so. I am not qualified to pass on the benefits of the hospitalization of the whole population, I am afraid. I have only been studying it from the viewpoint of the veteran himself.

The CHAIRMAN. You have not made any study of this bill, S. 1606, with a view of passing your judgment on it?

General BRADLEY. As a whole; no, sir.

Senator ELLENDER. Well, General, would you venture the number of veterans that may not be entitled to the services indicated in your statement?

General BRADLEY. Well, they are all entitled to hospitalization as the result of service-connected disabilities and in eligible non-service-connected cases, if we have a bed available.

Senator ELLENDER. But, are you able to look into the future at the moment and state the number of veterans that may not be entitled to any service under the veterans' program?

In other words, are there any?

General BRADLEY. I do not foresee any; any war veterans who meet eligibility requirements.

Senator ELLENDER. I see.

General BRADLEY. War veterans are entitled to it. Peacetime veterans not in receipt of pension for service-connected disability or not discharged for disability incurred in line of duty and certain other cases are not.

Senator ELLENDER. And this service is for the benefit of those men as well as their families.

General BRADLEY. Not under the laws administered by the Veterans' Administration. The veterans themselves only are eligible.

PROTECTION OF THE VETERANS' FAMILIES

Senator ELLENDER. How would you suggest that we take care of the family of the veteran?

General BRADLEY. Well, that is a thing, I think, you would have to work out, as I understand, in some second part of this bill, where you are going to set up the machinery and the method of financing it. I think it has to be considered very carefully.

Senator ELLENDER. I am just wondering how it would be possible to separate the veteran himself from his family, if it is the desire to aid the family.

You would have to do it, possibly, on the basis of charging a veteran less than you would the individual who is not entitled to the services under the veterans' program?

General BRADLEY. Either that or you may make this contribution dependent on the number in the family, in which case he would be excluded, possibly, as one of the family.

Senator ELLENDER. Yes.

Senator DONNELL. Mr. Chairman, may I ask the General a few questions, please?

The CHAIRMAN. Yes.

General BRADLEY. I might add just one other statement.

Senator DONNELL. Certainly.

General BRADLEY. There are certain veterans not entitled to hospitalization, if they were discharged under other than honorable conditions. A very small group, of course.

Senator ELLENDER. Yes.

Senator DONNELL. General Bradley, in your statement, I observe on page 2, the second full paragraph, this language:

In passing it is noted also that the bill would limit the period of hospitalization, whereas under the laws administered by the Veterans' Administration there is no such limitation. The period of hospitalization is determined by application of medical principles.

I take it from that that the Veterans' Administration proceeds upon the theory that whatever medical principles would demonstrate to be a wise period of hospitalization should govern, rather than some arbitrary number of days fixed without reference to those principles?

General BRADLEY. Some of them are in a few days; some of them are in for years.

Senator DONNELL. Yes, sir.

I notice, for instance, on page 3 of your statement, you point out that "the average period of hospitalization for a general-medical and surgical patient was 38.6 days" but "for a tuberculous patient, 173.9 days," and "for a psychiatric or mental patient 370.4 days."

General, I am wondering if you have read personally, subdivision (c) of section 210 of the bill on page 59, which provides that:

The maximum number of days in any benefit year for which any individual may be entitled to hospitalization benefit under section 201 or 202 shall be 60: Provided, however, That when the Surgeon General finds that moneys in the

account are adequate, he may increase the maximum with respect to hospitalization benefit provided under section 201 or section 202, or both, to not more than 120 days for the following calendar year.

You are familiar with that?

General BRADLEY. That was the reason for making this statement here.

Senator DONNELL. I assumed that that was the reason for your statement calling attention to the fact that under the laws administered by the Veterans' Administration there is no such limitation, and under those laws the period of hospitalization is determined by the application of medical principles.

General BRADLEY. We would hate to see anything affect our present system of hospitalizing for what is necessary, and we do not think anything should be put in this bill, even along that line, which would affect our period of hospitalization.

Senator DONNELL. Yes, sir; I understand that to be your point.

The CHAIRMAN. You think that it would be a wise principle to apply that to this bill?

General BRADLEY. I do not know about that. We did not want anything to affect our present period of hospitalization, because about half of our patients are mental patients who are in for a long time.

Senator DONNELL. General, do you favor the administration of medical and surgical treatments being granted to the veterans in a program administered by the Veterans' Administration?

General BRADLEY. Yes.

Senator DONNELL. Yes, sir.

General BRADLEY. In other words, we think it should continue as it is at the present time.

Senator DONNELL. Yes, sir.

General BRADLEY. For the treatment of veterans. In other words, we would hate to see anything interfere with our present hospitalization program for veterans, as it is already provided by law.

Senator DONNELL. Yes, sir.

The CHAIRMAN. But you feel that to the extent you are not able to provide medical care to the families of the veterans, that it would be a wise thing to permit the Federal Government to handle that situation in some other manner?

General BRADLEY. That would certainly be an entirely different program.

Senator DONNELL. General, would you prefer that medical and surgical services for dependents of veterans should be administered under the facilities of the Veterans' Administration rather than some other facilities?

General BRADLEY. Dependents of veterans?

Senator DONNELL. Yes, sir.

General BRADLEY. No, sir.

Senator DONNELL. You would rather not have them?

General BRADLEY. We would rather not, because we do not believe we can take care of that large a load.

Senator DONNELL. Yes, sir.

The CHAIRMAN. You think, then, that the President's advice on that subject is proper advice, and the Veterans' Administration would go along with the President's program in that direction?

General BRADLEY. Toward the dependents?

The CHAIRMAN. Yes.

General BRADLEY. I am afraid we have not studied that enough to know the practicability of it, and so forth.

The CHAIRMAN. But you think some program should be provided, whether it is this program or some other program?

General BRADLEY. We agree with the President in anything that improves the health of the people of the country, and that is certainly desirable.

We have found, as you know, in examining people that came up for selective service, that what we thought was a lot of men, an alarming percentage of them were not qualified for service. A lot of that was due to defects that might have been corrected at an earlier stage in life.

The CHAIRMAN. To the extent, however, that the Veterans' Administration finds it impossible to render that service to the family and dependents of the veterans, a national program of health insurance would be a proper program, which would provide full and complete care for the families and the dependents of the veterans.

General BRADLEY. Well, I am afraid I am not qualified to testify on the over-all effectiveness of any bill.

The CHAIRMAN. Well, the point I make is this: If it is not possible for the Veterans' Administration to provide adequate medical care and hospitalization to the families of veterans and their dependents, that program should be taken care of in some other manner.

General BRADLEY. We certainly cannot; no, sir.

The CHAIRMAN. No. So that you are in accord with the President's desire to find some manner and means of accomplishing that?

General BRADLEY. Some means; yes.

The CHAIRMAN. Yes. But you do not purport to pass on 1606?

General BRADLEY. That is right.

The CHAIRMAN. As the proper method?

General BRADLEY. That is right.

The CHAIRMAN. You are not examining that and analyzing that bill or passing on it, for or against it?

General BRADLEY. That is right, sir.

The CHAIRMAN. Except to the extent that you do approve of the President's program under which he desires to find some manner of providing for the care of the people generally and particularly of the families and the dependents of the veterans?

General BRADLEY. Some means; yes.

The CHAIRMAN. Yes.

Senator DONNELL. General, by the use of the term "program" as contained in the chairman's question, there might be an ambiguity. I understand, as I think the chairman indicated, in the first place you are in favor of the general desire of the President to see that adequate measures of some kind be taken for the public health?

General BRADLEY. That is right.

Senator DONNELL. Point No. 1.

But as to whether or not S. 1606, this bill, would accomplish those results satisfactorily, you are not undertaking to testify?

General BRADLEY. I do not feel qualified to say.

Senator DONNELL. You have not studied that bill with that in mind: That is correct, is it not?

General BRADLEY. Yes, sir.

Senator DONNELL. General, going back for just a moment to the veterans, do you feel that it is wise that the Veterans' Administration, itself, shall provide complete medical care for veterans including non-service-connected disabilities?

General BRADLEY. The question of furnishing complete medical service is dependent on two things.

Senator DONNELL. Yes, sir.

General BRADLEY. First, the desire of Congress to build that many hospitals and pay that much for it.

Second, on whether or not you will ever be able to get enough doctors for full-time service with the Government to staff that many hospitals.

Senator DONNELL. Would you regard it as desirable, General, that a veteran receive medical care under two different programs, as, for illustration, have his military wound cared for in a veterans' hospital, and his treatment for some other disability of a lung nature, for instance, cared for in another hospital? Would you favor that?

General BRADLEY. I do not think that would be necessary, because a man with a service-connected disability is entitled to both hospitalization and out-patient service. In many cases the non-service-connected disability aggravates the service connected disability or in the example you cite a bed would probably be available.

Senator DONNELL. Yes, sir.

General BRADLEY. And with the program we are working on now, we would be able to furnish that out-patient service for the first two types I mentioned reasonably near his home.

Senator DONNELL. Yes, sir.

General BRADLEY. In a serious ailment, or periods when he has to have hospital care, that would be furnished in a veterans' hospital not too far away, after we have these new hospitals constructed.

We believe, in general, he would prefer to have that out-patient service furnished by us in his own community or in one of our hospitals. At least, we believe we can make that hospital service second to none and one a man would be proud of.

Senator DONNELL. And I take it you would favor the idea of the veteran following through and having his treatment under the Veterans' Administration, and this out-patient service, if sufficient funds are granted by Congress, to bring that about.

General BRADLEY. That is right.

Senator DONNELL. Rather than having two programs under which he would receive part of his treatment in one hospital and part under another program. Am I right in that?

General BRADLEY. I do not see any particular advantage to furnishing a second one to the man himself, particularly a disabled veteran, who is entitled to full hospital care.

Senator DONNELL. In fact, two programs might prove confusing and would duplicate services.

General BRADLEY. I would not say it would be confusing at all.

Senator DONNELL. You would not?

General BRADLEY. The point we are trying to make, here is a man who is already entitled to hospitalization.

Senator DONNELL. Yes.

General BRADLEY. So, in working out any scheme for a national health program in which you are going to have a contributory system,

we think you must give careful consideration that you do not charge a disabled veteran for something which is already provided by the Federal Government.

Senator DONNELL. I do not think I made my question quite clear.

Here is a veteran. I understand you would like, if possible, to administer hospital care and out-patient treatment to that veteran rather than have part of the treatment administered by the Veterans' Administration and part of it by some other independent fashion.

General BRADLEY. I do not think that would be our choice. I think that would be his.

Senator DONNELL. But you think there is an advantage having the veteran receive treatment for these various disabilities of all kinds from the Veterans' Administration? You believe that to be true, do you not, General?

General BRADLEY. I do not see if it would be any more advantageous. But we think this is a good service and we do not think he should be charged for another one unless he particularly wants to, because of protection to his family.

Senator DONNELL. Yes.

General BRADLEY. If he wants to join another system, because of local conditions or desire to protect his family, this of course, would provide that for him.

Senator DONNELL. Yes, sir.

OUT-PATIENT TREATMENT UNDER VETERANS' PROGRAM

The CHAIRMAN. General, because of this great demand on the veterans' service, you have entered into some arrangement whereby the veterans may receive out-patient treatment from the medical profession.

How has that been accomplished? How do you handle that situation?

General BRADLEY. We are trying to make arrangements in most cases with the State Medical Society, because most of the qualified doctors usually belong to that.

The CHAIRMAN. Yes.

General BRADLEY. And it is machinery already set up, with which we can deal without setting up of additional overhead to handle it.

The CHAIRMAN. I see.

General BRADLEY. We make the arrangement with them. We are planning on a scheme whereby the veteran who has a disability will carry a card which shows what his disability is. When he gets sick, caused by that disability, he can take that card to a doctor accredited by us, get his treatment, and the doctor sends in the bill through the Medical Society to our State regional office, and it is paid.

That is what we are working toward. It has not been accomplished fully in all States.

The CHAIRMAN. You enter into contracts with the medical societies in the various States under which they will undertake to provide this out-patient treatment to veterans?

General BRADLEY. That is done in some States.

The CHAIRMAN. That is done in some States.

General BRADLEY. We have not furnished that completely.

The CHAIRMAN. You have negotiated some contracts of that kind in certain States?

General BRADLEY. Yes.

The CHAIRMAN. Have you got a copy of that contract?

General BRADLEY. It varies with each State, because they all have different machinery set up in the various States.

The CHAIRMAN. I see.

How are the fees worked out?

General BRADLEY. That is worked out with the State Medical Society.

The CHAIRMAN. With the State Medical Society.

General BRADLEY. Depending on the customs in the particular part of the country, and they vary from State to State, but it is worked out with negotiation with the State society.

The CHAIRMAN. So the fees are not necessarily the same in all the States?

General BRADLEY. That is right.

The CHAIRMAN. How many States have you already entered into contracts with, contracts of that kind?

General BRADLEY. I am afraid I do not have that figure. I can furnish that.

The CHAIRMAN. Will you furnish that and give us the form of the contracts?

(The information is as follows:)

VETERANS' ADMINISTRATION,
Washington 25, D. C., April 20, 1946.

Hon. JAMES E. MURRAY,

United States Senate, Washington, D. C.

MY DEAR SENATOR MURRAY: Reply is made to your letter of April 10, 1946, in which you indicate that the Committee on Education and Labor needs a summary of the Veterans' Administration program of contracting for health services with physicians, dentists, and hospitals, or with organizations representing them.

The Veterans' Administration is consummating contracts with an intermediary in each State, which contracts authorize the intermediaries to solicit subcontracts with all individual hospitals in their respective States, and expedite administrative procedures incidental to hospitalization of eligible veterans, including payments to the approved hospitals.

Contracts and subcontracts are executed on a cost basis subject to Veterans' Administration approval.

At present the Veterans' Administration has active hospital contracts in Michigan, North Carolina, and Kansas. Contracts with Oregon and Maine are in central office, Washington, for approval as of this date.

Further, negotiations are actively under way in the following States: North Dakota, South Dakota, Rhode Island, Iowa, Louisiana, Minnesota, Oklahoma, Washington, Alabama, Wisconsin, Indiana, Arizona, Pennsylvania, New York, Ohio, Missouri, New Hampshire, Vermont, Virginia, Tennessee, Illinois, California, Colorado, and Massachusetts.

In all, 40 of the States have to date, officially endorsed the Veterans' Administration program through their State hospital associations.

In cooperation with the Committee on Economics, American Dental Association, there has been accomplished a revision of the fee schedule which has received the approval of the chief medical director. This revised fee schedule will be used as a control schedule with deviation permitted at State level, to meet fees usually charged for similar services. At the present time necessary action is being taken to have this approved fee schedule printed in the appendix, Regulations and Procedure (A) 6015 of the Veterans' Administration, and the publication of required instructions for its operation.

You are advised that it is not the intent of the dental service of the Veterans' Administration to negotiate separate contracts with dentists or hospitals to furnish treatment to eligible beneficiaries. It is believed that the operation of this approved fee schedule as planned, will meet the requirements of the dental service and afford the opportunity for all ethical dentists to participate in this program.

In order to render prompt and efficient service to eligible veterans in need of treatment on an out-patient basis agreements or contracts have been arranged

with a number of States and it is anticipated that when this work is completed, there will be an agreement together with a fee schedule for each State in the Union. At the present time there are agreements in successful operation within the States of Washington, Oregon, California, Kansas, Michigan, New Jersey, North Carolina, and the District of Columbia. There are in the process of negotiation and completion, proposals from a number of other States. These contracts are with the State medical societies or with an organization recommended to the Veterans' Administration by the State medical societies. These agreements will make available medical services on an out-patient basis to each eligible veteran in the locality where he resides.

In addition, the Veterans' Administration has many contracts and agreements with mental hygiene clinics, out-patient departments of hospitals, general medical and surgical clinics where out-patient treatment will be available. These contracts and agreements will supplement the work of our own full-time clinics in operation in regional offices and subregional offices and out-patient departments of our own hospitals.

Very truly yours,

OMAR N. BRADLEY,
General, United States Army,
Administrator.

VETERANS' ADMINISTRATION CONTRACTS FOR MEDICAL SERVICES NEGOTIATED THROUGH
COOPERATION OF STATE MEDICAL SOCIETIES

The Department of Medicine and Surgery of the Veterans' Administration has been faced with the problem of securing a tremendous number of examinations for compensation and pension purposes, and in rendering out-patient treatment and hospital care to a far greater number of eligible veterans than could be handled by our own medical staffs and hospital facilities. We have, accordingly, solicited the help of the medical profession throughout the country in meeting our obligations to ex-service men and women. In accordance with this policy, agreements have been made, through the cooperation of various State medical societies, for furnishing medical service to veterans in Kansas, Michigan, California, New Jersey, Oregon, Washington, North Carolina, West Virginia, Maine, and Ohio. Negotiations are now in process for furnishing medical service to veterans in a number of other States, including Massachusetts, New York, Pennsylvania, Illinois, Colorado, Connecticut, Florida, Indiana, Iowa, Minnesota, Missouri, Montana, Nebraska, North Dakota, South Dakota, Tennessee, Utah, and Wisconsin.

So far two types of plans have been evolved for furnishing medical services. Typical of these two types are those of Kansas and Michigan. There are attached hereto copies of the agreement made with the Kansas State Medical Society and the applicable schedule of fees. There are also attached a copy of the contract signed with the Michigan Medical Service (sponsored by the Michigan State Medical Society) and the applicable fee schedule.

It will be noted that the essential difference between the Kansas and the Michigan plans is that the Veterans' Administration pays the Kansas physicians direct for services rendered, whereas in Michigan, the physicians are paid by the Michigan Medical Service who, in turn, bill the Veterans' Administration at the end of each month for all the services rendered under the contract. The fees paid by the Veterans' Administration to the Michigan Medical Service include a 7 percent overhead to cover the administrative costs of carrying out the terms of the contract, such as the making of contacts, maintenance of records, making of reports of examinations and treatments, progress reports, etc. (Under the Kansas agreement the administrative aspects are handled directly by the Veterans' Administration.) The fees charged are based on the type of services rendered and are not in excess of those charged for similar services in the communities concerned. In fact, they are usually lower than the prevailing fee charged the general public.

All of the State medical societies so far contacted have been very cooperative in entering into agreements for furnishing medical services to veterans either under the so-called Kansas or Michigan plans.

There have been instances, however, in which individual physicians have refused to render service through an intermediary, such as the Michigan Medical Service. In such instances, it has been the policy of this office, if the physician concerned is qualified and of good standing, to appoint him as a fee designated

physician and to pay him direct for services rendered at the same rate he would be paid if he was registered with and working through the Michigan Medical Service.

With regard to contracts for hospital care, it may be stated that in collaboration with the American Hospital Association, the Blue Cross Plan Commission, various State hospital associations, and Federal agencies, including the Department of Labor, Federal Security Agency, and the Budget Bureau, the Veterans' Administration has developed a plan for the purchase of hospital care, in which plan an intermediary is designated by the Veterans' Administration, upon approval of the State hospital associations and the medical profession as a whole. The designated participants are authorized to solicit contracts with private, civil, and State hospitals for the use of available beds in the hospitalization of eligible veterans.

Civilian hospitals, under this program, are required to submit certified statements of operational costs similar to those submitted for participation in other Federal hospitalization programs, namely, Emergency Maternity Infant Care (EMIC) and Vocational Rehabilitation (Crippled Children's Program).

The objects in this program are:

- (a) To expedite hospitalization to eligible veterans.
- (b) To provide hospitalization as near to the homes of eligible veterans as possible when no beds are feasibly available in Veterans' Administration or any other governmental hospitals.
- (c) To provide prompt payment to private, civil, and State hospitals where such hospitalization is utilized.

Participants in this program function on a nonprofit basis, and are allowed reimbursement for administrative costs only. These costs have been set at 7 percent in all instances with the exception of that in North Carolina, where administrative costs of 8 percent were justified. At the present time, the Veterans' Administration has contracts with intermediaries in the following States: Michigan, North Carolina, Oregon, Kansas, and Maine. Negotiations are actively under way for contracts in an additional 27 States.

It is of interest that at the mid-year conference of the American Hospital Association, February 7, 8, 9 of this year, 41 of the States endorsed the Veterans' Administration program in principle. The remaining 7 States were absent from that conference.

Specimen copies of the North Carolina and Kansas contracts follow.

WASHINGTON, D. C., November 30, 1945.

Maj. Gen. PAUL R. HAWLEY,
Acting Surgeon General, Veterans' Administration,
Washington, D. C.

MY DEAR GENERAL HAWLEY: In accordance with a conference held in your office this date the Kansas State Medical Society proposes the following program in rendering medical services to veterans residing in the State of Kansas:

1. The Kansas State Medical Society will submit a list of its members who desire to do work for the Veterans' Administration in accordance with the attached schedule of fees in relation to examinations, office, out-patient care, and hospital care. It is proposed that for a general examination the regular blank, Medical form 2545, would be filled and completed in accordance with the instructions on said blank.

2. The Kansas State Medical Society will furnish to the Veterans' Administration a list of the physicians who are competent to do such work in their respective fields. On the basis of these lists which will be submitted to the manager, Wichita, Kans., Veterans' Center and which will be augmented from time to time, members of the society will be appointed as fee-designated Veterans' Administration physicians.

3. The Kansas State Medical Society proposes to zone the State in order that the nearest qualified physician will be called upon to render the medical service.

4. The Veterans' Administration will establish an office adjacent to the office of the Kansas State Medical Society in Topeka, Kans., which office will be staffed with a full-time or part-time Veterans' Administration physician and adequate clerical personnel to handle the administrative work. It will be the function of the Veterans' Administration physician to authorize out-patient examinations and treatments (in-patient and out-patient) and to arrange for the necessary transportation of the veteran. The Veterans' Administration physi-

cian will review reports of examinations and reports of treatments rendered to determine their adequacy and will return those deemed inadequate to a board of physicians appointed by the Kansas State Medical Society for indicated action. No fees will be paid for examinations or reports which are not acceptable to the Veterans' Administration. It shall be the duty of the board appointed by the Kansas State Medical Society to disqualify any physician from further work with the Veterans' Administration whose work is incomplete or unsatisfactory at the discretion of the board.

5. The Kansas State Medical Society does not propose to make any charge for any service rendered to the Veterans' Administration in connection with the supervision of the work performed by its members. It is the purpose of the Kansas State Medical Society in collaboration with the Veterans' Administration to render the best possible medical service to veterans in the State of Kansas.

Respectfully submitted.

KANSAS STATE MEDICAL SOCIETY,
By W. P. CALLAHAN, President.

*Schedule of fee submitted by the Kansas Medical Society and approved by the
Veterans' Administration*

1. Bronchoscopy	\$40.00
2. Bronchoscopy and biopsy	50.00
3. Dermatological examination	7.00
4. Electrocardiogram with interpretation	10.00
5. Esophagoscopy	40.00
6. Examination of ears, nose, and throat (separately or together)	5.00
7. Special ear examination, including audiometric test, with chart	10.00
8. Special ear examination to include either caloric or Barany test, or both, with report	10.00
9. Examination of eyes (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings—the latter by chart in all cases of optic atrophy)	10.00
10. Examination of eyes with refraction, if mydriatic is used (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings—the latter by chart in all cases of optic atrophy)	12.50
11. Combined examination of eyes, ears, nose, and throat, with refraction (with or without mydriatic)	15.00
12. Gastroscopy	40.00
13. Genitourinary examination without cystoscopy	5.00
14. Genitourinary examination with cystoscopy	15.00
15. Genitourinary examination with cystoscopy and ureteral catheterization	25.00
16. Gynecological examination	5.00
17. Complete examination of heart, including electrocardiography	15.00
18. Physical examination of heart or lungs, or both	10.00
19. Neurological examination (complete)	5.00
20. Neuropsychiatric examination (complete)	10.00
21. Routine office examination, including treatment	3.00
22. Orthopedic examination	7.50
23. Physical examination to determine need for hospitalization	3.00
24. Complete physical examination	7.50
25. Proctoscopy or sigmoidoscopy	7.50
26. General surgical examination	5.00

SIMPLE FRACTURES

27. Carpal bone, one	35.00
28. Carpal bones, each additional	5.00
29. Clavicle	40.00
30. Coccyx removal	50.00
31. Femur	125.00
32. Femur, when suture, plating or nailing is necessary	135.00
33. Fibula or tibia, or both (including Potts fracture)	75.00

Schedule of fee submitted by the Kansas Medical Society and approved by the Veterans' Administration—Continued

34. Fibula or tibia, or both (including Potts fracture) when suture or plating is necessary-----	\$100.00
35. Finger, one-----	15.00
36. Fingers, each additional-----	5.00
37. Humerus-----	75.00
38. Humerus, when suture or plating is necessary-----	100.00
39. Malar bone-----	20.00
40. Maxilla inferior (wiring if necessary) Double-----	75.00 100.00
41. Maxilla superior (wiring if necessary) or raising-----	75.00
42. Metacarpel, bone, one-----	15.00
43. Metacarpal bones, each additional-----	5.00
44. Metatarsal bone, one-----	20.00
45. Metatarsal bones, each additional-----	5.00
46. Nasal bones-----	25.00
47. Patella-----	50.00
48. Patella, when suture or plating is necessary-----	75.00
49. Pelvis-----	100.00
50. Pelvis, when suture or plating is necessary-----	125.00
51. Radius or ulna, or both (including Colles' fracture)-----	50.00
52. Radius or ulna, or both (including Colles' fracture), when suture or plating is necessary-----	75.00
53. Rib, one-----	15.00
54. Ribs, each additional-----	5.00
55. Sacrum-----	50.00
56. Scapula-----	50.00
57. Skull-----	100.00
58. Sternum-----	75.00
59. Tarsal bone, one-----	15.00
60. Tarsal bones, each additional-----	5.00
61. Toe, one-----	15.00
62. Toes, each additional-----	5.00
63. Vertebra, one or more-----	100.00

NOTE.—These amounts include 30 days' routine aftercare, exclusive of hospital charges, anesthetic, and X-ray fees.

COMPOUND FRACTURES

In all compound fractures add 40 percent additional fee.

DISLOCATIONS

64. Carpel bone, one-----	\$25.00
65. Carpal bones, each additional-----	5.00
66. Clavicle-----	35.00
67. Elbow-----	35.00
68. Finger, one-----	10.00
69. Fingers, each additional-----	5.00
70. Hip-----	60.00
71. Knee-----	50.00
72. Maxilla inferior-----	15.00
73. Metacarpal bone, one-----	15.00
74. Metacarpal bones, each additional-----	5.00
75. Metatarsal bone, one-----	15.00
76. Metatarsal bones, each additional-----	5.00
77. Patella-----	40.00
78. Pelvis-----	75.00
79. Shoulder-----	40.00
80. Shoulder, recurrent or habitual-----	35.00
81. Tarsal bone, one-----	15.00
82. Tarsal bones, each additional-----	5.00
83. Thumb-----	15.00
84. Toe, one-----	10.00
85. Toes, each additional-----	5.00
86. Vertebra, one or more-----	100.00

Schedule of fee submitted by the Kansas Medical Society and approved by the Veterans' Administration—Continued

AMPUTATIONS

87. Upper arm	\$100.00
88. Forearm	75.00
89. Finger, one	25.00
90. Fingers, each additional	10.00
91. Foot	75.00
92. Hand	75.00
93. Leg	75.00
94. Thigh	100.00
95. Toe	25.00
96. Toes, each additional	10.00

NOTE.—These amounts include 30 days' routine after care exclusive of hospital charges, anesthetic, and X-ray fees.

ABSCESSES, INCISION AND DRAINAGE

97. Brain abscess	150.00
98. Cellulitis, incision and drainage	25.00
99. Deep abscess (including Ishiorectal)	40.00
100. Empyema, incision and drainage, including rib resection	100.00
101. Liver abscess	150.00
102. Oral abscess (not to include dental or peridental)	15.00
103. Prostatic abscess, incision and drainage	75.00
104. Superficial abscess	5.00
105. Subphrenic abscess	150.00

NOTE.—These amounts include 30 days' routine after care, exclusive of hospital charges, anesthetic, and X-ray fees, except as to items numbered 99 and 104.

OPERATIONS

106. Abdominal, fixation for prolapse of rectum	125.00
107. Adenectomy, cervical, inguinal, etc. (minor)	20.00
108. Adenectomy, cervical, inguinal, etc. (radical)	125.00
109. Anal fissure, operation for	75.00
110. Anastomosis, intestinal	150.00
111. Anastomosis, uretero-intestinal	150.00
112. Ankle joint, excision of	75.00
113. Apicolysis	100.00
114. Appendectomy	100.00
115. Arthroplasty, major joint	125.00
116. Biopsy	10.00
117. Bone graft (long bones)	150.00
118. Bone plate, removal of	50.00
119. Breast, resection of (simple)	75.00
120. Breast, resection of (radical)	150.00
121. Caricinoma of lower lip, excision of	50.00
122. Caricinoma of rectum, excision of	200.00
123. Carcinoma of tongue, excision of	75.00
124. Cardiospasm, dilatation for	25.00
125. Cartilage of condyle of femur, removal of	70.00
126. Semilunar cartilage, removal from joint	75.00
127. Cervix, amputation of	75.00
128. Cholecystectomy	150.00
129. Cholecystotomy	100.00
130. Choledochotomy	150.00
131. Chordotomy	125.00
132. Circumcision	25.00
133. Claw foot, operation for	75.00
134. Coccyx, excision of	50.00
135. Colostomy	100.00
136. Colporrhaphy and perineorophy	100.00
137. Cystotomy, cuprapubic	75.00
138. Dupuytren's contraction, operation for	100.00
139. Elbow joint, excision of	75.00

Schedule of fee submitted by the Kansas Medical Society and approved by the Veterans' Administration—Continued

140. Epididymectomy	\$10.00
141. Esophagus, dilation of by means of Bougies or sounds	10.00
142. Femoral artery, ligation of	75.00
143. Fecal fistula, abdominal, operation for	150.00
144. Fistula, rectovaginal, operation for	100.00
145. Fistula, urethral, operation for:	
First	50.00
Second	25.00
146. Fistula, vesicovaginal, operation for	75.00
147. Fistula-in-ano, operation for	75.00
148. Fulguration of tumor of bladder:	
Closed	50.00
Open	75.00
149. Fulguration of tumor, superficial	10.00
150. Gasserian ganglion, excision of	150.00
151. Gastrectomy (partial)	150.00
152. Gastroenterostomy	150.00
153. Hallux valgus, operation for	75.00
154. Hallux valgus, bilateral, operation for	75.00
155. Hammer toe, operation for	25.00
156. Heart, operations on	150.00
157. Hemorrhoidectomy	75.00
158. Herniotomy, diaphragmatic	150.00
159. Herniotomy, ventral, \$100.00; inguinal, \$75.00, or femoral, \$75.00.	
160. Herniotomy, ventral, \$100.00; inguinal, or femoral (bilateral)	125.00
161. Hip joint, excision of	150.00
162. Hydrocele, aspiration of	5.00
163. Hydrocele, operation for	50.00
164. Hysterectomy, abdominal or vaginal (including removal of adnexa, if indicated)	150.00
165. Ingrown toenail, excision of	15.00
166. Intestinal obstruction, operation for	100.00
167. Knee joint, excision of	100.00
168. Laminectomy	150.00
169. Laparotomy and drainage, general peritonitis	125.00
170. Litholapaxy	75.00
171. Lobectomy	150.00
172. Meckel's diverticulum, excision of	125.00
173. Nephrectomy or Nephrotomy	150.00
174. Nephropexy	150.00
175. Nerve, suture of	100.00
176. Supraorbital nerve, injection of	10.00
177. Neuroma, resection of	75.00
178. Orchidectomy	75.00
179. Osteomyelitis, operation for. Depended on site	40.00 to 100.00
180. Ovariotomy	100.00
181. Papilloma of bladder, operation for	100.00
182. Paracentesis of abdomen	15.00
183. Paracentesis of pericardium	25.00
184. Paracentesis of thorax	25.00
185. Perineum, repair of	75.00
186. Phrenic nerve operation	75.00
187. Pneumolysis, extrapleural or intrapleural	100.00
188. Pneumonectomy	200.00
189. Pneumonotomy, cautery	100.00
190. Pneumoperitoneum, first induction	25.00
191. Pneumoperitoneum, refills	10.00
192. Artificial pneumothorax, first induction	25.00
193. Artificial pneumothorax, refills	10.00
194. Prostatectomy, perineal	150.00
195. Prostatectomy, suprapubic (one or two stages)	150.00
196. Prostatic resection, transurethral	125.00
197. Cisterna puncture, including local anesthetic and obtaining fluid	50.00
198. Lumbar puncture, including local anesthetic and obtaining fluid	10.00

Schedule of fee submitted by the Kansas Medical Society and approved by the Veterans' Administration—Continued

199. Pyelotomy, with removal of calculus-----	\$150.00
200. Pyloroplasty-----	125.00
201. Salpingectomy-----	150.00
202. Sealenotomy-----	50.00
203. Sequestrum, removal of (deep) depending on size and location-----	150.00
204. Sequestrum, removal of (superficial)-----	25.00
205. Shoulder joint, excision of-----	125.00
206. Skull, decompression of-----	150.00
207. Fixation of spine, operation for (Albee or Hibb's)-----	150.00
208. Splenectomy-----	125.00
209. Stricture of rectum, operation for-----	50.00
210. Sympathectomy, cervical-----	175.00
211. Sympathectomy, periarterial-----	100.00
212. Tenorrhaphy, one-----	40.00
213. Tenorrhaphy, each additional-----	15.00
214. Tenotomy-----	35.00
215. Thoracotomy-----	100.00
216. Thoracoplasty, each stage-----	125.00
217. Thyroid artery, ligation of-----	75.00
218. Thyroidectomy-----	150.00
219. Torticollis, operation for-----	75.00
220. Tumor, abdominal, removal of-----	125.00
221. Tumor of brain, operation for-----	200.00
222. Tumor, gastrointestinal tract, resection of, including intestinal anastomosis-----	200.00
223. Tumor or cyst, deep, removal of. Depending on site-----	25.00 to 50.00
224. Tumor or cyst, superficial, removal of-----	10.00
225. Ulcer, gastric or duodenal, operation for-----	150.00
226. Ureteral stone, removal of-----	125.00
227. Urethral stricture, dilation of-----	5.00
228. Urethrotomy, external-----	40.00
229. Urethrotomy, internal-----	40.00
230. Prolapsus uteri, operation for, including perineal repair-----	150.00
231. Uterine displacement, abdominal, operation for-----	125.00
232. Uterus, dilatation and currétage of-----	50.00
233. Varicocele, operation for-----	50.00
234. Varicose veins, injection treatment, each injection-----	5.00
235. Varicose veins, one leg, operation for-----	75.00
236. Varicose veins, both legs, operation for-----	125.00
237. Venesection-----	15.00
238. Whitehead's operation-----	75.00
239. Wrist joint, excision of-----	75.00

NOTE.—These amounts include 30 days past operative exclusive of hospital charges, anesthetic, and X-ray fees.

SURGICAL CARE OF TRAUMATIC WOUNDS

240. Incised. Depending on size and location-----	{ 5.00 to 50.00
241. Lacerated. Depending on size and location-----	{ 5.00 to 50.00
242. Punctured. Depending on size and location-----	{ 5.00 to 50.00

NOTE.—These amounts include 30 days routine after care, exclusive of hospital charges, anesthetic, and X-ray fees.

ANESTHESIA

243. Avertin anesthesia-----	10.00
244. General anesthetic :	
(a) By visiting physician-----	15.00
(b) By interne or nurse-----	5.00

(In case of gas anesthesia, an additional allowance of \$5 may be authorized for the gas used.)

Schedule of fee submitted by the Kansas Medical Society and approved by the Veterans' Administration—Continued

245. Local anesthesia—no fee will be allowed for local anesthesia in cases which require a local anesthetic for examination, treatment, or surgical operation.	
246. Rectal anesthesia-----	\$10.00
247. Spinal anesthesia, including anesthetic-----	20.00

EYE OPERATIONS

248. Cataract, needling operation for-----	50.00
249. Cataract, operation for-----	100.00
250. Chalazion, operation for-----	10.00
251. Corneal ulcer, cauterization of-----	10.00
252. Extensive peripheral corneal ulcer, cauterization of-----	20.00
253. Ectropion, operation for-----	50.00
254. Entropion, operation for-----	50.00
255. Eneucleation of eye-----	75.00
256. Foreign body, removal from conjunctiva (dissection)-----	15.00
257. Foreign body, removal from conjunctiva (magnet)-----	10.00
258. Foreign body, removal from cornea (dissection)-----	25.00
259. Foreign body, removal from cornea (magnet)-----	20.00
260. Foreign body, removal from eyeball (deep)-----{	50.00
	75.00
261. Grattage of lids for trachoma-----	10.00
262. Hordeolum, operation for-----	5.00
263. Iridectomy-----	75.00
264. Lacrymal duct, dilatation of-----	10.00
265. Lacrymal sac, excision of-----	50.00
266. Pterygium, operation for-----	50.00
267. Ptosis, skin and tarsal resection, operation for-----	75.00
268. Strabismus, operation for-----	100.00

NOTE.—These amounts include 30 days routine after care, exclusive of hospital charges, anesthetic, and X-ray fees.

EAR OPERATIONS

269. Mastoid, acute, operation for-----	100.00
270. Mastoid, radical, operation for-----	150.00
271. Ossiculectomy-----	75.00
272. Paracentesis-----	10.00
273. Polypus, removal of-----	25.00
274. Lateral sinus, drainage of-----	150.00

NOTE.—These amounts include 30 days routine aftercare, exclusive of hospital charges, anesthetic, and X-ray fees.

NOSE AND THROAT OPERATIONS

275. Adenoidectomy-----	25.00
276. Antrum, intranasal, drainage of-----	25.00
277. Antrum, radical, operation for-----	100.00
278. Cleft palate, operation for, complete closure-----	150.00
279. Harelip, operation for-----	75.00
280. Intubation-----	35.00
281. Laryngectomy-----	150.00
282. Larynx, cauterization of-----	10.00
283. Tumor of larynx, removal of-----	100.00
284. Nasal, Polypus, removal of-----	25.00
285. Nasal septum, submucous resection of-----	75.00
286. Pharyngeal abscess, operation for-----	20.00
287. Accessory nasal sinuses, irrigation of-----	10.00
288. Ethmoid sinus, radical, operation for-----	75.00
289. Frontal sinus, intranasal, drainage of-----	50.00
290. Frontal sinus, radical, operation for-----	100.00
291. Sphenoid sinus, drainage of-----	50.00
292. Tonsillar abscess, operation for-----	20.00

Schedule of fee submitted by the Kansas Medical Society and approved by the Veterans' Administration—Continued

293. Tonsillectomy	\$35.00
294. Tonsillectomy and adenoidectomy	45.00
295. Tracheotomy	75.00
296. Turbinete bone, galvano-cauterization of	20.00
297. Turbectomy	25.00

NOTE.—These amounts include 30 days routine aftercare, exclusive of hospital charges, anesthetic, and X-ray fees.

X-RAY WITH INTERPRETATION

298. Abdomen, flat plate	10.00
299. Ankle joint, anteroposterior and lateral views	7.50
300. Arm, humerus, anteroposterior and lateral views	10.00
301. Bladder, with injection, anteroposterior view	10.00
302. Chest, for pulmonary, cardiac or rib fracture, diagnosis, plain	10.00
303. Chest, for pulmonary, cardiac or rib fracture diagnosis, stereoscopic	15.00
304. Clavicle, anteroposterior view	7.50
305. Elbow, anteroposterior and lateral views	7.50
306. Fluoroscopy, when required without film	5.00
307. Foot, anteroposterior and lateral views	7.50
308. Forearm, radius and ulna, anteroposterior and lateral views	7.50
309. Foreign body in eye, location of (the fragment charted in three planes and its dimensions ascertained by the method of Sweet or equivalent	25.00
310. Gall bladder, Graham technic, including cost of dye	15.00
311. Gastrointestinal tract, complete X-ray study including fluoroscopy	35.00
312. Hand, anteroposterior and lateral views	5.00
313. Hip joint, anteroposterior view, plain	10.00
314. Hip joint, anteroposterior view, stereoscopic	15.00
315. Intestine, barium enema, 14 by 17 films for positions and outline	10.00
316. Jaw, upper and lower	7.50
317. Kidneys, right and left for comparison	10.00
318. Knee joint, anteroposterior and lateral views	7.50
319. Leg, tibia and fibula, anteroposterior and lateral views	7.50
320. Lipiodel injection for bronchiectasis, etc., including roentgenograms	25.00
321. Pelvis, anteroposterior view, plain	10.00
322. Pelvis, anteroposterior view, stereoscopic	15.00
323. Pyleography, using uroselectan or similar preparation (including cost of drug)	15.00
324. Pyleography, retrograde	7.50
325. Scapula	25.00
326. Shoulder joint, anteroposterior view, plain	7.50
327. Shoulder joint, anteroposterior view, stereoscopic	10.00
328. Sinuses, frontal and ethmoid, anteroposterior and lateral views	10.00
329. Sinuses, mastoid, right and left sides for comparison	10.00
330. Sinuses, maxillary, anteroposterior and lateral views	10.00
331. Sinuses, frontal, ethmoid and maxillary, anteroposterior and lateral views	15.00
332. Skull, anteroposterior and lateral views, plain	10.00
333. Skull, anteroposterior and lateral views, stereoscopic	15.00
334. Spine, cervical, anteroposterior and lateral views	10.00
335. Spine, dorsal, anteroposterior and lateral views	12.50
336. Spine, lumbosacral, with coccyx, anteroposterior and lateral views	12.50
337. Spine, entire (items 334, 335, and 336)	22.50
338. Stomach, barium or bismuth meal, 14 by 17 film; after ingestion, four 8 by 10 films for detection of duodenal cap; total of five films, including fluoroscopy	25.00
339. Teeth, single (up to and including 7 films) each	1.00
340. Teeth, series (7 films to and including full mouth) series	7.00
341. Thigh, femur, anteroposterior and lateral views	7.50
342. Wrist, anteroposterior and lateral views	5.00

Schedule of fee submitted by the Kansas Medical Society and approved by the Veterans' Administration—Continued

INTERPRETATION OF ROENTGENOGRAMS

343. Bones and joints, plain anteroposterior and lateral views-----	\$5.00
344. Chest for pulmonary diagnosis, plain or stereoscopic-----	5.00
345. Gastrointestinal series-----	5.00
346. Genitourinary tract-----	5.00
347. Kidney films-----	5.00
348. Skull, following ventriculography or encephalography-----	5.00
349. X-ray therapy, deep, per treatment-----	10.00-25.00

(Maximum expenditure allowed not to exceed \$100 where additional treatments are necessary, special authority must be obtained from central office.)

350. X-ray therapy, superficial-----	5.00
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MISCELLANEOUS

351. Blood transfusion-----	35.00
352. Amount allowed for blood furnished, when not donated, per 100 cc-----	5.00
353. Application of plaster cast, chest (including material)-----	15.00
354. Application of plaster cast, thighs and hips (including material)-----	25.00
355. Application of plaster cast, thigh and leg (including material)-----	10.00
356. Application of plaster cast, torso (including material)-----	25.00
357. Application of plaster cast, torso and hips (including material)-----	30.00
358. Application of plaster cast, torso, entire body (chest to feet, including material)-----	50.00
359. Application of plaster cast for disease or injury of vertebrae (including material)-----	15.00
360. Office visit-----	2.00

Day calls at fee of \$3 will be paid to home or hospital. It is understood that a call will be classified as any call within the city limits of any incorporated city. Night calls will apply the same with a fee of \$5 to home or hospital. It will be the duty of the Kansas Medical Society to see that the State is zoned whereby the nearest physician in rural districts must be called in case of emergency. The veteran will not be allowed to call a physician from a farther distance of his own accord. In zoning an arbitrary line must be divided upon all sides of the nearest physician in that community. Mileage of \$0.75 per mile one way will be paid in this zone. This line must be an equal division of distance from one physician to another.

CLINICAL LABORATORY EXAMINATIONS

Bacteriological examinations

361. Cultural examination for fungi-----	5.00
362. Microscopic examination for fungi-----	2.00
363. Pneumococcus typing-----	5.00
364. Pus or exudate (smear)-----	1.00
365. Pus or exude, cultural examination, classification-----	5.00
366. T. pallidum (dark field)-----	5.00
367. Throat culture, classification of organism-----	5.00
368. Throat smear-----	1.00

Blood

369. Agglutination test for typhoid, paratyphoid, or undulant fever-----	2.00
370. Bleeding time-----	1.00
371. Blood calcium-----	3.00
372. Blood chlorides-----	3.00
373. Blood culture, including classification-----	5.00
374. Blood platelet count-----	1.00

Schedule of fee submitted by the Kansas Medical Society and approved by the Veterans' Administration—Continued

375. Blood smear for malaria-----	\$2.00
376. Blood typing (grouping)-----	1.00
377. Carbon dioxide combining power of blood plasma-----	5.00
378. Chemical examination of blood, complete, including creatinin, dextrose, urea, nitrogen (or nonprotein N), and uric acid-----	15.00
379. Cholesterol-----	3.00
380. Coagulation time-----	1.00
381. Complement fixation test—gonococcus infection-----	3.00
382. Complement fixation test for syphilis-----	3.00
383. Complement fixation test for tuberculosis-----	3.00
384. Creatinin-----	3.00
385. Dextrose-----	3.00
386. Total erythrocyte count-----	2.00
387. Fragility test for erythrocytes-----	5.00
388. Hemoglobin estimation-----	2.00
389. Hydrogen iron concentration-----	5.00
390. Differential leucocyte count-----	2.00
391. Total leucocyte count-----	2.00
392. Complete blood count, including total counts-----	5.00
393. Nonprotein nitrogen-----	3.00
394. Occult blood-----	1.00
395. Blood phosphorous-----	2.00
396. Precipitation test for syphilis-----	2.00
397. Reticulocyte count-----	2.00
398. Sedimentation rate-----	2.00
399. Estimation of sugar tolerance-----	10.00
400. Urea nitrogen-----	3.00
401. Uric acid-----	3.00
402. Van den Bergh blood test for icterus-----	2.00
403. Volume index-----	3.00

Feces

404. Cultural examination of feces for causative microorganism (classification of bacterium)-----	7.50
405. Fat in feces-----	1.00
406. Parasites and ova-----	5.00

Pathological examinations

407. Autopsy, complete, with report, including histological examination-----	50.00
408. Tissue examination, with report-----	5.00

Skin tests

409. Protein sensitization tests (series), including allergens, for purpose of establishing causative factor-----	25.00
410. Tuberculin -----	3.00

Spinal fluid

411. Examination of spinal fluid for causative organism (smear)-----	3.00
412. Cell count-----	2.00
413. Colloidal gold reaction-----	5.00
414. Complement fixation test for syphilis-----	3.00
415. Cultural examination of spinal fluid, including classification of causative microorganism-----	5.00
416. Globulin test-----	1.00
417. Complete examination of spinal fluid, including complement fixation test colloidal gold, globulin test, and cell count-----	10.00
418. Precipitation test for syphilis-----	3.00

Schedule of fee submitted by the Kansas Medical Society and approved by the Veterans' Administration—Continued

Sputum

419. Tubercle bacillus (plain smear)-----	\$3.00
420. Tubercle bacillus (concentration method)-----	5.00
421. Examination of duodenal content for pancreatic ferments-----	3.00
422. Examination of gastric content for acidity, by histamine-----	7.50
423. Examination of gastric content for pepsin-----	3.00
424. Routine chemical (including test meal with withdrawal of stomach contents)-----	10.00

Urine

425. Chemical examination, routine-----	1.00
426. Chemical and microscopical examination-----	2.00
427. Chlorides-----	3.00
428. Creatinin-----	3.00
429. Cultural examination including classification of microorganism-----	5.00
430. Hydrogen iron concentration-----	1.00
431. Mosenthal test-----	2.00
432. Total nitrogen-----	3.00
433. Renal function test (including phono-sulphonephthalein)-----	3.00
434. Tubercle bacilli-----	3.00
435. Urea nitrogen-----	3.00
436. Uric acid-----	3.00
437. Urobilin-----	1.00

Miscellaneous examinations

438. Animal inoculation for diagnosis, with report of autopsy-----	10.00
439. Preparation of autogenous vaccine-----	10.00
440. Determination of basal metabolic rate-----	5.00

MISCELLANEOUS

441. Blood transfusion (administration only, without venesection)-----	5.00
442. Nonsurgical drainage of gallbladder-----	10.00
443. Electrocardiograms, interpretation of-----	5.00
444. Hypodermoclysis-----	3.00
445. Injection of alcohol, trigeminal nerve-----	25.00
446. Intravenous injection, exclusive of cost of drug-----	3.00
447. Application of plaster cast, chest-----	15.00
448. Application of plaster cast, thighs and hips-----	25.00
449. Application of plaster cast, thigh and leg-----	10.00
450. Application of plaster cast, torso-----	25.00
451. Application of plaster cast, torso and hips-----	30.00
452. Application of plaster cast, entire body-----	50.00

(Date)

To: The Administrator of Veterans Affairs:

Kansas Hospital Service Association, Inc., contracts with the Veterans' Administration to do the following:

1. To obtain the consent of accredited Kansas hospitals to furnish hospital care to veterans to the extent and in the manner hereinafter provided, and keep the Veterans' Administration advised of those hospitals which have so consented.

2. The hospitals eligible to furnish service under this contract shall include hospitals participating in Kansas Hospital Service Association, Inc., subject to the approval of the Veterans' Administration. Hospitals in the State of Kansas which are not participating in the Kansas Hospital Service Association, Inc., may furnish service under this contract if approved by the American College of Surgeons. If not approved by the American College of Surgeons, such hos-

pitals may participate if registered by the American Medical Association and located in a community where no participating hospital is available, if approved by the Veterans' Administration.

3. The hospital care to be provided shall include bed care in rooms with two or more beds, or in single rooms when medically indicated. The services to be provided by the hospital shall be all services which the hospital provides its patients and for which expenditures have been made during the year, such costs having been included in the Statement of Reimbursable Cost submitted to the Kansas Hospital Service Association, Inc. Such services as are not included in the Statement of Reimbursable Cost shall be reimbursed in accordance with the attached schedule of fees, which is made a part of this contract. All special and expensive drugs for which the hospital has made no expenditures during the preceding year shall be paid for on the basis of the actual cost to the hospital.

4. The hospital shall accept payment according to the agreed rates as full payment for all services provided, and shall accept no payment in excess of the agreed rates from the patient or from other persons for such services. In the event that the patient requests and obtains luxury accommodations beyond those provided by this contract, the patient shall assume full responsibility for the complete cost of hospitalization, which assumption of responsibility shall become a direct contract between the hospital and the patient. When a patient is examined or treated as an in-patient or out-patient by a member, or members, of a hospital staff whose salaries are included in the Statement of Reimbursable Cost, no additional payment shall be made for such medical services.

5. (a) It is agreed that the rate of payment for out-patient visits in any clinic or division of a recognized out-patient department of a hospital shall be reimbursed at an inclusive rate figure that covers all services provided the patient by the hospital. The rate of payment shall be based upon calculation by the hospital of the reimbursable cost per out-patient visit, as outlined under section F of the hospital statement of reimbursable cost submitted to the Kansas Hospital Service Association, Inc. For services rendered and not included in the inclusive rate, the hospital shall be reimbursed in accordance with the attached schedule of fees. For all items not included in the schedule, the hospital shall be paid on the basis of actual cost to the institution. (If the hospital is unable to segregate expenses for out-patients in order to calculate the reimbursable cost for out-patient visits, the rate of payment shall be at the inclusive rate of \$1.65 per visit.)

(b) In instances where payment based on a rate of reimbursable cost per out-patient visit is not feasible for private out-patient visits, because the hospital made no expenditure for such services, the Kansas Hospital Service Association, Inc., may pay for such services (i. e., X-ray, physical therapy, etc., rendered to out-patients, at rates established by the Veterans' Administration and included under the fee schedule in this contract).

6. The hospitals will make available their facilities for hospital care to veterans under this agreement, having due regard to their obligations to and the need for hospital care of other citizens of the community, and under the general rules and regulations, then in force, of the particular hospital which is to furnish the care.

7. Authorization for furnishing such services will be issued to Kansas Hospital Service Association, Inc., by the Veterans' Administration in each individual case. Kansas Hospital Service Association, Inc., will then furnish the veteran a list of hospitals in his community available for service, and the veteran will be admitted to one of these hospitals, after the necessary arrangements have been made by his doctor having staff privileges at the particular hospital.

8. If a veteran receiving in-patient care is absent from a hospital for a period longer than 24 hours, no charge will be made for his or her maintenance during such absence. However, the hospital is not bound to reserve either bed or board during such absence.

9. A report of admissions, discharges, or deaths of patients, also of injuries or accidents affecting patients of Veterans' Administration, will be furnished in the manner and form prescribed by said Administration. During the period of hospitalization, when requested, and within 3 days after discharge of any patient admitted under the terms of this contract, a complete report of the findings, including diagnoses established during hospitalization, will be forwarded by the hospital to the Kansas Hospital Service Association, Inc.

10. In the event of the death of a hospitalized Veterans' Administration patient, the hospital shall immediately assemble, inventory, and properly safeguard his personal effects and valuables within the hospital, and shall transmit a complete itemized inventory to Veterans' Administration within 24 hours after

death. The hospital shall assume full responsibility for such personal effects, and shall not surrender any portion thereof (except articles of clothing necessary for proper burial) until authorized to do so by the Veterans' Administration.

11. The Kansas Hospital Service Association, Inc., will be responsible to see that reports required by the Veterans' Administration are in proper form and that proper records are maintained which will be available for review by the Veterans' Administration at any time. The Veterans' Administration will review reports of service and will return to Kansas Hospital Service Association, Inc., for further action, without additional cost to the Veterans' Administration, those which do not meet the requirements of the Veterans' Administration.

12. The Veterans' Administration will pay monthly to Kansas Hospital Service Association, Inc., for the hospital care furnished under this contract. In the event a veteran remains in a hospital longer than 30 days, Kansas Hospital Service Association, Inc., shall bill the Veterans' Administration for such veteran's care at the end of each month. In determining the length of the veteran's stay in the hospital for which payment will be made, the date of the admission, but not the date of the discharge, shall be counted.

13. The formula for determining patient-day cost under this contract shall be similar to Joint Hospital Form 1 currently used by the United States Department of Labor (Children's Bureau) and the Federal Security Agency (Office of Vocation Rehabilitation), a copy of which is attached and made part of this contract, except where modified for the purposes of this contract. If the cost per patient day established by a hospital's Statement of Reimbursable Cost appears excessive as compared with costs per patient day for services of comparable quality in other hospitals in the State of Kansas, the Veterans' Administration shall establish the maximum rate to be paid under this contract.

14. Kansas Hospital Service Association, Inc., will furnish to the Veterans' Administration a list of the hospitals which have agreed to render service under this contract, and also a statement for each hospital of the patient day cost, as outlined in paragraph 13 hereof and determined from the formula similar to that covered by Joint Hospital Form 1, or a certified statement from the State health department as to the hospital's reimbursable cost approved by that agency, based on Joint Hospital Form 1. It will also furnish a statement of the number of beds which each hospital will, insofar as possible, have available for the care of veterans, and list any limitations as to the type of patients which may be accommodated, e. g., male, female, T. B., G. M. & S., N. P., colored or white. Each participating hospital shall submit to Kansas Hospital Service Association, Inc., at least every 12 months, a statement of reimbursable cost for the hospital's most recent accounting year, and one may be submitted more frequently (not more often than every 6 months, however) but must cover a full 12 months period. Whenever a new rate of payment is approved it shall be effective as of the date of approval, and not prior to such date.

15. Kansas Hospital Service Association, Inc., intends that the performance of this contract will be without profit to it. A statement of the cost of administering this program shall be submitted semiannually by the Kansas Hospital Service Association, Inc., to the Veterans' Administration. If operating results are at variance with this intention, revisions will be proposed to produce such a nonprofit operation. The Veterans' Administration shall be authorized to examine pertinent records of the Kansas Hospital Service Association, Inc., to verify nonprofit operation.

16. It is expressly agreed and understood that the Veterans' Administration, in respect to the hospitalization, care, and treatment of patients of the Veterans' Administration under this contract, shall have the right to the privileges when desired as hereinafter mentioned:

(a) Inspection of the hospital and all appurtenances by an authorized representative of the Veterans' Administration designated for this purpose, to determine whether the standards maintained conform to the requirements necessary.

(b) Extension to a designated medical officer of the said Administration of the privileges of consultation with the medical staff of the institution, insofar as it concerns the medical care and treatment of Veterans' Administration patients.

(c) Extension, if permitted by the regulations of the institution, to a designated medical officer of said Administration, of the privilege of supervising the treatment of Veterans' Administration beneficiaries admitted under the terms of this contract.

17. This contract shall become effective as of _____, and may be terminated by either party by giving 30 days written notice to that effect.

18. This contract, if mutually satisfactory, may be renewed indefinitely for periods of 1 year each, upon notice in writing to the contractor at least 60 days

prior to the expiration of each period of 1 year, and written statement from the contractor within 30 days after such notification agreeing to the renewal.

19. *Notice to bidders.*—Prices bid should include any applicable Federal excise taxes, as the United States is not exempt from payment of such taxes.

20. No Member of or Delegate to Congress, or Resident Commissioner, shall be admitted to any share or part of this contract or to any benefit that may arise therefrom unless it be made with a corporation for its general benefit.

21. Kansas Hospital Service Association, Inc., and each hospital participating hereunder, individually agrees that in performing this contract it will not discriminate against employee or applicant for employment because of race, creed, color or national origin.

KANSAS HOSPITAL SERVICE ASSOCIATION, INC.,

By _____.

Approved and accepted:

VETERANS' ADMINISTRATION,

R. C. KIDD,

Director of Supplies.

(If bidder is a corporation, Form 1264 must be filled out and attached to the contract.)

Return This Statement to Your Official State Agency

U. S. DEPARTMENT OF LABOR

CHILDREN'S BUREAU

and

FEDERAL SECURITY AGENCY

OFFICE OF VOCATIONAL REHABILITATION

Joint Hospital Form 1

July 1945

Budget Bureau No. 44-R 403.2

Approval Expires 7-31-47

HOSPITAL STATEMENT OF REIMBURSABLE COST

Name of hospital¹: _____

Address: _____

Period covered by statement: From _____, 194____, to _____, 194____

A. TYPE OF CONTROL² (CHECK ONE ONLY)

- | | | |
|--|--|--|
| <i>Government</i> | <i>Nonprofit organizations</i> | <i>Proprietary</i> |
| <input type="checkbox"/> State <input type="checkbox"/> City | <input type="checkbox"/> Church related—Catholic | <input type="checkbox"/> Individual or partnership |
| <input type="checkbox"/> County <input type="checkbox"/> City-county | <input type="checkbox"/> Church related—Other | <input type="checkbox"/> Corporation |
| <input type="checkbox"/> Nonprofit associations | | |

B. STATISTICAL DATA

In-patient statistics:

1. Beds (exclusive of bassinets) available at beginning of account year_____
2. Beds (exclusive of bassinets) available at end of account year_____
3. Bed-days³_____
4. Total in-patient days (exclusive of newborn-infant days⁴)_____

 - (a) In rooms with only 1 bed_____
 - (b) In rooms with 2 or more beds_____

5. Percent of in-patient days in rooms with 2 or more beds (item 4 divided by item 4)_____
6. Percent occupancy (total in-patient days, item 4, divided by bed-days, item 3)_____

¹ Hospitals, as the term is used in this Statement, include maternity homes providing delivery service and convalescent homes.

² Type of control indicates ownership or auspices under which the institution is conducted.

³ Bed-days should be currently compiled count of beds available each day, or if this is not possible, the bed complement at the end of the report year multiplied by 365 days.

⁴ Newborn-infant days to be excluded from the count of total in-patient days are only those days when an infant occupies a bassinet (in the nursery) during the mother's hospitalization. Thus, the count of days for a prematurely born infant remaining in the hospital after the mother is discharged, or for an infant delivered at home and later admitted to the hospital, or for an infant admitted or transferred out of the nursery for an illness is included in the total in-patient days reported.

7. Discharges (including deaths) _____
 8. Average length of stay (in-patient days, item 4, divided by discharges, item 7) _____

Out-patient statistics:

9. Total out-patient visits⁶ provided during account year (sum of items 10, 11, 12 below) _____
 10. Visits by clinic patients _____
 (a) Clinic visits _____
 (b) Visits for special services (laboratory, X-ray, etc.) _____
 11. Visits to emergency service _____
 12. Visits by private patients (laboratory, X-ray, etc.) _____

NOTE.—For any terms not defined here, see the manual "Hospital Accounting and Statistics" of the American Hospital Association.

C. TOTAL OPERATING EXPENSES

1. Total amount of expenses per books⁷ _____
 2. Expenses to be deducted⁷ (if included in item 1 above)
 (a) Research expense and medical education _____
 (b) Cost of gift shops, lunch counters, etc. _____
 (c) Cost of guest meals or meals paid for by employees _____
 (d) Cost of telephone and telegraph charges paid for by
 patients, guests or employees _____
 (e) Cost of drugs or supplies that are purchased by in-
 dividuals not admitted as in-patients or out-
 patients _____
 (f) Provision for depreciation of buildings and equip-
 ment _____
 (g) Bad debts or provision therefor _____
 (h) Estimated value of donated or voluntary services⁸ _____
 (i) Interest expense _____
 (j) Real estate taxes and income taxes _____
 (k) Rent expense _____
 (m) Other⁹ (specify) _____

(n) Total of items (a) through (m) _____

3. Total amount of operating expenses applicable to in-patient and
out-patient services (item C-1 minus item C-2 (n)) _____

⁶ Out-patient visits for the purpose of this statement are the occasion of any personal, professional services to an out-patient (an individual registered for and receiving service in the institution but not occupying a regular hospital bed or bassinet) on any single admission in any subdivision of an out-patient department, clinic, or hospital. This count includes visits of out-patients to regular clinics of an organized out-patient department and also visits of individuals (including private service patients) who are not admitted to in-patient service but who receive care in emergency rooms, or X-ray, laboratory, physical therapy, and similar services.

If an individual receives services in more than one subdivision of an out-patient department, or in other service divisions of a hospital or clinic, a visit should be recorded for each separate service, for instance:

A patient served at a medical clinic, referred to the surgical clinic, to the X-ray department for examination, and also to the physical-therapy service for treatment, would have four visits recorded. Also, a private patient referred to the X-ray and laboratory services for examinations would have two visits recorded.

Note that visits of private out-patients are included, for the purposes of this statement, in the count of out-patient visits.

⁷ The amount to be entered should be as follows:

In reporting on the	Amount to be entered
Accrual basis	Total expenses.
Cash basis	Total cash disbursements.
Modified cash basis	Total cash disbursements after giving effect to adjustments.

Do not include in item C-1 expenditures for land, buildings, and permanent improvements and equipment, whether replacements or additions.

⁸ If the public accountant certified that the "total amount of expenses" (C-1) did not include any of the items listed under item C-2, entries should be made for items C-1 and C-3 only.

⁹ Any estimated value for the services of sisters or other members of religious orders who serve in the hospital are to be included in this item.

⁶ Among the types of expenses included in item C-2 (m) that are to be deducted will be those for services furnished not by the hospital's own personnel but by other persons for whom the hospital acts as a billing and collection agency. X-ray, laboratory, and physical-therapy services are sometimes provided in this manner. Fuller explanation is made in footnote 12, which discusses the distinction between items D-12, D-13, D-15, and C-2 (b).

D. OPERATING EXPENSES FOR CALCULATING REIMBURSABLE COSTS¹⁰

Classification of expenses	Total	In-patient service	Out-patient service ¹¹		
			Total—clinic and	Clinic	Private
(1)	(2)	(3)	(4)	(5)	(6)
1. Administration.....					
2. Dietary.....					
3. Laundry.....					
4. Housekeeping.....					
5. Heat, light, power, and water.....					
6. Maintenance and repairs.....					
7. Motor service.....					
8. Medical and surgical service.....					
9. Nursing service and nursing education.....					
10. Medical records and library.....					
11. Social service.....					
12. X-ray ¹²					
13. Laboratories ¹²					
14. Pharmacy.....					
15. Physical therapy ¹²					
16. Other special services ¹² (Specify).....					
17. Total.....					

(Item 17 (2) should equal item C-8)

¹⁰The expenses for all services provided by the hospital to all patients are to be included in this section.

A hospital having fewer than 25 available beds may elect to submit a statement of operating expenses in accordance with the classification per books of the hospital instead of using the classification of expenses given in section D. Such a hospital should, however, complete all items in sections A, B, and C.

Maintenance of student nurses and members of religious orders who serve in the hospital may be included in the appropriate departmental items 1 through 15.

Detailed instructions of expenses to be included under each heading and a method of allocating in-patient and out-patient operating expenses are given in the manual, "Hospital Accounting and Statistics," of the American Hospital Association.

¹¹Columns 4, 5, and 6 should cover all expenses incurred in rendering service to out-patients (as defined in footnote 5) as differentiated from in-patients.

Hospitals that provide out-patient services both to clinic out-patients and to private out-patients may at their own option distribute their total out-patient expenses between these two types of out-patient care. If this is done, columns 4, 5, and 6 should be used. If the hospital does not wish to distribute the out-patient expenses, only column 4 should be used.

Hospitals that furnish out-patient services to clinic patients only should fill in column 5.

Hospitals without organized out-patient clinics, that furnish services to private out-patients only, should fill in column 6.

If in-patient and out-patiented expenses cannot be segregated according to the method advocated by the American Hospital Association or by a comparable method, estimated expenses to be entered in item 17 may be computed as follows:

For hospitals that do not separate expenses but do furnish services to both clinic and private out-patients—

Multiply the total number of out-patient visits (B-9) by \$1.50 and enter the result in item 17, column 4.

For hospitals that furnish services to clinic out-patients only—

Multiply the number of visits of clinic patients (B-10 plus B-11) by \$1.50 and enter the result in item 17, column 5.

For hospitals that furnish services to private out-patients only—

Multiply the sum of the number of visits to emergency services and visits by private patients (B-11 plus B-12) by \$1.50 and enter the result in item 17, column 6.

¹²If the hospital provides all X-ray services, including the professional services of a radiologist, all expenses are to be included here. (This refers to any individuals who receive salaries, fees, commissions, or maintenance.)

If the hospital provides X-ray services exclusive of the professional services of a radiologist, only the expenses to the hospital should be included in this item. (The radiologist may bill separately for his professional services.)

If the X-ray department of a hospital is rented outright to a radiologist, any expenses recorded in the hospital's books are to be excluded from this item and should be shown in item C-2 (m).

If the hospital acts as the billing and collection agency for radiologists or other individuals not employed by the hospital who provide service in this department, the amounts collected for, and paid to, these individuals should be excluded from this item and should be shown in item C-2 (m) if recorded in the hospital's books.

These instructions should be followed in determining cost for laboratory or physical-therapy service.

¹³List each special service not elsewhere included, such as cardiography, basal metabolism, and special expenses such as salary and maintenance of chaplain or maintenance of chapel.

E. CALCULATION OF REIMBURSABLE COST OF IN-PATIENT SERVICE

1. Total amount of operating expenses for in-patient service (from item D-17, column 3) -----
2. Less: Income from Federal or State public health agencies for nursing education, including income for maintenance, uniforms, supplies, etc.¹⁴ -----
3. Balance (E-1 minus E-2) -----
4. Number of in-patient days (item B-4) -----
5. Average computed per diem reimbursable cost (E-3 divided by E-4) -----
6. Supplementary allowance for depreciation of buildings and equipment, rent, interest, etc. (10 percent of item E-5) -----
7. Total (E-5 plus E-6) -----
8. Reimbursable cost of in-patient service per patient-day¹⁵ (85 percent of E-7, unless more than 70 percent of all in-patient-days are in rooms with two or more beds (B-5)¹⁶) -----
9. Administrative cost for Kansas Hospital Service Association, Inc., participation in this program—7 percent-----

F. CALCULATION OF REIMBURSABLE COST OF OUT-PATIENT VISIT¹⁷

Item (1)	Total— clinic and private (2)	Clinic --- (3)	Private (4)
1. Total operating expenses (item D-17) ¹⁸ -----			
2. Number of out-patient visits ¹⁹ -----			
3. Average cost per visit (F-1 divided by F-2)-----			
4. Supplementary allowance for depreciation of buildings and equipment, rent, interest, etc. (10 percent of item F-3)-----			
5. Reimbursable cost per visit (F-3 plus F-4) ²⁰ -----			
6. Administrative cost for Kansas Hospital Service Association, Inc., participation in this program—7 percent-----			

¹⁴ The amount chargeable to Federal or State public health agencies during the accounting year covered by the statement should be entered, not the amount of cash received.

¹⁵ Subject to the maximum rate established by the State.

¹⁶ The table follows:

Percent of in-patient days in rooms with <u>2 or more beds</u> to total in-patient days in all accommodations (excluding new-born-infant days) (Item B-5)	Percent to be used in computing reimbursable cost of in-patient service per patient day (Item E-8)	Percent of in-patient days in rooms with <u>2 or more beds</u> to total in-patient days in all accommodations (excluding new-born-infant days) (Item B-5)	Percent to be used in computing reimbursable cost of in-patient service per patient day (Item E-8)				
More than 98	Not more than 98	Percent	More than 82	Not more than 82	Percent	More than 98	Not more than 98
96	98	99	80	82	91		
94	96	98	78	80	90		
92	94	97	76	78	89		
90	92	96	74	76	88		
88	90	95	72	74	87		
86	88	94	70	72	86		
84	86	93	0	70	85		

¹⁷ The columns in which entries are to be made in this section will depend on whether organized clinic out-patient services are provided and whether the expenses for such services are separated from private out-patient services. See footnote 11.

¹⁸ If the entry in item D-17 is in column 4, enter the same figure in column 2 of item F-1; if the entry in item D-17 is in column 5, enter the same figure in column 3 of item F-1; if the entry in item D-17 is in column 6, enter the same figure in column 4 of item F-1. If all three columns are filled in for item D-17, the same figures should be used in the three columns of item F-1.

¹⁹ The number of out-patient visits used here will depend on the entries in item F-1. If column 2 is used, the number of out-patient visits should be item B-9; if column 3 is used, the number of visits should be item B-10 plus B-11; if column 4 is used, the number of visits should be the sum of B-11 and B-12.

²⁰ Subject to the maximum rate established by the State agency.

G. FORM OF CERTIFICATION BY OFFICER OF HOSPITAL²¹

(Name of hospital) (City) (State)
do certify that I have examined the accompanying statement of total expenses,
the allocation thereof between in-patient and out-patient services, and the cal-
culation of reimbursable cost of in-patient service per patient day and of out-
patient service per visit for the hospital for the year ended _____
194_____, and that to the best of my knowledge and belief it is a true and correct
statement prepared from the books and records of the hospital in accordance
with instructions issued by the Children's Bureau, United States Department of
Labor, and Office of Vocational Rehabilitation, Federal Security Agency, Wash-
ington, D. C., under date of July 1945 (except as indicated below) as contained
in this Statement.

A certification by a public accountant of the correctness of the amount entered in item C-1 is attached.

* I certify that the hospital could not obtain the services of a public accountant to make an audit to determine the total expenses of the hospital during the year.

I further certify that the records of the hospital for the period covered by the operating statement were maintained on the _____ basis.

(Accrual, cash, or modified cash)

(Signed)

Officer or Superintendent of Hospital.

(Title)

H. FORM OF CERTIFICATION BY PUBLIC ACCOUNTANT

I hereby certify that the amount of \$----- shown in item C-1 of the accompanying statement of total expenses of -----

(Name of hospital)

200

— (SMA-4) —

(City) _____ (State) _____
_____, 194_____, is correct in accordance with my audit of the books
and records of the hospital after giving effect to all adjustments resulting from
my examination of the books of the hospital, and to the instructions outlined
by the Children's Bureau and Office of Vocational Rehabilitation for preparation
of Statement of Reimbursable Cost under date of July 1945.

My examination was made in accordance with generally accepted auditing standards applicable in the circumstances and it included all procedures that I consider necessary (except as qualified below).

The amount entered in item C-1 includes items listed under item C-2.

The records of the hospital for the period covered by the operating statement
were maintained on the _____ basis.

(Accrual, cash, or modified cash)

(Signature of public accountant)

**Veterans' Administration
Form 1264**

FORM OF CERTIFICATE TO BE USED WHERE BIDDER IS A CORPORATION

(In all cases where the contractor or bidder is a corporation, three copies of this certificate, duly executed by the secretary of the corporation or other officer having custody of its records and seal, must be forwarded to central office with the contract or proposal.)

I, _____, do hereby certify that I reside at _____, in the State of _____, and am the _____, of the _____, Inc., and that as such I have custody of its records and seal; that the said corporation is organized under the laws of the State of _____.

²¹The statement of expenses should be based upon the amount of total expenses certified to by a public accountant who is not an employee of the hospital.

This form is to be executed by every hospital. A hospital operated by city, county, or State government may furnish certification by the superintendent or an officer of the hospital. For form to be used by public accountants, see p. 8.

*Delete this sentence if certification by public accountant is attached.

-----; that ----- is the ----- of said corporation and is duly authorized to execute contracts on its behalf; that the following is a true and correct copy of so much of the by-laws or resolutions* of the said corporation, or its board of directors, as confers authority upon ----- to execute contracts on behalf of said corporation.

In witness whereof I have hereunto set my hand and affixed the seal of said corporation at ----- this ----- day of -----, 19----.

[AFFIX CORPORATE SEAL]

(Title)

* If resolutions are copied herein, date thereof shall be stated.

(Date)

To THE ADMINISTRATOR OF VETERANS' AFFAIRS:

The Michigan Medical Service agrees to make available during the fiscal year ending June 30, 1946, all services outlined below in accordance with the terms and conditions hereinafter prescribed:

(1) The Michigan Medical Service will arrange, through physicians registered with it for the rendition of the medical services covered by this agreement, for examinations, treatments, and counsel in such cases as may be authorized by the Veterans' Administration, Michigan Medical Service reserving the right, however, to decline any particular case.

(2) The Veterans' Administration will authorize examinations, treatments, and counsel. Authorizations for such services will be issued to the Michigan Medical Service; the Michigan Medical Service will advise the veteran to report to a physician of the veteran's selection in his community, such selection to be limited to those physicians registered with Michigan Medical Service for the rendition of services under this agreement.

(3) The Michigan Medical Service will be responsible to see that reports required by the Veterans' Administration are in proper form and that proper records are maintained which will be available for review by the Veterans' Administration at any time. The Veterans' Administration will review reports of services and will return to Michigan Medical Service for further action, without additional cost to the Veterans' Administration, those which do not meet the requirements of the Veterans' Administration.

(4) Fees for medical services will be in accordance with the fee schedule, which is attached hereto and made a part of this contract. It is understood that unusually involved cases and services not scheduled will be subject to review and recommendation by Michigan Medical Service to the Veterans' Administration for determination of appropriate fee.

(5) The Michigan Medical Service will make payment to the individual physicians for services rendered on all cases in which authorizations have been issued and will in turn bill the Veterans' Administration at the end of each month. Veterans' Administration will remit in accordance with such bill within a reasonable time after receipt thereof.

(6) The Michigan Medical Service contemplates that the performance of this contract will be without profit to it and if operating results are at variance with this intention revisions will be proposed to produce such a nonprofit operation.

The Michigan Medical Service warrants that the rates charged herein are not in excess of the rates charged other persons, who are not Veterans' Administration beneficiaries, for the same service.

It is impossible to determine the exact or estimated amount which will be expended under this contract. However, it is understood that upon acceptance of this proposal, the Veterans' Administration will issue authorizations for such services as are necessary and Michigan Medical Service will carry out its undertaking hereunder.

This contract shall become effective as of -----, 19----, and may be terminated by either party by giving 30 days' written notice to that effect.

This contract, if mutually satisfactory, may be renewed indefinitely for periods of 1 year each, upon notice in writing to the contractor at least 60 days prior to the expiration of each period of 1 year, and written statement from the contractor within 30 days after such notification agreeing to the renewal.

Notice to bidders.—Prices bid should include any applicable Federal excise taxes, as the United States is not exempt from payments of such taxes.

No Member of or Delegate to Congress, or Resident Commissioner, shall be admitted to any share or part of this contract or to any benefit that may arise therefrom unless it be made with a corporation for its general benefit.

Michigan Medical Service agrees that in performing this contract it will not discriminate against any employee or applicant for employment because of race, creed, color, or national origin, and that it will include a similar provision in all of its subcontracts.

MICHIGAN MEDICAL SERVICE,
By _____

(Title)

Approved and accepted:

VETERANS' ADMINISTRATION,
R. C. KIDD,
Director of supplies.

(If a bidder is a corporation, Form 1264 must be filled out and attached to the contract.)

*Michigan State Medical Society—Minimum Uniform Fee Schedule for
Governmental Agencies*

ABDOMINAL SURGERY

1. Esophagoscopy	\$42.80
2. Esophagoscopy and biopsy or removal of foreign body	53.50
3. Gastroscopy	42.80
4. Liver abscess	123.00
5. Abdominal fixation for prolapse of rectum	123.00
6. Anastomosis, intestinal	128.40
7. Anastomosis, uretero-intestinal, one stage	107.00
Anastomosis, uretero-intestinal, two stages	160.50
8. Appendectomy	80.25
9. Cardiospasm, dilatation for	32.10
10. Cholecystectomy	149.80
11. Cholecystotomy	107.00
12. Choledochotomy	149.80
13. Colostomy	80.25
14. Esophagus, dilatation, by means of Bougies	32.10
15. Fulguration, tumor-bladder, trachea, or esophagus (minor)	48.15
16. Gastrectomy (partial)	160.50
17. Gastroenterostomy	144.45
18. Herniotomy, diaphragmatic	107.00
19. Herniotomy—ventral, inguinal, or femoral—single	80.25
Herniotomy—ventral, inguinal, or femoral—bilateral	133.75
20. Hysterectomy, abdominal or vaginal (including removal of adnexa)	160.50
21. Intestinal obstruction, operation for	107.00
22. Laparotomy, exploratory	107.00
23. Laparotomy and drainage, general peritonitis	107.00
24. Litholapaxy	80.25
25. Meckel's diverticulum, excision of	107.00
26. Papilloma of bladder, operation for	53.50
27. Paracentesis of abdomen	10.70
28. Paracentesis of pericardium	26.75
29. Pyelotomy, with removal of calculus	107.00
30. Pyloroplasty	133.75
31. Splenectomy	144.45
32. Tumor, abdominal, removal of	107.00
33. Tumor, gastrointestinal tract, resection	160.50
34. Ulcer, gastric or duodenal, operation for	133.75

Michigan State Medical Society—Minimum Uniform Fee Schedule for Governmental Agencies—Continued

AMPUTATIONS

35. Upper arm-----	\$74. 90
36. Forearm-----	74. 90
37. Finger-----	21. 40
38. Fingers, each additional-----	10. 70
39. Foot-----	69. 55
40. Hand-----	69. 55
41. Leg-----	90. 95
42. Thigh-----	96. 30
43. Toe-----	21. 40
44. Toe, each additional-----	10. 70

ANESTHESIA

45. Anesthesia, for the first hour-----	10. 70
46. Anesthesia, for each additional hour or any fraction thereof-----	5. 35

DISLOCATIONS

47. Carpal bone, one-----	26. 75
48. Carpal bone, each additional-----	5. 35
49. Clavicle-----	26. 75
50. Elbow-----	26. 75
51. Finger-----	5. 35
52. Finger, each additional-----	5. 35
53. Hip-----	64. 20
54. Knee-----	32. 10
55. Mandible-----	10. 70
56. Metacarpal bone, one-----	16. 05
57. Metacarpal bones, each additional-----	5. 35
58. Metatarsal bone, one-----	16. 00
59. Metatarsal bones, each additional-----	5. 35
60. Patella-----	32. 10
61. Rib-----	10. 70
62. Shoulder-----	32. 10
63. Shoulder, recurrent or habitual (non-oper.)-----	26. 75
64. Tarsal bone, one-----	26. 75
65. Tarsal bones, each additional-----	5. 35
66. Thumb-----	5. 35
67. Toe, one-----	5. 35
68. Toes, each additional-----	5. 35
69. Vertebra, one or more-----	107. 00

EXAMINATIONS

70. Dermatological examination-----	6. 40
71. Electrocardiogram, with interpretation-----	10.70
72. Examination of ears, nose, and throat (separately or together)-----	5. 35
73. Special ear examination, including audiometric test with chart-----	10.70
74. Special ear examination, to include either caloric or Barany test or both, with report-----	10. 70
75. Examination of eyes (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings—the latter by chart in all cases of optic atrophy)-----	10. 00
76. Examination of eyes with refraction, if mydriatic is used (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings—the latter by chart in all cases of optic atrophy)-----	13. 40
77. Combined examination of eyes, ears, nose, and throat with refraction (with or without mydriatic)-----	16. 05
78. Genitourinary examination without cystoscopy-----	5. 35
79. Gynecological examination-----	5. 35
80. Complete examination of heart, including electrocardiography-----	16. 05
81. Physical examination of heart or lungs-----	5. 35

*Michigan State Medical Society—Minimum Uniform Fee Schedule for
Governmental Agencies—Continued*

82. Neurological examination	\$5.35
83. Neuropsychiatric examination	10.70
84. Routine office examination, including treatment	3.20
85. Orthopedic examination	5.35
86. Physical examination to determine need for hospitalization	3.20
87. General routine physical examination	5.35
88. Proctoscopy or sigmoidoscopy	5.35
89. General surgical examination	5.35
90. Ventriculography, air injection through skull for diagnostic purposes (not including X-ray)	42.80

COMPOUND FRACTURES

91. Carpal bone, one	48.15
92. Carpal bones, each additional	16.05
93. Clavicle	42.80
94. Coccyx	53.50
95. Femur	133.75
96. Femur, when suture, plating, or nailing	160.50
97. Fibula	42.80
98. Fibula, suture or plating	80.25
99. Finger, one	21.40
100. Fingers, each additional	10.70
101. Humerus	80.25
102. Humerus, suture or plating	133.75
103. Malar bone	53.50
104. Mandible (wiring if necessary)	85.60
105. Metacarpal bone, one	26.75
106. Metacarpal bone, each additional	10.70
107. Metatarsal bone, one	26.75
108. Metatarsal bones, each additional	10.70
109. Nasal bones	26.75
110. Patella	53.50
111. Patella, suture or plating	107.00
112. Pelvis	85.60
113. Pelvis, suture or plating	160.50
114. Radius or ulna, or both	58.85
115. Radius or ulna, or both, suture or plating	133.75
116. Rib, one	16.05
117. Ribs, each additional	5.35
118. Sacrum	64.20
119. Scapula	48.15
120. Skull, vault	107.00
121. Sternum	64.20
122. Tarsal bone, one	48.15
123. Tarsal bones, each additional	16.05
124. Tibia	64.20
125. Tibia, suture or plating	107.00
126. Tibia and fibula	80.25
127. Tibia and fibula, suture or plating	133.75
128. Toe, one	21.40
129. Toes, each additional	10.70
130. Vertebra, one or more	133.75

SIMPLE FRACTURES

131. Carpal bone, one	32.10
132. Carpal bone, each additional	5.35
133. Clavicle	26.75
134. Coccyx	16.05
135. Femur	90.95
136. Femur, suture or plating	133.75
137. Tibia or fibula, including Potts' fracture	53.50
138. Tibia or fibula, including Potts' fracture, suture or plating	133.75
139. Finger, one	10.70
140. Fingers, each additional	5.35
141. Humerus	53.50

Michigan State Medical Society—Minimum Uniform Fee Schedule for Governmental Agencies—Continued

142. Humerus, suture or plating	\$107.00
143. Nalar bone	21.40
144. Mandible (wiring if necessary)	80.25
145. Maxilla superior (wiring if necessary)	80.25
146. Metacarpal bone, one	16.05
147. Metacarpal bones, each additional	5.35
148. Metatarsal bone, one	16.05
149. Metatarsal bone, each additional	5.35
150. Nasal bones	16.05
151. Patella	26.75
152. Patella, suture or plating	80.25
153. Pelvis	53.50
154. Pelvis, suture or plating	133.75
155. Radius or ulna, including Colles' fracture	37.45
156. Radius or ulna, including Colles' fracture, suture or plating	107.00
157. Rib, one or more	10.70
158. Sacrum	26.75
159. Scapula	26.75
160. Skull	26.75
161. Sternum	26.75
162. Tarsal bone, one	16.05
163. Tarsal bones, each additional	5.35
164. Toe, one	10.70
165. Vertebra, one or more	53.50
166. Vertebra, transverse process only	10.70

GENERAL SURGERY

167. Adenectomy, cervical, inguinal (minor)	10.70
168. Adenectomy, cervical, inguinal (radical)	69.55
169. Biopsy	10.70
170. Breast, resection of (simple)	53.50
171. Breast, resection of (radical)	133.75
172. Carbuncle, excision of	26.75
173. Deep abscess (including ischio-rectal)	42.80
174. Superficial abscess	5.35
175. Femoral artery, ligation of	53.50
176. Fulguration of tumor, superficial	16.05
177. Ingrown toenail, excision of	10.70
178. Thyroid artery, ligation of	80.25
179. Thyroidectomy	133.75
180. Tumor or cyst, deep, removal of	26.75
181. Tumor or cyst, superficial, removal of	10.70
182. Varicose veins, injection treatment, each	3.20
183. Varicose veins, one leg, operation for	42.80
184. Varicose veins, both legs, operation for	64.20

JOINT RESECTIONS

185. Elbow joint, excision of	107.00
186. Hip joint, excision of	160.50
187. Knee joint, excision of	107.00
188. Shoulder joint, excision of	160.50
189. Wrist joint, excision of	80.25

CLINICAL LABORATORY EXAMINATIONS

BACTERIOLOGICAL EXAMINATIONS

190. Cultural examination for fungi	5.35
191. Microscopic examination for fungi	2.15
192. Pneumosoccus typing	5.35
193. Pus or exudate (smear)	1.10
194. Pus or exudate, cultural exam. classification	5.35
195. T. Pallidum (dark field)	5.35
196. Throat culture, classification of organism	5.35
197. Throat smear	1.10

*Michigan State Medical Society—Minimum Uniform Fee Schedule for
Governmental Agencies—Continued*

BLOOD

198. Agglutination test for typhoid, paratyphoid, or undulant fever-----	\$2.15
199. Bleeding time-----	1.10
200. Blood calcium-----	3.20
201. Blood chlorides-----	3.20
202. Blood culture, including classification-----	5.35
203. Blood platelet count-----	1.10
204. Blood smear for malaria-----	2.15
205. Blood typing (grouping)-----	1.07
206. Carbon dioxide combining power of blood plasma-----	5.35
207. Clinical examination of blood, complete including creatinin, dextrose, urea, nrea, nitrogen (or non-protein N) and uric acid-----	16.05
208. Cholesterol -----	3.20
209. Coagulation time-----	1.10
210. Complement fixation test—gonococcus infection-----	3.20
211. Complement fixation test for syphilis-----	3.20
212. Complement fixation test for tuberculosis-----	3.20
213. Creatinin -----	3.20
214. Dextrose-----	3.20
215. Total erythrocyte count-----	2.15
216. Fragility test for erythrocytes-----	5.35
217. Hemoglobin estimation-----	2.15
218. Hydrogen iron concentration-----	5.35
219. Differential leucocyte count-----	2.15
220. Total leucocyte count-----	2.15
221. Complete blood count, including total counts-----	5.35
222. Non-protein nitrogen-----	3.20
223. Occult blood-----	1.10
224. Blood phosphorous-----	2.15
225. Precipitation test for syphilis-----	2.15
226. Reticulocyte count-----	2.15
227. Sedimentation rate-----	2.15
228. Estimation of sugar tolerance-----	10.70
229. Urea nitrogen-----	3.20
230. Uric acid-----	3.20
231. Van den-Bergh blood test for icterus-----	2.15
232. Volume index-----	3.20

FECES

233. Cultural exam of feces for caustative micro-organism (classification of bacterium)-----	8.00
234. Fat in feces-----	1.10
235. Parasites and ova-----	5.35

PATHOLOGICAL EXAMINATIONS

236. Autopsy, complete, with report, including historical examination-----	53.50
237. Tissue examination, with report-----	5.35

SKIN TESTS

238. Protein sensitization tests (series) including allergens for purpose of establishing causative factor-----	26.75
239. Tuberculin-----	3.20

SPINAL FLUID

240. Examination of spinal fluid for causative organism (smear)-----	3.20
241. Cell count-----	2.15
242. Colloidal gold reaction-----	5.35
243. Complement fixation test for syphilis-----	3.20
244. Cultural examination of spinal fluid, including classification of causative microorganism-----	5.35

Michigan State Medical Society—Minimum Uniform Fee Schedule for Governmental Agencies—Continued

245. Globulin test	\$1. 10
246. Complete examination of spinal fluid, including complement fixation test, colloidal gold, globulin test, and cell count	10. 70
247. Precipitation test for syphilis	3. 20

SPUTUM

248. Tubercle bacillus (plain smear)	3. 20
249. Tubercle bacillus (concentration method)	5. 35
250. Examination of duodenal content for pancreatic ferments	3. 20
251. Examination of gastric contents for acidity, by histamine	8. 05
252. Examination of gastric contents for pepsin	3. 20
253. Routine chemical (including test meal with withdrawal of stomach contents)	10. 70

URINE

254. Chemical examination, routine	1. 10
255. Chemical and microscopical examination	2. 15
256. Chlorides	3. 20
257. Creatinin	3. 20
258. Cultural examination including classification of micro-organism	5. 35
259. Hydrogen iron concentration	1. 10
260. Mosenthal test	2. 15
261. Total nitrogen	3. 20
262. Renal function test (including phenosulphonephthalein)	3. 20
263. Tubercle bacilli	3. 20
264. Urea nitrogen	3. 20
265. Uric acid	3. 20
266. Urobilin	1. 10

MISCELLANEOUS EXAMINATIONS

267. Animal inoculation for diagnosis, with report of autopsy	10. 70
268. Preparation of autogenous vaccine	10. 70
269. Determination of basal metabolic rate	5. 35

MISCELLANEOUS

270. Blood transfusion (administration only, without venesection)	5. 35
271. Nonsurgical drainage of gall bladder	10. 70
272. Electrocardiograms, interpretation of	5. 35
273. Hypodermoclysis	3. 20
274. Injection of alcohol, trigeminal nerve	26. 75
275. Intravenous injection, exclusive of cost of drug	3. 20
276. Application of plaster cast, chest	16. 05
277. Application of plaster cast, thighs and hips	26. 75
278. Application of plaster cast, thigh and leg	10. 70
279. Application of plaster cast, torso	26. 75
280. Application of plaster cast, torso, and hips	32. 10
281. Application of plaster cast, entire body	53. 50

NEURO-SURGERY

282. Encephalography, air injection by spinal route for diagnostic purposes	26. 75
283. Brain abscess	160. 50
284. Chordotomy	107. 00
285. Gasserian ganglion, excision of	133. 75
286. Laminectomy	133. 75
287. Nerve, suture of	107. 00
288. Supraorbital nerve, injection of	16. 05
289. Neuroma, resection of	53. 50
290. Cisterna puncture, including local anesthesia and obtain fluid	26. 75

*Michigan State Medical Society—Minimum Uniform Fee Schedule for
Governmental Agencies—Continued*

291. Lumbar puncture, including local anesthesia and obtaining fluid	\$5.35
292. Skull, decompression of	107.00
293. Sympathectomy, cervical and lumbar	133.75
294. Sympathectomy, periarterial	107.00
295. Tumor of brain, operation for	160.50

NOSE AND THROAT

296. Oral abscess (not to include dental or peridental)	10.70
297. Adenoideectomy	16.05
298. Antrum, intranasal, drainage of	16.05
299. Antrum, radical, operation for	85.60
300. Cleft palate, operation for	107.00
301. Harelip, operation for	53.50
302. Intubation, laryngeal	21.40
303. Laryngectomy	160.50
304. Larynx, cauterization of	26.75
305. Tumor of larynx, removal of	53.50
306. Nasal polypus, removal of	21.40
307. Nasal septum, submucous resection of	53.50
308. Pharyngeal abscess, operation for	16.05
309. Accessory nasal sinuses, irrigation of	10.70
310. Ethmoid sinus, radical, operation for	80.25
311. Frontal sinus, intranasal, drainage of	53.50
312. Frontal sinus, radical, operation for	107.00
313. Sphenoid sinus, drainage of	53.50
314. Tonsillar abscess, operation for	10.70
315. Tonsillectomy	32.10
316. Tonsillectomy and adenoideectomy	32.10
317. Tracheotomy	37.45
318. Turbinete bone, galvano-cauterization of	10.70
319. Turbinectomy	10.70

OBSTETRICS AND GYNECOLOGY

320. Pregnancy, delivery only (all types except Caesarean)	42.80
321. Miscarriage—to 6 months	21.40
322. Miscarriage, to 6 months (with D and C)	32.10
323. Miscarriage, after 6 months	42.80
324. Caesarean section, vaginal or abdominal	107.00
325. Pregnancy, ectopic (also ruptured)	133.75
326. Bartholin's Gland, incision	10.70
327. Bartholin's Gland, excision	32.10
328. Urethral caruncle, removal	16.05
329. Labial tumors and cysts, removal	26.75
330. Atresia of vagina, correction of	53.50
331. Perineorrhaphy and rectoceir	53.50
332. Colporrhaphy, anterior	32.10
333. Fistula, recto- or vesico-vaginal	107.00
334. Cul-de-sac, drainage	32.10
335. Cauterization of cervix	21.40
336. Dilatation and curettage	32.10
337. Tubal inflation	16.05
338. Uterine polypi, removal	26.75
339. Trachelorrhaphy	53.50
340. Conization	21.40
341. Cervix, amputation	53.50
342. Hysterectomy, vaginal or abdominal	160.50
343. Myomectomy	107.00
344. Uterine flexions, etc., correction	107.00
345. Oophorectomy	107.00
346. Ovariectomy	80.25
347. Salpingectomy, with or without oophorectomy or appendectomy	107.00

*Michigan State Medical Society—Minimum Uniform Fee Schedule for
Governmental Agencies—Continued*

OPHTHALMOLOGY

348. Cataract, needling operation for	\$53.50
349. Cataract, operation for	107.00
350. Chalazion, operation for	5.35
351. Corneal ulcer, cauterization	5.35
352. Extensive peripheral corneal ulcer, cauterization of	26.75
353. Ectropion, operation for	32.10
354. Entropion, operation for	32.10
355. Enucleation of	80.25
356. Foreign body, removal from conjunctiva (dissection)	10.70
357. Foreign body, removal from conjunctiva (magnet)	10.70
358. Foreign body, removal from cornea (dissection)	10.70
359. Foreign body, removal from cornea (magnet)	16.05
360. Foreign body, removal from eyeball (deep) with or without magnet	107.00
361. Grattage of lids for trachoma	10.70
362. Hordeolum, operation for	5.35
363. Iridectomy	53.50
364. Lacrymal duct, dilatation of	5.35
365. Lacrymal sac, excision of	64.20
366. Pterygium, operation for	32.10
367. Ptosis, skin and tarsal resection, operation	80.25
368. Strabismus, operation for	80.25

ORTHOPEDIC

369. Arthroplasty, major joint	160.50
370. Bone graft (long bone)	160.50
371. Bone plate, removal of	37.45
372. Cartilage of condyle of femur, removal of	80.25
373. Semilunar cartilage, removal from joint	80.25
374. Clas foot, operation for	80.25
375. Coccyx, excision of	53.50
376. Hallux valgus, operation for	53.50
377. Hallux valgus, bilateral, operation for	80.25
378. Hammer toe, operation for	53.50
379. Osteomyelitis, operation for	53.50
380. Sequestrum, removal of (deep)	53.50
381. Sequestrum, removal of (superficial)	16.05
382. Tenorrhaphy, one	37.45
383. Tenorrhaphy, each additional	16.05
384. Tenotomy	37.45
385. Torticollis, operation for	80.25

OTOLOGY

386. Mastoid, acute, operation for	107.00
387. Mastoid, radical, operation for	133.75
388. Ossiculectomy	107.00
389. Paracentesis	5.35
390. Polypus, removal of	26.75
391. Lateral sinus, drainage	133.75

PROCTOLOGY

392. Anal fissure, operation for	26.75
393. Carcinoma of rectum, excision of	160.50
394. Fecal fistula, abdomen, operation for	80.25
395. Fistula, rectovaginal, operation for	107.00
396. Fistula, urethral, operation for	64.20
397. Fistula, vesico-vaginal, operation for	107.00
398. Fistula-in-ano, operation for	53.50
399. Hemorrhoidectomy	66.88
400. Stricture of rectum, operation for	74.90
401. Whitehead's Operation	80.25

*Michigan State Medical Society—Minimum Uniform Fee Schedule for
Governmental Agencies—Continued*

THORACIC SURGERY

402. Bronchoscopy	\$42.80
403. Bronchoscopy and biopsy or removal of foreign body	53.50
404. Thoracoscopy	53.50
405. Thoracotomy, incision and drainage, including rib resection	64.20
406. Subphrenic abscess	128.40
407. Apicolysis	107.00
408. Lobectomy	133.75
409. Oleothorax	53.50
410. Paracentesis of thorax, diagnostic	5.35
411. Phrenic nerve operation	32.10
412. Pneumolysis, extra or intrapleural	107.00
413. Pneumonectomy	160.50
414. Pneumonotomym cautery	107.00
415. Pneumoperitoneum, first induction	16.05
416. Pneumoperitoneum, refills	10.70
417. Artificial pneumothorax, first induction	16.05
418. Artificial pneumothorax, refills	10.70
419. Scaloniotomy	53.50
420. Thoracotomy, without rib resection	42.80
421. Thoracoplasty, each stage	133.75

SURGICAL CARE OF TRAUMATIC WOUNDS

422. Incised, minor procedure (office type)	6.42
423. Lacerated	10.70
424. Punctured	6.42

UROLOGY

425. Genito-urinary examination with cystoscopy	21.40
426. Prostatic abcess, incision and drainage	53.50
427. Circumcision (infant)	10.70
428. Circumcision (adult)	16.05
429. Cystotomy, suprapubic	53.50
430. Epididymectomy	69.55
431. Hydrocele, aspiration of	5.35
432. Hydroceles, operation for	53.50
433. Nephrectomy or nephrotomy	144.45
434. Nephropexy	107.00
435. Orchidectomy	53.50
436. Prostatectomy, perineal	160.50
437. Prostatectomy, suprapubic (one or two stages)	160.50
438. Prostatic resection, transurethral	107.00
439. Urethral stone, removal of	133.75
440. Urethral stricture, dilation of	5.35
441. Urethrotomy, external	80.25
442. Urethrotomy, internal	53.50
443. Varicocele, operation for	53.50

VISITS

444. Visit to home or hospital (not over 3 miles from office)	4.30
445. Night visit away from office (not over 3 miles from office)	6.40
446. Office visit, with treatment	3.20
447. Visit out of city for examination or treatment (over 3 miles from office)	(¹)
448. Consultation in hospital	10.70

X-RAY

449. Abdomen, flat plate	8.05
450. Ankle joint, anterior, posterior, and lateral views	8.05
451. Arm, humerus, anterior, posterior, and lateral views	10.70

¹ Visit fee plus 75 cents per mile.

*Michigan State Medical Society—Minimum Uniform Fee Schedule for
Governmental Agencies—Continued*

452. Bladder, with injection, anterior, posterior, and lateral views.....	\$16.05
453. Chest, survey film.....	5.35
454. Chest, for pulmonary, cardiac, or rib fracture diagnosis, stereo.....	10.70
455. Chest, fluoroscopic.....	16.05
456. Colon, by barium enema.....	16.05
457. Clavicle, anterior, posterior, and lateral views.....	8.05
458. Elbow, anterior, posterior, and lateral views.....	8.05
459. Encephalography.....	16.05
460. Encephalography, including preliminary skull.....	26.75
461. Esophagus (only).....	10.70
462. Finger.....	5.35
463. Fistulae, contrast study.....	{ 10.70 to 16.05
464. Foot, anterior, posterior, and lateral views.....	8.05
465. Forearm, radium and ulna, anterior, posterior, and lateral views.....	10.70
466. Foreign body in eye, location of (Fragment charts in 3 planes and its dimensions ascertained by method of Sweet or equivalent.)	21.40
467. Gallbladder, Graham technic.....	16.05
468. Gallbladder, G. I., barium enema.....	53.50
469. Gastro-intestinal tract, complete X-ray study, including fluoroscopy.....	37.45
470. Gastro-intestinal tract by barium meal and enema.....	37.45
471. Hand, anterior, posterior, and lateral views.....	5.35
472. Heart, single teleoroentgenogram.....	{ 10.70 to 16.05
473. Hip joint, anterior, posterior, and lateral views.....	10.70
474. Kidneys, right and left for comparison.....	10.70
475. Kidney, ureter, and bladder.....	10.70
476. Knee joint, anterior, posterior, and lateral views.....	8.05
477. Kymograph (chest or abdomen).....	8.05
478. Leg, tibia and fibula, anterior, posteroiod, and lateral views.....	10.70
479. Lipiodal injection for bronchiactases, etc., including roentgen.....	26.75
480. Mammary gland study.....	16.05
481. Mandibles, each.....	10.70
482. Mastoids, regular.....	10.70
483. Mastoids, including petrous pyramids.....	10.70
484. Maxilla and facial bones.....	10.70
485. Myelography.....	21.40
486. Neck for soft tissue.....	10.70
487. Nose.....	10.70
488. Optic foramina.....	16.05
489. Pelvis, ant.-post., and lat. views.....	10.70
490. Pregnancy, with measurements.....	21.40
491. Pregnancy, without measurements.....	10.70
492. Pyelography, intravenous.....	26.75
493. Pyelography, retrograde.....	16.05
494. Sella turcica.....	10.70
495. Semi-lunar cartilage, both knees.....	16.05
496. Shoulder girdle.....	10.70
497. Sialography (without medium).....	10.70
498. Sinuses, paranasal.....	10.70
499. Skull.....	10.00
500. Smith-Peterson nail.....	26.75
501. Spine, cervical ant.-post. and lat. views.....	10.70
502. Spine, dorsal.....	10.70
503. Spine, lumbar-sacral, with coccyx.....	16.05
504. Spine, entire.....	26.75
505. Stomach and duodenum only.....	16.05
506. Stomach, duodenum and gallbladder (dye).....	26.75
507. Teeth, single.....	2.15
508. Teeth, one-fourth set.....	4.30
509. Teeth, one-half set.....	5.35

Michigan State Medical Society—Minimum Uniform Fee Schedule for Governmental Agencies—Continued

510. Teeth, complete (periapical examination)	\$10.70
511. Thorax, ribs	10.70
512. Thigh, femur, ant.-post. and lat. views	10.70
513. Toe	5.35
514. Urethro-cystography	10.70
515. Uterosalpingography	32.10
516. Ventriculography	16.05
517. Ventriculography, including preliminary skull	26.75
518. Wrist	8.05

FLUOROSCOPIC AND GENERAL

519. Reduction of fractures	5.35
520. Foreign body detection	5.35
521. Foreign bodies in esophagus or respiratory tract	10.70
522. Portable examination in hospital—add	5.35
523. Fluoroscopic—chest or abdomen	5.35

INTERPRETATION OF ROENTGENOGRAMS

524. Bones and joints, plain ant.-post. and lat	5.35
525. Chest for pulmonary diagnosis, plain or stereo	5.35
526. Gastrointestinal series	5.35
527. Genito-urinary tract	5.35
528. Kidney films	5.35
529. Skull, following ventriculography or encephalography	5.35

No. VAm 20656
 March 12, 1946
 Washington, D. C.

STATEMENT AND CERTIFICATE OF AWARD

Veterans Administration

METHOD OF OR ABSENCE OF ADVERTISING

(Section 3709 of the Revised Statutes)

1. After advertising in newspapers.
2. (a) After advertising by circular letters sent to _____ dealers.
 (b) And by notices posted in public places.
 (If notices were not posted in addition to advertising by circular letters sent to dealers, explanation of such omission must be made. The notation on the certificate below must be "2 (a) (b)" or "2 (a)," depending on whether or not notices were posted.)
3. Without advertising, under an exigency of the service which existed prior to the order and would not admit of the delay incident to advertising.
4. Without advertising in accordance with _____.
5. Without advertising, it being impracticable to secure competition inasmuch as there is only one source of supply in the State of North Carolina from which services administratively deemed necessary may be secured.

AWARD OF CONTRACT

- A. To lowest bidder as to price (Expenditures).
- B. To other than the lowest bidder as to price (Expenditures).
- C. To highest bidder as to price (Receipts).
- D. To other than the highest bidder as to price (Receipts).
- E. Only bidder.

CERTIFICATE

I certify that the foregoing statement is true and correct; that the agreement was made in consequence of No. 5 of the method of or absence of advertising and in accordance with award of contract lettered E, as shown above; that the total number of bids received is one, and that where lower bids (expenditure contracts)

or higher bids (receipt contracts) as to price were received a statement of reasons for their rejection, together with an abstract of bids received, including all lower than that accepted in case of expenditure contracts and all higher in case of receipt contracts, is given below or on the reverse hereof or on a separate sheet attached hereto; that the articles or services covered by the agreement (expenditure) are necessary for the public service, and that the prices charged are just and reasonable.

HOSPITAL SAVING ASSOCIATION OF NORTH CAROLINA, INC.,
Chapel Hill, North Carolina.

R. C. KIDD,
Director of Supplies.

NOTE.—This statement and certificate will be used to support all agreements, both formal contracts and less formal agreements of whatever character, involving the expenditure or receipt of public funds. It must be executed and signed by the contracting officer (unless the award is made by or is subject to approval by an officer other than the contracting officer, when execution and signature may be made by such officer).

To: The Administrator of Veterans' Affairs:

Hospital Saving Association of North Carolina, Inc., contracts with the Veterans' Administration to do the following:

1. To obtain the consent of accredited North Carolina hospitals to furnish hospital care to veterans to the extent and in the manner hereinafter provided, and keep the Veterans' Administration advised of those hospitals which have so consented.

2. The hospitals eligible to furnish service under this contract shall include hospitals participating in Hospital Saving Association of North Carolina, Inc., subject to the approval of the Veterans' Administration. Hospitals in the State of North Carolina which are not participating in the Hospital Saving Association of North Carolina, Inc., may furnish service under this contract if approved by the American College of Surgeons. If not approved by the American College of Surgeons, such hospitals may participate if registered by the American Medical Association and located in a community where no participating hospital is available, if approved by the Veterans' Administration.

3. The hospital care to be provided shall include bed care in rooms with two or more beds, or in single rooms when medically indicated. The services to be provided by the hospital shall be all services which the hospital provides its patients and for which expenditures have been made during the year, such costs having been included in the Statement of Reimbursable Cost submitted to the Hospital Saving Association of North Carolina, Inc. Such services as are not included in the Statement of Reimbursable Cost shall be reimbursed in accordance with the attached schedule of fees, which is made a part of this contract. All special and expensive drugs for which the hospital has made no expenditure during the preceding year shall be paid for on the basis of the actual cost to the hospital.

4. The hospital shall accept payment according to the agreed rates as full payment for all services provided, and shall accept no payment in excess of the agreed rates from the patient or from other persons for such services. In the event that the patient requests and obtains luxury accommodations beyond those provided by this contract, the patient shall assume full responsibility for the complete cost of hospitalization, which assumption of responsibility shall become a direct contract between the hospital and the patient. When a patient is examined or treated as an in-patient or out-patient by a member, or members, of a hospital staff whose salaries are included in the Statement of Reimbursable Cost, no additional payment shall be made for such medical services.

5. (a) It is agreed that the rate of payment for out-patient visits in any clinic or division of a recognized out-patient department of a hospital shall be reimbursed at an inclusive rate figure that covers all services provided the patient by the hospital. The rate of payment shall be based upon calculation by the hospital of the reimbursable cost per out-patient visit, as outlined under section F of the Hospital Statement of Reimbursable Cost submitted to the Hospital Saving Association of North Carolina, Inc. For services rendered and not included in the inclusive rate, the hospital shall be reimbursed in accordance with the attached schedule of fees. For all items not included in the schedule, the hospital shall be paid on the basis of actual cost to the institution. (If the hospital is unable to segregate expenses for out-patients in order to calculate the reimbursable cost for out-patient visits, the rate of payment shall be at the inclusive rate of \$1.65 per visit.)

(b) In instances where payment based on a rate of reimbursable cost per outpatient visit is not feasible for private out-patient visits, because the hospital made no expenditure for such services, the Hospital Savings Association of North Carolina, Inc., may pay for such services (i. e., X-ray, physical therapy, etc.) rendered to out-patients, at rates established by the Veterans' Administration and included under the fee schedule in this contract.

6. The hospitals will make available their facilities for hospital care to veterans under this agreement, having due regard to their obligations to and the need for hospital care of other citizens of the community, and under the general rules and regulations, then in force, of the particular hospital which is to furnish the care.

7. Authorization for furnishing such services will be issued to Hospital Saving Association of North Carolina, Inc., by the Veterans' Administration in each individual case. Hospital Saving Association of North Carolina, Inc., will then furnish the veteran a list of hospitals in his community available for service, and the veteran will be admitted to one of these hospitals, after the necessary arrangements have been made by his doctor having staff privileges at the particular hospital.

8. If a veteran receiving in-patient care is absent from a hospital for a period longer than 24 hours, no charge will be made for his or her maintenance during such absence. However, the hospital is not bound to reserve either bed or board during such absence.

9. A report of admissions, discharges, or deaths of patients, also of injuries or accidents affecting patients of Veterans' Administration, will be furnished in the manner and form prescribed by said Administration. During the period of hospitalization, when requested, and within 3 days after discharge of any patient admitted under the terms of this contract, a complete report of the findings, including diagnoses established during hospitalization, will be forwarded by the hospital to the Hospital Saving Association of North Carolina, Inc.

10. In the event of the death of a hospitalized Veterans' Administration patient, the hospital shall immediately assemble, inventory and properly safeguard his personal effects and valuables within the hospital, and shall transmit a complete itemized inventory to Veterans' Administration within 24 hours after death. The hospital shall assume full responsibility for such personal effects, and shall not surrender any portion thereof (except articles of clothing necessary for proper burial) until authorized to do so by the Veterans' Administration.

11. The Hospital Saving Association of North Carolina, Inc., will be responsible to see that reports required by the Veterans' Administration are in proper form and that proper records are maintained which will be available for review by the Veterans' Administration at any time. The Veterans' Administration will review reports of service and will return to Hospital Saving Association of North Carolina, Inc., for further action, without additional cost to the Veterans' Administration, those which do not meet the requirements of the Veterans' Administration.

12. The Veterans' Administration will pay monthly to Hospital Saving Association of North Carolina, Inc., for the hospital care furnished under this contract. In the event a veteran remains in a hospital longer than 30 days, Hospital Saving Association of North Carolina, Inc., shall bill the Veterans' Administration for such veteran's care at the end of each month. In determining the length of the veteran's stay in the hospital for which payment will be made, the date of the admission, but not the date of the discharge, shall be counted.

13. The formula for determining patient day cost under this contract shall be similar to Joint Hospital Form 1 currently used by U. S. Department of Labor (Children's Bureau) and the Federal Security Agency (Office of Vocational Rehabilitation), a copy of which is attached and made part of this contract, except where modified for the purposes of this contract. If the cost per patient-day established by a hospital's statement of reimbursable cost appears excessive as compared with costs per patient day for services of comparable quality in other hospitals in the State of North Carolina, the Veterans' Administration shall establish the maximum rate to be paid under this contract.

14. Hospital Saving Association of North Carolina, Inc., will furnish the Veterans' Administration a list of the hospitals which have agreed to render service under this contract, and also a statement for each hospital of the patient day cost, as outlined in paragraph 13 hereof and determined from the formula similar to that covered by Joint Hospital Form 1, or a certified statement from the State health department as to the hospital's reimbursable cost approved by that agency, based on Joint Hospital Form 1. It will also furnish a statement of the number

of beds which each hospital will, insofar as possible, have available for the care of veterans, and list any limitations as to the type of patients which may be accommodated, e. g., male, female, T. B., G. M. & S., N. P., colored or white. Each participating hospital shall submit to Hospital Saving Association of North Carolina, Inc., at least every 12 months, a statement of reimbursable cost for the hospital's most recent accounting year, and one may be submitted more frequently (not more often than every 6 months, however) but must cover a full 12-month period. Whenever a new rate of payment is approved it shall be effective as of the date of approval, and not prior to such date.

15. The Hospital Saving Association of North Carolina, Inc., intends that the performance of this contract will be without profit to it. A statement of the cost of administering this program shall be submitted semiannually by the Hospital Saving Association of North Carolina, Inc., to the Veterans' Administration. If operating results are at variance with this intention, revisions will be proposed to produce such a nonprofit operation. The Veterans' Administration shall be authorized to examine pertinent records of the Hospital Saving Association of North Carolina, Inc., to verify nonprofit operation.

16. It is expressly agreed and understood that the Veterans' Administration, in respect to the hospitalization, care, and treatment of patients of the Veterans' Administration under this contract, shall have the right to the privileges when desired as hereinafter mentioned:

(a) Inspection of the hospital and all appurtenances by an authorized representative of the Veterans' Administration designated for this purpose, to determine whether the standards maintained conform to the requirements necessary.

(b) Extension to a designated medical officer of the said Administration of the privileges of consultation with the medical staff of the institution, insofar as it concerns the medical care and treatment of Veterans' Administration patients.

(c) Extension, if permitted by the regulations of the institution, to a designated medical officer of said Administration, of the privilege of supervising the treatment of Veterans' Administration beneficiaries admitted under the terms of this contract.

17. This contract shall become effective as of March 15, 1946, and may be terminated by either party by giving 30 days' written notice to that effect.

18. This contract shall be effective for the period March 15, 1946, to June 30, 1946, and if mutually satisfactory, may be renewed indefinitely for periods of 1 year each, upon notice in writing to the contractor at least 60 days prior to the expiration of each period of 1 year, and written statement from the contractor within 30 days after such notification agreeing to the renewal.

19. *Notice to bidders.*—Prices bid should include any applicable Federal excise taxes, as the United States is not exempt from payment of such taxes.

20. No Member or Delegate to Congress, or Resident Commissioner, shall be admitted to any share or part of this contract or to any benefit that may arise therefrom unless it be made with a corporation for its general benefit.

21. Hospital Saving Association of North Carolina, Inc., and each hospital participating hereunder, individually agrees that in performing this contract it will not discriminate against employee or applicant for employment because of race, creed, color, or national origin.

HOSPITAL SAVING ASSOCIATION OF NORTH CAROLINA, INC.,
By E. B. CRAWFORD, *Executive Vice President.*
J. LYMAN MELEN, *Secretary-Treasurer.*

Approved and accepted: Veterans' Administration,

R. C. KIDD, *Director of Supplies.*

Date: March 12, 1946.

(If bidder is a corporation, Form 1264 must be filled out and attached to the contract.)

The CHAIRMAN. Can you tell us, in a general way, what those contracts provide?

General BRADLEY. I do not know enough of the details of those contracts, other than it just provides for the out-patient service of out-patient treatment to these service-connected cases.

The CHAIRMAN. I see.

The medical society in each State provides the doctors that will take care of these patients upon a fee system, a fee basis?

General BRADLEY. That is right.

The CHAIRMAN. And the fees are fixed, and you agree with them with reference to those fees?

General BRADLEY. Yes.

The CHAIRMAN. How are those fees paid to them? Are they paid to the patient and the patient pay the doctor, or are they paid directly to the medical profession?

General BRADLEY. They are not paid to the patient.

The CHAIRMAN. Are they paid to the medical society or to the particular doctors that perform the service?

General BRADLEY. I cannot answer that, either. In States where we have individual arrangements, I know we pay direct to the doctor, but in these other few States where we have the over-all set-up, I cannot answer the question.

The CHAIRMAN. But you can furnish that to us?

General BRADLEY. We can furnish that for the record; yes.

(The information referred to appears at beginning of this discussion.)

The CHAIRMAN. Together with the fee schedules under which you operate.

General BRADLEY. That is right.

The CHAIRMAN. Do you think in entering into contracts of that kind with the medical society, by which the cost of this medical care is paid in a lump sum and the medical society then pays it out to the doctors—do you think that would in any manner deteriorate the kind of service that is given to the veterans?

General BRADLEY. In the first place, I am not sure we pay it in a lump sum. But if we did, I do not see what effect it would have on the cost, if a man has submitted his own bill.

The CHAIRMAN. You do not think the fact that the patient himself has not entered into a contractual arrangement with the doctor would have any great effect on the doctor's services, or would deteriorate the quality of his service in any manner?

General BRADLEY. We have had no evidences of it yet.

Of course, we have got to remember that these veterans are getting very sympathetic hearing and treatment from people.

The CHAIRMAN. Well, that is right, of course.

That is what is often spoken of in these hearings as a form of State medicine, by which contracts are entered into with the medical society, and under which the medical society performs the services, and the service is being paid for by the Government. That is true, is it not?

General BRADLEY. I believe it is sometimes referred to in that form.

The CHAIRMAN. Yes. And you do not think that lessens the value of the care that is given to the patient, and you have not heard of any complaint?

General BRADLEY. I have not heard of any complaints.

The CHAIRMAN. That is, made by the patient with reference to the character of care that they get from the doctors.

Senator DONNELL. General, in reference to the fact that the Veteran's Administration has developed a plan whereby contractual arrangements may be entered into through the cooperation of the State medical society for services of physician members, this was medical care on a fee basis, have you, generally speaking, found the

State medical societies to be cooperative in affording the services, to be of help and assistances in these matters?

General BRADLEY. As far as I know, we have run into no difficulty on it.

Senator DONNELL. Yes, sir.

General BRADLEY. There may be difficulties I have not heard about yet, because we have arranged it in only a few States so far. It takes time. We can furnish that for the record, if you would like, the number of States we have arranged this with, and there are any number of States that may have refused to do so.

The CHAIRMAN. Have some States refused to do it?

General BRADLEY. I say, if they have.

Mr. Birdsall tells me there are seven that have already signed up.

The CHAIRMAN. How many?

General BRADLEY. Seven.

The CHAIRMAN. Seven

Senator DONNELL. General, have you found, so far as you know, the State medical socities to be cooperative in evidencing the desire to cooperate with the Veterans' Administration?

General BRADLEY. I have not heard anything to the contrary.

Senator DONNELL. Yes, sir.

That is all, General.

The CHAIRMAN. In your negotiations with the various medical societies, you find that each society has proposals of its own, and it is necessary for you to carry on negotiations with them to work out a program. In other words, you do not submit one single program to the medical societies and ask them to accept it, but you negotiate independently with each medical society in each state?

General BRADLEY. Yes.

The CHAIRMAN. For the service that is to be rendered?

General BRADLEY. And, as I understand it, and this is all done by the Medical Section, and I have not gone into many of the details, but I have talked with them, and as I understand it, the fees vary in different parts of the country and different States for different methods of control, so it is necessary to deal with each State separately.

The CHAIRMAN. Who is in charge of those negotiations that you mention in your set-up?

General BRADLEY. I believe Dr. Harding is in charge.

The CHAIRMAN. Dr. Harding. Who is the head of the medical staff?

General BRADLEY. Dr. Hawley.

The CHAIRMAN. They are both members of the American Medical Association?

General BRADLEY. Yes, sir.

The CHAIRMAN. And through them these negotiations are carried on?

General BRADLEY. I say "yes," they are members. I am reasonably sure they are.

The CHAIRMAN. I assume that.

General BRADLEY. I know Dr. Hawley is diplomatic, and is considered very highly by the medical profession. I assume he must be a member of it.

The CHAIRMAN. He is a member of the American Medical Association in good standing.

General BRADLEY. He must be.

The CHAIRMAN. And these gentlemen carry on the negotiations with the medical societies of the various States?

General BRADLEY. That is right.

The CHAIRMAN. All right.

Senator DONNELL. Mr. Chairman, a very important matter has been omitted this morning.

The Chairman. What is that?

Senator DONNELL. From what State do you come, General?

The CHAIRMAN. I just assume it is Montana.

Senator DONNELL. We are very proud of the general, indeed, and want the record to show that.

The CHAIRMAN. You are not familiar with the Blue Cross hospital insurance system, are you, General?

General BRADLEY. Not very much, no, sir.

The CHAIRMAN. And you have not made any study of the relative value of compulsory insurance as opposed to voluntary insurance?

General BRADLEY. No, sir; I have not.

The CHAIRMAN. I see.

General, I am informed that the backlog in the Veterans' Administration health program is quite large.

General BRADLEY. By that you refer to the men waiting for hospitalization?

The CHAIRMAN. Yes.

General BRADLEY. In the last report, I believe there were 26,000 non-service-connected cases awaiting hospitalization, none of them of an emergency type.

Most of them are elective types of operation.

And the total number receiving hospital treatment was 85,727 and about one-third of the total number, or less than one-third of the total number, receiving hospitalization.

At the present time, we are trying to staff and take over 18 or 20 surplus Army hospitals, to be used temporarily while we are constructing the permanent hospitals, which have been authorized by Congress. There are about 78 of them.

After those are provided, we will have a total of some 135,000 beds.

We are also attempting to increase the number of patients taken care of by increasing the turn-over.

As I brought out here in the testimony, there is about 30 days, which is much higher than the turn-over in civilian hospitals.

That is caused by the fact that a civilian hospital can discharge a man, let him go home, and then watch him, because he is in the same town, and continue to treat him at home.

Whereas in our case, non-service-connected case, we can not give him treatment outside of the hospital, so we have to keep him there until he is cured.

We are trying to step that up. We think we can cut down the number of days required for a turn-over in those places where we have tied in with medical centers.

For example, one hospital where we used to do 8 major operations a week, we are now doing over 50. That would speed up the turn-over considerably.

The CHAIRMAN. Have you encountered any resistance from these medical societies in any States against this program whereby you negotiate with them for service on the veterans' fee schedule?

General BRADLEY. It has not been called to my attention.

The CHAIRMAN. It has not been called to your attention.

General BRADLEY. It may be there is some difficulty in meeting terms with some of them. That may be the reason we have not had over seven of them.

We will furnish that for the record.

(The information appears at beginning of this discussion.)

The CHAIRMAN. You do not know what particular questions are involved there which slow up the negotiations of those contracts?

General BRADLEY. No; I do not.

The CHAIRMAN. All right.

Very well, General, that is all, I guess.

Any other questions?

Senator DONNELL. No, sir.

The CHAIRMAN. Thank you, General.

Mr. Fred Bailey will be the next witness, legislative counsel of the National Grange.

Will you state your full name and the organization you represent, please?

STATEMENT OF FRED BAILEY, LEGISLATIVE COUNSEL, THE NATIONAL GRANGE, ACCCOMPANIED BY LLOYD C. HALVORSON

Mr. BAILEY. My name is Fred Bailey, legislative counsel of the National Grange.

I have a prepared statement.

The CHAIRMAN. You may proceed with your statement.

Mr. BAILEY. I want to comment very briefly on title I of S. 1606, a bill to provide for a national health program, and to devote somewhat more time to title II, the compulsory public health insurance portion of the bill.

TITLE I

Title I deals with cooperative endeavors by the Federal, State, and local governments to deal with specific health problems of a national nature. The Federal Government provides advice and financial assistance, while control is retained by the State and local authorities.

Likewise, the States share according to their individual ability in financing of the program. Those features—non-Federal control and administration and joint Federal-State contributions—are in accord with the principles long espoused by the National Grange.

For a great number of years the Grange has taken a keen interest in the problem of improving rural health. We have held that it is essential to the whole Nation that rural people share fully in the benefits of medical science regardless of their economic status, race, or geographical location.

GRANGE RECOMMENDATIONS ON MEDICAL CARE

A Grange committee collecting information regarding hospitalization and medical care for rural people has made preliminary reports, but still has not completed its work in this broad field. Consequently,

our policies have not been completely formed. We have, however, made some rather specific recommendations. A resolution incorporating those recommendations was adopted at the 1945 annual session of the National Grange in Kansas City last November. The recommendations are:

1. That because of the uneven and unpredictable cost of illness, it is of prime importance that rural people should spread the risks and share the costs of sickness by developing a comprehensive form of prepayment plans for hospital bills and health insurance.

2. That since many rural families and rural areas are too poor to support doctors and hospital services even with any form of health insurance, public or private funds be combined with insurance funds to equalize the ability of these families and these areas to secure and maintain needed health services.

3. That the people and doctors in every rural area should have access to modern diagnostic facilities and a hospital of good standing.

4. That since many rural areas cannot provide these facilities and service through their own efforts alone, State and Federal funds be made available for the construction of new hospitals and the improvement of some existing hospitals serving rural areas, but with the management of these institutions remaining in the hands of local people.

5. That adequate diagnostic and hospital facilities and stabilization of paying power through insurance are not only important for enabling rural people to secure modern medical services but they are also prerequisites for attracting and holding physicians, dentists, nurses, and other health personnel in rural areas and assuring them stable incomes.

6. That public health services with fully trained personnel be established in every rural section to improve sanitation, prevent and control disease, and promote good health.

7. That health and welfare services for the protection of children in rural areas be greatly expanded.

8. That States should provide scholarships to make it possible for able young men and women to study medicine in the medical schools of the State or of a neighboring State, under conditions which will cause them to start practice in rural sections after they have been trained.

9. That rural people should organize locally to study their health needs, and to make and carry out plans with the needed expert advice from their physicians, from their farm organizations, and from agencies of their State and National Governments.

TITLE II

Title II of S. 1606 goes considerably beyond anything proposed or approved by the National Grange. Moreover, it is a proposed extension of Federal authority and activity on which there has been no opportunity for an expression of opinion by the public generally.

I think most of us will agree with the objectives of title II, but possibly not the methods. The objectives, as we understand health insurance, are a wider distribution of medical services, universal participation as far as possible in health-insurance programs; provision of medical treatment for indigent groups and promotion of national health and efficiency.

This bill provides one approach to that problem. That approach is not in conformity with our concept of the scope of the Federal Government. We are not at all certain that the objectives expressed in the bill would best be attained by that method.

There is no disagreement as to the need for improving the national health; the more urgent necessity of making medical and dental care available to everyone who needs and wants it.

Basically, there are two approaches. We need to choose between them.

One is through a continuation of our slow but steady growth of the voluntary system, including the increasingly popular cooperative or group insurance. The other is through the type of a program proposed in this bill—compulsory insurance.

We should weigh carefully both the advantages and disadvantages of each system * * * we need to choose the one which will best meet our needs. We do not want to minimize in any way the problems of rural health.

We are painfully aware that many of the underlying causes of the so-called farm problem have their roots embedded in lack of proper medical and dental care. There is a direct relation between low health standards and low productivity and low income.

It is difficult to say which is the cause and which is the result—poor health and low income. If we take sound measures to improve rural health, there would be a resultant economic improvement. Likewise, if we take proper steps to improve income of farmers the result would be to obtain improved medical care. Probably we need to attack the problem from two directions—increased productivity and income and improved medical facilities.

OBJECTIVES OF A MEDICAL CARE PROGRAM

From the strictly medical direction, which is the only one before this committee, we suggest five objectives:

1. We must do something to ease the financial burden of illness so that medical and dental services are within the purse limitation of all.
2. Facilities, like hospitals and health centers, have to be constructed and sanitation must be improved.
3. More doctors, dentists, and nurses must be attracted to rural areas.
4. Good preventive public health services must be organized and people must be better educated about health and disease.
5. The scientific quality of rural medicine and related services must be elevated.

Those objectives are essential steps which must be taken in attaining the goal of improved rural health. Our present medical system has made commendable progress in the field of rural health. Yet, there are flaws in continuation of our present methods of meeting rural health problems. Our needs are not being met fully.

Medical facilities are not now adequate to meet needs. We need more physicians and more hospitals. Rural areas generally have fewer advantages in that respect than urban, although the need is equally as great.

Physicians operating on a fee basis hesitate to establish themselves in areas where people cannot afford to pay for their services and

where hospitals and other advanced medical facilities are not available.

Voluntary, prepayment group hospital insurance, such as the Blue Cross, has made remarkable progress. Group surgical insurance is another form of voluntary cooperative insurance. But these plans have their defects and limitations.

In the first place many plans are not very comprehensive as to the types of medical care provided. Second, some people do not have sufficient income to pay the specific subscription rates.

Compulsory insurance is a short-cut. It spreads the cost among all the people—decreasing the burden on those who require more than usual medical care and increasing it on others. There are, however, hidden costs in this new approach which we need to weigh carefully. Having weighed those costs against the desirability of making medical care equally available to all, we should make our choice.

DANGER OF BUREAUCRACY

We are reasonably certain that if we assign this problem to the sphere of governmental responsibility, it will mean probably the greatest expansion of Federal bureaucracy that we have ever witnessed in peace times. It would be difficult to estimate the number of Government employees required to administer such a system. It would add enormously to the cost of maintaining national health—without assurance that it would in the long run do a better job under our present democratic system of free enterprise.

Records and estimates available indicate that the number of persons directly included in such a national health insurance plan would be more than 125,000,000. All of these cases would have to go through the processes of certification, filing, inspection, payment, complaints, and adjustments. If an adequate staff and organization were provided, it would mean an army of Government employees.

Under our "spoils" system, such an expansion in the number of Federal employees could mean patronage—patronage for whatever political party was in power, patronage beyond anything dreamed of in the past, patronage down into every local community in the United States.

This does not necessarily condemn the proposed experiment in compulsory medical insurance, but it is a factor that must be considered. If we bring our doctors under Federal control, farmers, lawyers, veterinarians, and other serving the public interest, may well wonder if they will be next.

It is possible to expand the Federal Government to a point where States become merely administrative districts under direction from Washington. We have traveled so far in the direction of national control over our economic life that further steps in this direction must necessarily be considered in relation to the distance we already have come.

Whether it would be wise to embark upon a further expansion in Federal control of such magnitude, with the attendant growth in patronage, is a question to which we should at least give thoughtful consideration. We question whether one in a hundred persons understands the implications of this proposed expansion of Federal authority into their very homes.

There is no question as to the need for expanded medical services. Unquestionably, the need is proportionately greater in rural and small-town areas than in urban. There is urgent need for additional hospital facilities and the National Grange recently appeared before Congress in support of a bill to provide Federal aid in expanding the number of hospitals.

As I pointed out earlier, S. 1606 has a number of commendable features. One which we regard favorably is the provision for grants-in-aid for medical education, research, and prevention of disease and disability. That is section 213 of the bill. This would, we believe, be helpful in increasing both the number of physicians and their skill in applying the most modern methods of medical science.

S. 1606 WOULD BE TOO EXPENSIVE

No contention is made in support of title II that the bill would decrease the national cost of medical service. Rather, it would tend toward an enormous increase in the cost.

We have seen no factual data to support contentions of some people that such a system could result in improve national health. We can think of a number of reasons why it might not. We are far from certain that the advantages claimed for compulsory medical insurance, even if fully realized, would outweigh the obvious disadvantages.

In the ordinary relationship between patient and physician, the patient of average means is anxious to shorten the period of treatment and he avoids unnecessary claims on the physician's time. The physician, likewise, is anxious to effect a cure as speedily as possible, retain the patient's good will, and build up his own professional reputation.

Under compulsory insurance these conditions are subject to some strange inversions. There is a tendency on the part of too many people to "enjoy" a long illness; to run to a physician with every small or imaginary illness. Some physicians, with fees based on the number of calls or patients seen, would yield to the temptation to profiteer, both at the public expense and at the expense of other patients, who might have a more legitimate claim on their time.

This bill has been, mistakenly we believe, castigated as "social medicine." Yet it undeniably is a step in that direction. It is the natural tendency of a strong central government to seek to expand and enlarge its authority. That fact is amply illustrated today in economic controls. Those who seek constantly to enlarge central authority over States, cities, communities, and individuals do not follow the original concepts of our democracy.

Compulsory health insurance is not a cure-all. It is not a magic elixir for our ills. A number of labor unions, for example, have tried compulsory health insurance for their members—and have abandoned it as ineffective, expensive, and unworkable. There are no factual data to prove it would work on a national scale.

COMPULSORY MEDICAL INSURANCE IS UNAMERICAN

Compulsory medical insurance is incompatible with the preservation of private medical practice. The Government would establish the fees and other rules and regulations governing the relations between physicians and patients. Physicians' books recording confi-

dential information relating to their patients could be opened to Government inspection.

Compulsory medical insurance is as un-American as the Gestapo. Theoretically, each physician could refuse to participate in the plan. Actually, because few people would refuse to avail themselves of services already paid for in taxes, the clientele left to nonparticipating physicians would be negligible.

Available experience shows that current individualistic fee-for-service medical practice and tax-supported medicine are incompatible. It is one thing to have a patient pay a doctor for each visit or service rendered and a far different thing to have a third party make the payment.

There is a parallel between public medicine through taxation and food subsidies. Today we are taxing—or piling up debt to be paid out of future taxation—at the rate of 2 billion dollars a year to pay a part of the food bill of every American family.

For tomorrow, it is proposed in S. 1606, we shall levy still more taxes out of which we are to build another huge Federal bureaucracy to administer Federal payment of medical and dental bills. If we do that, where are we to stop, short of taxing to meet all the needs of all the people, to make certain that everyone has the same sort of a car, the same sort of a house, the same sort of clothes, and gets to see the same movies?

The medical profession has made great progress in recent decades under our present system. That is amply demonstrated by our constantly decreasing death rate due to preventable diseases and the increasing longevity of our people. There is no conclusive evidence that a compulsory system such as that proposed would not tend to arrest progress made under the free enterprise system.

It is not to be inferred from that that we oppose cooperative medicine and hospital insurance—we do, however, seriously question the use of compulsion. Compulsion is justifiable only when it can be clearly shown—as in the case of contagious diseases—that the public interest is best served by that approach.

There has been a healthy and commendable growth in recent years of voluntary medical and hospital insurance—group insurance for those who want it. There is every reason to believe that voluntary insurance of that type is in many ways more desirable and economical than the compulsory type suggested under title II of this bill.

It would seem to us to be more desirable for the Federal, State, and local governments to offer financial assistance, where necessary, in development of voluntary consumer cooperative insurance. The financial resources of some communities, undeniably, are insufficient to provide adequate medical services either on a cooperative or on a fee-for-service basis. Other communities have built up cooperative health insurance plans which they like, can afford, and want to keep.

There is, I believe, too much of a tendency in Washington to want to manage the lives and activities of everyone, whether or not they want or need such Federal supervision. We believe that, at this time, the disadvantages outweigh the advantages. Federalized medicine seems to us to be another step in the wrong direction; that is, toward surrender of more State, local, and personal rights to a centralized Federal authority. There is no conclusive evidence that Washington officials have a monopoly, nor even a preponderance, of wisdom in the

Nation. Yet the spread of Federal authority over the past generation has occurred at a rate which should give us cause for grave concern.

Today one out of every seven employed persons is on the public pay roll. There are more people who want the Federal Government to support them than there are who want to support the Federal Government.

For the reasons stated, we are opposed to enactment of compulsory Federal medical insurance in principle. We are opposed specifically to several provisions in title II of the Murray-Wagner-Dingell bill. I should like to suggest several changes which, if such a bill is enacted, we feel would make title II less objectionable.

PROPOSED AMENDMENTS

It is not to be taken that we suggest these things except as improving the present bill.

1. It would place in the hands of the Surgeon General tremendous funds with almost unlimited powers for allocation. We suggest that Congress should write into the bill a specific formula for distribution of funds.

2. The bill concentrates vast authority in the hands of Federal officials over local and State authorities. We suggest inclusion of a clear-cut policy providing for State administration of finances and programs.

3. The administrative boards should include nonmedical representatives of the public. In rural areas provision should be made for including farmer representatives.

4. Hospitals should be established not on the ability or inability of communities to pay, but upon the basis of need.

5. The two principal reasons why young doctors are not attracted to rural areas are lack of sufficient income and lack of proper medical facilities. We suggest special financial inducements, such as a guaranteed annual income, for physicians establishing themselves in rural areas.

6. The Surgeon General should be required to review rural health problems and progress and report to Congress each year.

7. A health program is fully effective only if it reaches all the people. The bill should provide for a special health-education program to be administered by local organizations, both Government and private.

The CHAIRMAN. Now, Mr. Bailey, you have discussed in some degree the need for an expansion of medical services in the country.

Mr. BAILEY. Yes.

The CHAIRMAN. You believe there is a genuine need for some way of meeting that problem?

Mr. BAILEY. We are firmly convinced of that, sir.

The CHAIRMAN. And the question which confronts you is the question of whether or not it should be a voluntary system or a compulsory system?

Mr. BAILEY. That is right.

The CHAIRMAN. And you have expressed the belief that a voluntary system may be expanded and provide a sufficient cure for the problem that we are confronted with?

Mr. BAILEY. We think so.

The CHAIRMAN. Have you given careful study to the various voluntary systems which have been proposed in the country?

Mr. BAILEY. The Grange is active, and has been for quite some time, in enlisting our members in the Blue Cross system, which is a form of voluntary insurance.

The CHAIRMAN. How long have you been interested in that?

Mr. BAILEY. I would have to ask our counsel, Dr. Halvorson here. He is more familiar with that than I am.

Dr. HALVORSON. I think it is in the last several years in which the plan has been expanding rapidly.

The CHAIRMAN. In the last several years.

Of course, this problem has confronted the country for a great many years, has it not?

Mr. BAILEY. Certainly.

The CHAIRMAN. Only in the last several years, since this agitation with reference to a program for meeting the problem has come up, have you become interested in the problem of voluntary insurance systems?

Mr. BAILEY. I would not say that at all, Senator. It is only in the last several years that we have actively adopted this particular method, the Blue Cross.

There have been various other methods we have been interested in for many years, but the Blue Cross is the only one in the last few years.

The CHAIRMAN. What other voluntary systems have you sponsored other than the Blue Cross?

Mr. BAILEY. I do not know any by name other than the local communities, and the Grange forming pools working in those districts.

Dr. HALVORSON. I think they have several Grange insurance companies. I am not sure how long they have been in operation. There is at least one. The Grange has contact, or works with at least one commercial insurance company.

The CHAIRMAN. How many people are served by those particular systems?

Dr. HALVORSON. I never made a complete survey of that. That will be done, I believe, this year.

The CHAIRMAN. But it is a relatively insignificant proportion of the farm population?

Dr. HALVORSON. It is yet, but we expect the number to increase right along.

Mr. BAILEY. It has been increasing steadily, Senator, at a very healthy rate of increase.

The CHAIRMAN. It has increased steadily during the last few years?

Mr. BAILEY. During the last few years.

The CHAIRMAN. You are familiar with the reports of the Selective Service System, which showed that as the result of ill health and defects which we found in the young men coming from the farm areas, that it was necessary to reject a very high proportion?

Mr. BAILEY. I believe the records on that will show a very high number were rejected for medical reasons, but a great number were also rejected for illiteracy, but the record does not distinguish between the two, psychiatric cases, where also it is questionable whether medical aid would have prevented it.

It is a question of how many actually were rejected because of that.
The CHAIRMAN. You are not a physician yourself?

Mr. BAILEY. No, sir.

The CHAIRMAN. The information which you are giving us now is the judgment of physicians, I assume?

Mr. BAILEY. That is based on reports which we have seen.

The CHAIRMAN. Which you have seen?

Mr. BAILEY. Prepared by physicians.

The CHAIRMAN. Did you have any assistance from medical men in the preparation of the statement you presented here?

Mr. BAILEY. I did not consult any medical men.

The CHAIRMAN. Who assisted you in the preparation of your statement?

Mr. BAILEY. Dr. Halvorson and I prepared it.

The CHAIRMAN. He is a member of the medical profession?

Mr. BAILEY. He is an economist.

The CHAIRMAN. He is not a medical doctor?

Mr. BAILEY. No.

The CHAIRMAN. I see. He assisted you in preparing the statement?

Mr. BAILEY. That is correct.

The CHAIRMAN. I see. Did he prepare the entire statement for you?

Mr. BAILEY. No, sir.

The CHAIRMAN. What part did he prepare?

Mr. BAILEY. I would not say any particular part at all. I wrote it and worked with it and consulted with him on it as to its economic soundness.

The CHAIRMAN. Did you consult with him before you started to prepare the report?

Mr. BAILEY. Yes.

The CHAIRMAN. You discussed it and went into it very carefully and determined on the manner in which you were going to present the matter, and after having discussed the whole program with him, you sat down to prepare your report?

Mr. BAILEY. That is right.

The CHAIRMAN. Dr. Halvorson, will you give your full name?

Dr. HALVORSON. Lloyd C. Halvorson.

The CHAIRMAN. You are a doctor of philosophy?

Dr. HALVORSON. That is right.

The CHAIRMAN. You are also an economist?

Dr. HALVORSON. That is right.

The CHAIRMAN. You made a study of the Blue Cross system?

Dr. HALVORSON. I have been with the Grange since last September only. I have only seen some of the reports put out by the previous committees who have worked on that. I will be making extra studies myself.

The CHAIRMAN. When did you first become interested in the voluntary insurance system?

Dr. HALVORSON. As far as any working with the organization is concerned, it has only been recently, after I started working with the National Grange, within the beginning of the year.

Mr. BAILEY. We have been meeting with our hospital study group, of which I spoke on the first page here. Dr. Halvorson has been working with those.

The CHAIRMAN. You have given a very careful study, then, to the Blue Cross system in the country during the time you have been associated with the National Grange?

Dr. HALVORSON. I would not say a very careful or thorough study at the present; no.

The CHAIRMAN. You know, of course, only about one-half to three-quarters of a million of your people have been interested in this Blue Cross system?

Dr. HALVORSON. That is about right; yes, sir.

The CHAIRMAN. How long, about, did it take to develop that number, approximately?

Dr. HALVORSON. I do not believe it got under way within the last several years, 40 years or so.

Mr. BAILEY. We began our activities to promote it only about that length of time, Senator.

The CHAIRMAN. The National Grange has known for a considerable period of time of this lack of medical care in rural sections of the country?

Mr. BAILEY. We have been painfully aware of that.

The CHAIRMAN. That is generally known to the people of the entire country?

Mr. BAILEY. Yes, sir.

The CHAIRMAN. No effort, of course, has been made by the American Medical Association, or any medical groups, to remedy that situation?

Mr. BAILEY. Are you asking me or telling me?

The CHAIRMAN. I am asking you.

Mr. BAILEY. I do not know.

The CHAIRMAN. You do know, however, that as a result of the lack of medical care in the rural sections, people frequently go without medical care and without necessary hospitalization?

Mr. BAILEY. That is right, sir.

The CHAIRMAN. What was your judgment a moment ago with reference to the report of the Selective Service Administration?

Mr. BAILEY. The records that I have seen do not distinguish between illiteracy and psychiatric cases and others which could have been prevented by medical care.

The CHAIRMAN. What reports do you refer to?

Mr. BAILEY. I do not have them with me; I would have to send them to you, Senator. I have seen them.

The CHAIRMAN. How are they described? Could you designate them to us?

Mr. BAILEY. The one I have is the one put out by the Department of Agriculture, and said that approximately one million of four million rejected were so rejected for illiteracy. That rate was much higher in the rural areas than in the urban areas. Approximately 800,000 were psychiatric cases. Those are the figures that are issued, I am fairly certain, through the Department of Agriculture.

The CHAIRMAN. What were the number of cases that were due to health conditions, say, defective health, and deformities resulting from lack of medical care at the time of birth?

Mr. BAILEY. Assuming that those figures are correct as to illiteracy and psychiatric cases, possibly I would say about 55 percent, that

being the remaining number, were rejected for medical reasons, assuming those figures are correct, out of 4 million.

The CHAIRMAN. Investigation of that report seems to have revealed the fact that rejections in the farm areas were at a higher rate than in urban areas?

Mr. BAILEY. That is right.

The CHAIRMAN. And you estimate that was due to the fact that there was a lower degree of medical care in the country than in the urban areas?

Mr. BAILEY. I think there is no question of that, sir.

The CHAIRMAN. You acknowledge there should be some way to cover those conditions, thereby providing a better degree of medical care in the rural sections of the country?

Mr. BAILEY. Certainly.

The CHAIRMAN. You have said, in some parts of your statement here, that the compulsory insurance system should be given very careful consideration before it is accepted?

Mr. BAILEY. Yes, sir.

The CHAIRMAN. Do you think that if it could be shown that a compulsory system of health insurance, such as we propose here, would be more successful than a voluntary system, that there would be no objection to it?

Mr. BAILEY. That is correct.

The CHAIRMAN. It all depends upon how far a voluntary system can go in curing and meeting this problem.

Mr. BAILEY. And another attendant disadvantage that we see to a compulsory system, yes.

The CHAIRMAN. What are the disadvantages to the compulsory system? What are the main ones?

Mr. BAILEY. There are a number of them. I believe I have tried to put them out here, Senator.

Number one is that in doing this, we tend to regiment our physicians. We build up a tremendous Federal bureaucracy.

The CHAIRMAN. Would you tell me, right there, how does it regiment the physicians?

The CHAIRMAN. That also, I believe, I tried to cover there. It is to this extent, Senator: any physician deciding not to become a member of this organization which the Government would set up, decided to stay outside of it, would have its practice very much limited since most people who pay through medical service through taxes would not want to go and pay a fee again on top of that.

The CHAIRMAN. If the Congress determined that a compulsory system is necessary system for the country, the physician could join it if he wished?

Mr. BAILEY. He could if he wished, and if he did not, he could starve to death, maybe.

The CHAIRMAN. Of course, he has no patent on this. He has no vested interest in the right to serve the people of this country as a doctor, has he?

Mr. BAILEY. No; I would not say he had any vested interest in it, or right, along that line, but if we establish that sort of a system, Doctor, I would judge from the bill that the Surgeon General would have the power, after consulting with his advisory council, to establish the rates of pay which each physician might collect.

The CHAIRMAN. That system is followed right now with the Veterans' Bureau, and it seems to be working very satisfactorily.

The Administrator of the Veterans' Bureau was just on the witness stand a moment ago. He described that system as it is operated in the Veterans' Bureau, and he says it has no bad effect on the character of the service or deterioration of the ability of the medical profession and that it works out very satisfactorily.

Mr. BAILEY. The only difference I see there, that in the case of the Veterans' Administration, the veteran has ample opportunity outside of that system to operate if he so desires. He would operate under the system entirely voluntarily.

Under a national system his opportunity to operate outside of that system would be limited.

The CHAIRMAN. However, if the system is satisfactory and results in good medical care and proper compensation for the service he renders, why is it necessary he should have an outside practice in addition to that? Some of these men in the Veterans' Bureau, I suppose, devote their entire time to the practice.

Mr. BAILEY. I presume some of them do, and perhaps some of them devote only a portion of their time to that, so they could divide it as they wish.

The CHAIRMAN. That is possible under this bill. That provides for a part-time practice.

Mr. BAILEY. However, any one taking medical service from a physician who is not a member of this board, or a system, would have to pay an additional fee on top of the taxes for this service.

The CHAIRMAN. What I mean is a doctor is at liberty to participate in any program to a limited extent and then carry on private practice outside.

Mr. BAILEY. To carry on such a practice for a fee?

The CHAIRMAN. Yes; for a fee. Therefore, you could do under this system exactly what you say would be possible to be done under the Veterans' Administration.

Mr. BAILEY. It is possible entirely, Senator, but I was only questioning whether the system would work out practically that way or not.

If I pay \$200 a year taxes for medical care, I am going to be just a little bit reluctant to seek a physician who is not under the system and pay for him extra on top of that.

The CHAIRMAN. You say that there is no question as to the need for expanded medical services in the country?

Mr. BAILEY. That is right.

The CHAIRMAN. You presume that your program would be better, then, for bringing this expanded medical care in the country entirely on a voluntary basis?

Mr. BAILEY. Yes; on a voluntary basis, but with this qualification, Senator: as I pointed out here, there are a number of communities in areas which cannot support a voluntary system of medicine either on a group-health-insurance basis or on a fee-for-service basis. Where that condition exists, I would be perfectly happy to see the Federal Government or the State government render assistance to those cooperative medical associations through grants, if necessary, or loans.

The CHAIRMAN. You say:

No contention is made in support of title II that the bill would decrease the national cost of medical service. Rather, it would tend toward an enormous increase in the cost.

You believe it would greatly increase the cost of medical care?

Mr. BAILEY. Yes, sir.

The CHAIRMAN. You mean to the country as a whole and not to the individual?

Mr. BAILEY. I mean to the country as a whole. Perhaps not to the individual—to some individuals, yes; to some others, no.

The CHAIRMAN. The very purpose of the bill is to lower the cost of medical care to the individual; is that not so?

Mr. BAILEY. I did not think that. I thought the purpose of the bill was to spread the cost.

The CHAIRMAN. That is true, of course, but that means in spreading the cost, it lowers it for the individual.

Mr. BAILEY. It lowers it for some individuals. In that case, it would have to raise it for others.

The CHAIRMAN. You have not studied the bill sufficiently to enable you to determine that point?

Mr. BAILEY. I believe that is a correct statement. I have not studied it sufficiently to come to that conclusion.

The CHAIRMAN. The bill is designed for that very purpose of lowering costs of medical care to the individual, so as to make it available to all the people and not to a special class.

Under the existing situation in our country, the rich are able to get the very best medical care. The people in between and in the lower sections of the income in this country are not able to get the best quality of medical care because they cannot afford it.

Mr. BAILEY. It has been said that only the very rich and the very poor receive adequate medical service in this country.

The CHAIRMAN. The people in between are the ones who suffer as a result of the existing system, because it is a great strain on them, and results eventually in great injury to their family; is that not true?

Mr. BAILEY. That seems to be the consensus.

The CHAIRMAN. Therefore, you recognize the great need of some way of meeting this problem of the country?

Mr. BAILEY. Certainly, we agree wholeheartedly to that, Senator.

The only thing we disagree with at all is the use of compulsion without adequate data to support contentions that that is the best way to do it.

The CHAIRMAN. The compulsion here is the compulsion which would require everybody in the country to participate in the national insurance program and make contributions to it for the purpose of lowering the cost to the people as a whole.

Mr. BAILEY. That is true.

The CHAIRMAN. What objections have you to that kind of compulsion?

Mr. BAILEY. It is another form of Federal control, putting another tax load on the Federal Government. If, as intended, the tax collected from this would go, all of it, to medical care, then the objection would be less. A portion of that tax to be collected will go

to maintain an army, practically, of Federal agents, Federal bureaus, that would have to take all these cases, put them through the process of certification, filing, inspection, payment of claims and adjustments. All of those things must be paid for from the medical bill, from taxes that would otherwise go to the payment of medical bills.

It would increase the expenses and it would decrease the amount of money that would actually go to medical treatment.

The CHAIRMAN. Have you made such a thorough analysis of this bill that you could make that as your own conclusion?

Mr. BAILEY. That is my own conclusion. I think it is inescapable.

The CHAIRMAN. You think it is inescapable that the overhead expenses of this program would be so extensive that it would make it impossible to operate satisfactorily?

Mr. BAILEY. I do not say it would make it impossible, but would make it more difficult.

The CHAIRMAN. I wish you would point out in what way that could be the result.

Mr. BAILEY. I think, Senator, that what I am trying to get at here is this: This bill, as I see it, does not fully meet the need of the country, that is, for more hospital facilities, for more medical facilities, it merely provides for the financing of those facilities.

If we are going to get the fees for doctors, and expend a good portion of that money for other than physicians—that is, for people to do this filing, instruction, payment of claims and adjustments, and so forth—then we are reducing the amount of money which is available strictly for medical care.

The CHAIRMAN. In your statement here, you say: "This bill has been, mistakenly we believe, castigated as socialized medicine."

Mr. BAILEY. That is right.

The CHAIRMAN. You say, "Yet it undeniably is a step in that direction."

Now, what objection do you have to the Government undertaking to provide a program whereby the people of the country would be better taken care of?

Mr. BAILEY. I have the same objection that, whereby the Government would, through taxation, take care of my building a house, take care of my buying a car, buying my food, my clothing, my railroad tickets, and pay my motion picture bills.

The CHAIRMAN. You have no objection to the Government providing programs whereby the farmers of the country are aided and assisted in matters pertaining to livestock and care of livestock and the manner in which they should be provided for, and so forth?

Mr. BAILEY. The Government has undertaken that not only in the field of agriculture, but in every other field, of course. They have been providing advice and technical assistance.

The CHAIRMAN. You make no objection to that?

Mr. BAILEY. No.

The CHAIRMAN. You made no objection to the Government controlling public utilities and setting up a manner in which they should have them kept?

Mr. BAILEY. That is right.

The CHAIRMAN. You have no objection to the Public Utilities Administration program, the Public Utilities Holding Company programs which were developed in the depression areas?

Mr. BAILEY. We have no objection to the protecting of the public in that manner.

The CHAIRMAN. You think wherever the Government sees where the public is not being provided for, that they should give a study to it and assist in some manner of bringing about a better situation?

Mr. BAILEY. Yes, certainly. We think the study in this case here is thoroughly justified and we think the committee is making such a study, and that the committee is working toward a final conclusion, and their work is very commendable.

The CHAIRMAN. Do you believe that the filing of this bill has developed great interest in the country and will bring about a complete study of the situation and probably result in some very satisfactory legislation?

Mr. BAILEY. We think that the introduction of the bill and the hearings being held by the committee will add considerably to the knowledge, interest, and understanding of the people on this kind of measure, and eventually will lead to solutions of the problems whereby the methods, suggestions, or otherwise, will be carried out.

The CHAIRMAN. You say here in your statement:

There is, I believe, too much of a tendency in Washington to want to manage the lives and activities of everyone, whether or not they want or need such Federal supervision.

Can you give me some examples of that?

Mr. BAILEY. An example of that would be the controls that we have had through the Office of Price Administration, a great many of them. They have tried to delve back into managing the affairs of the country and, as a result, we have had black markets, and disregard of regulations.

We have built up in this country an attitude of holding the law of the land very lightly.

The CHAIRMAN. In the last war, we had no such controls as that, did we?

Mr. BAILEY. Not of that exact type; no.

The CHAIRMAN. As I recall it, we had a very serious inflation in the country.

Mr. BAILEY. It has not been proved yet, I believe, Senator, that we will not have one this time.

The CHAIRMAN. It has held down the cost of living in this country tremendously during this war.

If we did not have those controls, we would have had a very serious inflation long before the present moment.

Mr. BAILEY. I have heard that argued both ways, Senator.

The CHAIRMAN. You would be in favor of taking off all these price controls and letting the law of supply and demand meet the situation?

Mr. BAILEY. I do not say I would be in favor of taking all the controls off. I think the controls which tend to decrease the supply of goods and increase the purchasing power of the country are in themselves inflationary.

The CHAIRMAN. What programs have accomplished that?

Mr. BAILEY. A number of programs have. The Office of Price Administration program of maximum average price, they have been slow in granting price increases after they have been granted wage increases and other costs. They have been tremendously slow in per-

mitting a manufacturer to obtain a price which would enable him to meet the wage increase costs, the other costs, and keep his production up.

We have increased inflation in this country by increasing the purchasing power, and increasing the amount of currency in circulation from about \$7,000,000,000 before the war to \$27,000,000,000 now.

Our bank deposits are tremendously increased. We did not tax during the war as we should have.

We built up a tremendous backlog of purchasing power, we piled up our debt, instead of it we put in subsidies which made food cheap and made the demand for food so enormous that we waste more food than we ordinarily should, and do. We have increased the demand for food tremendously. That has been the inflationary angle of it.

The CHAIRMAN. Of course, the accumulation during the war and all those other matters you have stated there, have a tendency to create inflation. However, the story is coming out of the recent convention being held by the National Chamber of Commerce, that seems to indicate that the business of the country are coming to realize that a continuation of the Office of Price Administration is absolutely necessary and it would be the most unwise thing that the country could do to remove those controls at this time.

Mr. BAILEY. I believe you will see that our testimony, both before the House and the Senate committees studying this, has been in favor of continuation of controls, but to make those controls workable.

The CHAIRMAN. Of course, that is absolutely logical.

If there is no need for a control, it should be removed.

However, the great dispute is as to the time when it should be removed.

You have stated in the conclusion of your statement here several changes which you think should be made in title II.

Have you any proposed amendments that you would like to submit to us, or are you merely suggesting?

Mr. BAILEY. I am suggesting objectives there, only, Senator.

The CHAIRMAN. You have no particular amendments that you wish to present?

Mr. BAILEY. No, sir. I would like to see amendments to obtain these objectives.

The CHAIRMAN. You are familiar with the Hill-Burton bill; I believe, are you?

Mr. BAILEY. I am not too well acquainted with it, but I am vaguely acquainted with it.

The CHAIRMAN. The Hill-Burton bill provides a program whereby hospitals could be secured in the sections of the country not now served by hospitals. It provides also that the local communities seeking such hospitals would have to prove their financial ability to support them.

How would you propose to meet that situation on otherwise than by a bill of this kind?

Mr. BAILEY. On that bill, I did not testify on that; Mr. Joseph Victor testified for us on that.

The thing he raised there was that this inability to pay must be based on some past period. You simply cannot go out and determine that now the community is not able to pay. You must base it on a period.

If we take measures to increase the income of those areas, then we may be able to afford the hospital. If they are not able to afford it, we then think an additional Federal or State aid would be needed to establish hospitals for communities that cannot support their fair share of it.

That is just a change in that bill to that extent, I believe.

The CHAIRMAN. Thank you for your testimony, Mr. Bailey.

Senator DONNELL, have you any questions?

Senator DONNELL. You are with the legislative counsel of the National Grange. How long has that organization been in existence?

Mr. BAILEY. Eighty years.

Senator DONNELL. What is its total approximate membership at this time?

Mr. BAILEY. Eight hundred thousand.

Senator DONNELL. The organization is composed very largely of farmers?

Mr. BAILEY. It is composed almost exclusively of farmers.

Senator DONNELL. Does the membership include men and women?

Mr. BAILEY. That is correct.

Senator DONNELL. Does it have any auxiliary branch in addition to its main body?

Mr. BAILEY. Well, we have a Juvenile Grange. They are not carried as Grange members, but they are juveniles below the age of 16. The age range is 12 to 16.

Senator DONNELL. Do women belong to the Grange itself or some auxiliary?

Mr. BAILEY. They belong to the Grange itself. They can hold offices just the same as men.

Senator DONNELL. How widely distributed over the United States is the membership of approximately 800,000?

Mr. BAILEY. We have organizations in 38 States. We have members in most of the other States, but they are not organized on a State-wide basis.

Senator DONNELL. The organization holds an annual meeting, does it not?

Mr. BAILEY. Yes.

Senator DONNELL. You refer to the 1945 annual meeting held in Kansas City, November 1945?

Mr. BAILEY. Yes, sir.

Senator DONNELL. How large an attendance was there at that meeting, Mr. Bailey; approximately?

Mr. BAILEY. I would have to answer that in two ways, Senator. The official attendance consists of representatives of each of the 38 States. The representatives from each State consist of the State master and his wife. We then have the officers of the national convention. That is the entire official attendance. It is a legislative body.

I would say that would make up about 125 who are official attendants.

At various times during the conventions, other people come in. I think the highest number we had at one time was approximately 3,000, at one time.

Senator DONNELL. That was held in a large building?

Mr. BAILEY. Yes, sir.

Senator DONNELL. That was held in the largest building in Kansas City, for that purpose, the auditorium?

Mr. BAILEY. That is right.

Senator DONNELL. Mr. Bailey, may I ask you some questions on your personal experience?

What was your occupation before you became the legislative counsel of the National Grange?

Mr. BAILEY. I was national farm editor for the United Press.

Senator DONNELL. How long did you have that connection?

Mr. BAILEY. 17 years.

Senator DONNELL. What was your background, and education in school?

Mr. BAILEY. I was born on a Texas farm, raised on a farm, went to high school at Commerce, Tex., and went to the East Texas State College of Commerce for 2 years, finished up at the University of Missouri, 2 years, graduated with a degree in agricultural journalism.

Senator DONNELL. I will call the attention of the chairman to the fact that the convention was held in Missouri, and that Mr. Bailey is from Missouri.

I might say that as I go over the list for next week, the first two people are from St. Louis.

The CHAIRMAN. You cannot say the chairman of this committee nor the committee has been unfair in distributing the witnesses.

Senator DONNELL. I would say they have been very fair.

Mr. BAILEY. I might add, you have asked, but my wife is a Missourian also.

Senator DONNELL. Now, Mr. Bailey, after you finished the University of Missouri, with your training there, did you go immediately to the United Press?

Mr. BAILEY. Yes, sir.

Senator DONNELL. That was in 1927?

Mr. BAILEY. Yes.

Senator DONNELL. You stayed there until 1944?

Mr. BAILEY. Yes, sir.

Senator DONNELL. In your connection with the United Press, did you have occasion to visit a portion of the United States?

Mr. BAILEY. I visited every State in the Union with one exception, as a reporter.

Senator DONNELL. You became acquainted with farm problems of the country, you think, quite well?

Mr. BAILEY. I felt that I understood them very well; yes.

Senator DONNELL. You believe you are familiar with the sentiment of the farmers of the country?

Mr. BAILEY. Yes, sir; being a farmer myself.

Senator DONNELL. Do you regard the expression that is made by the annual conventions of the National Grange as fairly representative of the sentiment of the great majority of the members of the Grange?

Mr. BAILEY. I will explain to you how the resolutions are passed, Senator. I believe that will answer the question better than any other way.

The resolutions which reach the National Grange floor first must originate in a subordinate grange, which is a local community grange.

It must then be passed to the county, which is a promoted grange, and consists of delegates of all the granges in the country. It is then sent to the State grange and must be passed there.

It is then sent to the National Grange. Every resolution has its roots in the farm home at the local level. It must come from that direction; it can come from no other.

Senator DONNELL. Do you know if the membership of this national body was familiar in 1945 with the fact that there was pending, or about to be pending, at any rate, a bill along this general line for compulsory health insurance?

Mr. BAILEY. I am not certain that the Committee which drafted this resolution was aware of that, Senator.

Senator DONNELL. Do you think that Committee knew of the fact that there had previously been introduced a bill called S. 1050, a year or two before that?

Mr. BAILEY. I think the Public Health Committee which drafted this was familiar with previous proposals.

Senator DONNELL. In other words, the proposal is generally known as the "Wagner-Murray-Dingell proposed legislation."

Mr. BAILEY. I suppose, since they have made a study of the subject, that they were familiar with it.

Senator DONNELL. As you have pointed out in your statement here, "Title II of S. 1606 goes considerably beyond anything proposed or approved by the National Grange." Is that not true, Mr. Bailey?

Mr. BAILEY. That is right.

Senator DONNELL. You were present at the Kansas City meeting yourself, I presume?

Mr. BAILEY. That is right.

Senator DONNELL. Now, Mr. Bailey, you made reference to various voluntary organizations. I am wondering if you have had it within your knowledge or called to your attention that out in California your organization has had some negotiations or possibly some contractual arrangements, I am not certain which, with the California Physicians Service looking to the furnishing by their organization of approximately 100,000 members of the Grange of certain facilities offered to the Grange.

Are you familiar with that?

Mr. BAILEY. I know about it, but I am not familiar with the details on it, Senator.

Senator DONNELL. You do not have that?

Mr. BAILEY. I know it is a voluntary system upon which we are working.

Senator DONNELL. Has that actually been entered into between the Grange and the California Physicians Service, do you know?

Mr. BAILEY. I am not certain.

Dr. HALVORSON. I believe I have seen an advertisement to that effect.

Senator DONNELL. Your membership in California is about 100,000, is it?

Mr. BAILEY. It is approximately that.

Senator DONNELL. You also referred in your testimony, page 8, to the fact, as you state:

A number of labor unions, for example, have tried compulsory health insurance for their members, and have abandoned it as ineffective, expensive, and unworkable.

Do you know how many labor unions have made that experiment?

Mr. BAILEY. Only two that I know of. I had reports and I did not bring them with me. This is based entirely upon reports which I have had and not upon personal experience.

The International Ladies' Garment Workers was one that tried it.

Senator DONNELL. Is that a Congress of Industrial Organizations organization?

Mr. BAILEY. I believe it is now affiliated with the Congress of Industrial Organizations.

Senator DONNELL. What else do you know about it?

Mr. BAILEY. Three or four years ago, they made a report in which they said that it had been unsuccessful for several reasons. It gave, as among those reasons, the fact that it increased the absenteeism of their members from work because they would be off ill and receive benefits. They would go to a doctor. They were using the services of a doctor when it was not necessary. The physicians who had made contractual relations with the organization had gypped them, in other words, to put it briefly.

Senator DONNELL. That has a bearing, I take it, on the point you make in your statement, and is illustrative there of, as you say in your report: "There is a tendency on the part of too many people to 'enjoy' a long illness; to run to a physician with every small or imaginary illness." The experience of the labor unions would bear out that point?

Mr. BAILEY. Yes, sir.

Senator DONNELL. Do you have the report with respect to the International Garment Workers in your office?

Mr. BAILEY. I believe I have it in my office. I had it in preparing this statement. I know it is in the file there and I would be glad to get it for you.

Senator DONNELL. I wonder if you would be kind enough to furnish the members with a copy of that?

Mr. BAILEY. I would be glad to. The thing is a reference to it and not the report itself. It is a quotation that someone else has made from it.

Senator DONNELL. Do you remember what the other one of the two labor unions to which you refer is?

Mr. BAILEY. My recollection is that it was the teamsters union.

Senator DONNELL. Would you be kind enough to refresh your memory and if it is not too much trouble to furnish to each member of the committee what information you have on that?

Mr. BAILEY. I would be glad to.

Senator DONNELL. Could you do that within the next few days, Mr. Bailey?

Mr. BAILEY. I think I could.

Senator DONNELL. I wanted to ask you also, with respect to your statement also, on pages 5 and 6, as to the various indicia of the fact that this would build up a very large list of Government employees.

Now, you mentioned here, I think, to my mind, at any rate, more clearly and definitely than any witness we have had, the different types of work that employees would have to do.

You mentioned the processes of certification, filing, inspection, and payment of claims and adjustments.

You figured here for something around 125,000,000 persons. I think the figures we have had here range from 107,000,000 to 112,000,000.

But at the rate of 107,000,000 people, and to have those functions performed by employees, with reference to 107,000,000, it is obvious to me that your point is quite clearly well taken; that it would require a very large number of employees.

The CHAIRMAN. You are familiar with the fact that we already have set up in this country a social-security system. We have administration headquarters here in Washington. That office is staffed with personnel that would take care of a lot of this work that you have mentioned here.

Mr. BAILEY. I am aware that you have that set-up; yes. I am not familiar with how it could operate in this case.

The CHAIRMAN. A large part of the office work that should be required under this system will be handled by the personnel of the Social Security Administration as it is now staffed.

Mr. BAILEY. Am I to infer from that, Senator, that it would not be necessary to add more people to the Social Security Board to carry this work?

The CHAIRMAN. It is possible that more may be added, but you approach it as though you would have to build up from a ground foundation a huge organization now to administer this particular bill.

Mr. BAILEY. I was assuming that it would be handled independently of any other agency now in existence.

Senator DONNELL. If I might interpolate at this point, Mr. Chairman, this may be a violent assumption, but I am assuming for the purpose of argument that the time of the employees' day is reasonably well occupied and that they are not sitting around idly with a lot of vacant space or time to be filled in. While they may be able to add to some extent to the duties to be performed, I would think it would be obvious that with a vast, new system such as this, registration, constant operation, complaints, et cetera, et cetera, certainly that would have to entail more people and a great deal more work.

The CHAIRMAN. Not necessarily very many more, because they already have that set-up now under the present Social Security system. It would merely mean a little more work, not much more, because the same people, to a large degree, are already involved in the Social Security program as we have it today.

Senator DONNELL. I am pleased that the chairman has mentioned this point as Mr. Bailey has emphasized his view on it, I think at some future hearing it would be helpful if we had some additional information from the Social Security Board along those lines.

The CHAIRMAN. We intend to present that.

Senator DONNELL. In addition to those that you have given here as employees that would be necessary, has your thought been directed to the provisions of subsection (d) of section 204, page 46, in which reference is made to the services of specialists or consultants? Now, I am not referring to those gentlemen or ladies, as the case may be, as the employees to whom I direct your attention, but I observe this: That the services of specialists and consultants under some instances may be available when requested by an individual entitled to those services as benefits and approved by a medical administrative officer appointed by the Surgeon General.

The point I direct your attention to is that in addition to the types of work you have mentioned, it would be contemplated by that subsection that the Surgeon General should appoint throughout the United

States all such necessary medical administrative officers as could pass upon questions of this kind.

You would agree to that, would you not?

Mr. BAILEY. I would agree to that, Senator.

The CHAIRMAN. Of course, that is another matter that would be considered when we produce the witnesses.

Senator DONNELL. Mr. Bailey, I am wondering if, in the course of your experience, we will say in my home State of Missouri—we have 114 counties in Missouri—I have never made any computation of this, but I would imagine certainly we have 114 county seats and possibly an average of not less than five towns to a county, and I would not be surprised if it would run into 8 or 9 or 10.

Suppose we would say an average of 5 sizeable towns to an average county, that would be 570 in round figures, to Missouri.

Now, there are 48 States. That would run, in the neighborhood, on the average, 570 to a State, it would run upwards of 25,000 towns of that size. I take it that you would agree, would you not, Mr. Bailey, that people might get sick in any one of those towns that might require or think they required special consultant service.

Would you not agree to that?

Mr. BAILEY. Yes.

Senator DONNELL. As these became ill and required or thought they required services, they would want pretty quick action, if necessary, in determining by some specialized administrative officer appointed by the Surgeon General.

Mr. BAILEY. They would like to have it.

Senator DONNELL. Of course, if the Surgeon General is going to appoint a requisite number of officers—I am not undertaking to say the number—but obviously, from all these cities, some of them large like Chicago, New York, Kansas City, and Dallas, Tex., and so forth, it would be necessary to have more than one in towns of that size. It would be quite a sizeable number of so-called medical administrative officers to be employed by the Surgeon General.

Mr. BAILEY. I would not estimate the number at all. I would say you are correct, it would be a sizeable number.

Senator DONNELL. I observe also, that not only are those to be administrative officers, but they are to be medical administrative officers. That would appear that they would have to have a qualification as doctor.

Mr. BAILEY. I would understand it, from that language, that they were to give consultant service.

Senator DONNELL. They are not to give the services, they are to approve or pass upon, I take it, the question as to whether the given patient, among all of those in the community, are entitled to specialist and consultant services that the patient may desire.

Mr. BAILEY. Oh, yes.

Senator DONNELL. So he would have to be reasonably expert along a good many lines in order to know whether a man or woman is entitled to that specialist or consultant service, would you not think?

Mr. BAILEY. I would think so.

Senator DONNELL. That would seem to involve the point you make, regarding the large number of Government employees that would be necessary.

Mr. BAILEY. Yes, sir.

Senator DONNELL. Have you ever heard of a book or publication on Doctor Crownhart on Sickness Insurance?

Mr. BAILEY. I am not familiar with it.

Senator DONNELL. My information is, though I have not seen the book, that this doctor states, in substance, that in European countries sickness-insurance schemes would indicate 1 government employee for each 100 insured persons are required to administer and police the insurance system. Now, whether that is right or wrong, I do not know. At any rate, I would like to have the record note that so we may not overlook it in our further considerations.

Mr. Bailey, you also referred to the Selective Service figures. You mentioned that there is an inclusion in those figures of illiteracy, and matters of that type. I ask you also if it is your understanding that in those figures are included such physical defects as club feet or deformed arms, or something that medicine cannot have anything to do with?

Mr. BAILEY. A great number of them consisted of flat feet among the men who were in the military service, they tell me that.

The CHAIRMAN. You consider that none of those diseases or defects could have been avoided with proper medical care in the families where those deformities occur?

Mr. BAILEY. I would not make it quite that inclusive, Senator; I am not a medical expert but I could not tell you.

The CHAIRMAN. Is it not a fact that a great many diseases result from failure to have proper attention at childhood?

Mr. BAILEY. A great number could be so considered.

The CHAIRMAN. Is it not true that the situation of lack of proper care in the case of childhood exists in the farm areas and exists there more so than in any other section of the country?

Mr. BAILEY. I am not familiar with the statistics, but I assume you are correct.

The CHAIRMAN. Therefore, a great many diseases caused by injuries to the brain or to the head, in childhood, might be avoided with proper medical attention in the rural areas?

Mr. BAILEY. Certain diseases, if they are caught in the early stages, are preventable, and curable, I should say, and if they are not caught in the early stages, they would make a person deformed for life.

The CHAIRMAN. Therefore, these deformities that you refer to are deformities in many instances that might have been avoided with proper prenatal care and care at time of birth?

Mr. BAILEY. Yes; but please do not misunderstand me, Senator. We are keenly aware of the very great need for medical service, particularly for rural people. We only question the method with which it is to be attained.

The CHAIRMAN. You were undertaking to tell us that all those things should be eliminated from consideration, that those are things that could not have been avoided. It seems to me that now you concede that many of those things could have been avoided.

Mr. BAILEY. Some of those things could. I think, even taking illiteracy, of which they say numbers 1,000,000, illiteracy is in part due to lack of proper medical care. That may seem strange, but the fact is that on some farms, the farm families are impoverished by

poor health to the extent that they cannot send their children to school.

We are not questioning for one moment the seriousness of the thing.

The CHAIRMAN. What you were undertaking to break down was this report of selective service, and point out that that is not such a bad record, after all, for the farmers, because most of those diseases are diseases such as deformities, and illiteracy and so forth, whereas it now appears from the testimony that a great many of those defects could have been avoided if we had proper medical care in the rural sections of the country.

Mr. BAILEY. If I gave that impression, Senator, misstated myself. I was not trying to detract from the seriousness of the situation, I was merely trying to point out there were other factors involved.

Senator DONNELL. I understood that was the case, Mr. Bailey. In fact, Mr. Bailey points out the resolutions here in 1945 which would clearly indicate the Grange, as I see it, that there is an importance attached to more adequate medical care.

We all realize the desirability of that.

What you were pointing out, as I understand, is that in this over-all figure, about the rejections, that there is a certain number—about the exact number to which you are not testifying—are those which are not diseases or types of bodily afflictions, which are susceptible to cure by medicine or surgery.

Mr. BAILEY. I have seen what seems to me to be authentic reports on that.

The CHAIRMAN. You think that report from the selective service people is quite a reflection on the lack of proper medical care in the rural sections of the country?

Mr. BAILEY. Yes.

Senator DONNELL. Now, about the United Press Association, that is one of the great press associations of the United States, is it not?

Mr. BAILEY. Yes.

Senator DONNELL. That, and the Associated Press, are the two outstanding ones?

Mr. BAILEY. Yes.

Senator DONNELL. I do not retain what position you had in the United Press.

Mr. BAILEY. I was National Farm editor.

Senator DONNELL. Do you mind tell us very briefly the duties you had in that capacity?

Mr. BAILEY. My duties in that capacity largely included the coverage in Washington of agricultural bills and measures affecting agriculture in Congress here.

It included coverage of the Department of Agriculture's developments here, attending conventions of farmers, and making personal investigation of farm conditions in various States. I traveled during that time, in every State in the Union, with one exception.

Senator DONNELL. Do you furnish the Kansas City Star any service?

Mr. BAILEY. I am not familiar with whom the United Press is serving now.

Senator DONNELL. I should say, during the time you were with it. Particularly, I was wondering if you furnished anything to the editor of the Star, Mr. William Cotchell.

Mr. BAILEY. I believe we did. I know him personally.

Senator DONNELL. One other question, Mr. Bailey, that is on the matter of costs.

You have stated here in your statement:

No contention is made in support of title II that the bill would decrease the national cost of medical service. Rather, it would tend toward an enormous increase in the cost.

The Chairman suggested the thought that the bill has in mind the decreasing of the cost to each and every person throughout the country.

I was interested to note your point, which I think is sound, that that is an impossibility. That is to say, unless the aggregate of expense is going to be decreased.

In other words, it is going to be a spreading, as I understand your theory.

Mr. BAILEY. That is my understanding of the purpose of it.

Senator DONNELL. It certainly cannot be depended upon to decrease the cost of everybody, or else you are going to have to decrease the entire cost.

I may put it the other way, unless there is to be a total decrease in the adequate medical expense of the country, it will be impossible to decrease it for anybody.

Mr. BAILEY. I think the total medical expense of the country should be increased, and not decreased, by supplying additional services.

Senator DONNELL. This insurance plan, as you understand it, is one under which there is going to be a spread of that cost. Some of us do not have to go to a doctor at all. Those that that is true of, we would contribute something more than we ever had been contributing under any plan. As to the fellow who had been spending lots of money with doctors, he would pay less.

Mr. BAILEY. How many cents out of every dollar that we pay out would go for medical care, and how many cents would go to administrative care, I am not certain of. It would be a very sizable amount of it.

Senator DONNELL. That is a very important question.

Now, the bill itself does not contain the financial provisions, does it?

Mr. BAILEY. I have not found that it does.

Senator DONNELL. May I just ask you, for the record, Dr. Halvorson, would you be kind enough to give us just a little further information on your background so we may know of your educational qualifications.

Doctor, will you be kind enough to tell us, first, where you were born?

Dr. HALVORSON. Swift County, Minn.

Senator DONNELL. What was your schooling?

Dr. HALVORSON. University of Minnesota. I graduated from the College of Agriculture. I spent 1 year of graduate work with the Iowa State College, and I went back to Minnesota, majoring 1 year in public administration, and ended up with a Ph. D. in agricultural economics.

Senator DONNELL. You received that degree from the University of Minnesota?

Dr. HALVORSON. Yes, sir.

Senator DONNELL. How long have you been with the Grange?

Dr. HALVORSON. Since last September.

Senator DONNELL. In what capacity, please?

Dr. HALVORSON. As an economist.

Mr. BAILEY. He formerly worked in Missouri with the Farm Credit Administration.

Senator DONNELL. I am glad to know that.

Doctor, you want to come back to Missouri, do you not?

Dr. HALVORSON. Yes.

Senator DONNELL. We would like to have you.

The CHAIRMAN. That was the only question I was going to ask him, if he had not at some time been connected with Missouri.

I would like to ask Mr. Bailey, again, whether in working out any solution of this problem for the expansion of medical care in the rural sections of the country, you do not advocate that it should be based on any system of charity to the farmers who are unable to pay, do you?

Mr. BAILEY. No, we do not believe in charity. We believe that the Farm Security Administration is helping those that cannot help themselves, and we believe we need Federal assistance to help them in a medical way, too.

The CHAIRMAN. You want every farmer to have good medical care as a matter of right?

Mr. BAILEY. Yes.

The CHAIRMAN. You want to see them pay for that care to the fullest extent that they are able to pay for it?

Mr. BAILEY. I want to see that ability to pay for it increased.

Senator DONNELL. Mr. Chairman, I wonder if you would mind asking the witness this question: At that point, I think it is appropriate to call his attention to this language on page 2 of his statement, and ask him if he would not kindly explain his views on that.

The language is—this is one of the recommendations of the meeting last year:

Since many rural families and rural areas are too poor to support doctors and hospital services even with any form of health insurance, public or private funds be combined with insurance funds to equalize the ability of these families and these areas to secure and maintain needed health services.

Would you please explain that, Mr. Bailey, just how you have in mind, the combination of those funds, the administration of it?

Mr. BAILEY. If Dr. Halvorson will check me on that, I will tell you what our understanding is; that is, that we will form cooperative medical groups in rural areas and to the best of our financial ability in those areas, support those groups. It may be necessary, in order to get them started and get them well established, get a physician in there, and hospital facilities in there, to supply some form of public assistance for the time being in the form of possibly State or Federal grants, perhaps.

I am not proposing how it should be done, but there should be some form of public assistance until that organization can get on its feet and provide the services.

It is a cooperative thing. We want to do all we can ourselves, and then if, for some reason, it is an area that does not have the financial means of doing it, we feel we should call upon the Government to help.

The CHAIRMAN. In other words, this program has not been fully worked out?

Mr. BAILEY. That is correct, sir.

The CHAIRMAN. However, in the meantime, for many years, these conditions have existed in the farm areas of the country as the result of which these rejections have occurred that I have mentioned in connection with the selective-service report, and the matter has been agitated a great deal, and yet no program has ever heretofore been advanced which took care of that situation?

Mr. BAILEY. We have made tremendous strides, of course, in medicine and medical care all over the country, not only in farm areas, but in others.

We have been successful largely in eliminating typhus. We have made progress.

The CHAIRMAN. Still, in a great many rural areas, there are people who do not have adequate medical facilities at all, nor adequate medical care.

Mr. BAILEY. That is right.

The CHAIRMAN. At this time, you do approve of title I of this bill?

Mr. BAILEY. Title I is in conformity with our program, yes.

The CHAIRMAN. That, together with Senate bill 191, the hospital construction bill, would go a long way toward building up these facilities in the backwood sections of the country and the rural areas.

Mr. BAILEY. We want some one to help us to help ourselves.

We do not want somebody to come in and do the whole thing.

We think there is too much of a tendency in the country for people to rely on people to do something for them.

We want to do it ourselves, and we can.

The CHAIRMAN. This program is based upon that policy. This program makes it possible for the American people to pay their way and not take care of their health under a system which reduces the cost to them so that they can pay their own way and not be recipients of charity.

That is the theory of the compulsory program, whereas the voluntary program, we argue, is not broad enough, it does not have the coverage, it denies the very people who are most in need of care the right to join those groups.

Mr. BAILEY. I understand 3 percent tax is proposed here; 3 percent out of many salaries.

The CHAIRMAN. It is $1\frac{1}{2}$ percent for the workers and $1\frac{1}{2}$ percent for the employers.

Mr. BAILEY. It adds up to 3 percent as a total, regardless of whether it is paid by the employer or whether the employee pays half of it. It is taken out of the salary of a person having an earning capacity of only \$1,000 a year, and it hurts him just about as badly as it does under the present system. It reduces his income.

When you get down to where it takes only \$30 or \$40 from a person, if that person is in difficult circumstances, that is liable to put him in a pinch.

The CHAIRMAN. It costs them more than that under the existing medical system.

Under the existing medical system, they would have to pay really more than that.

Mr. BAILEY. On the average, I would assume they probably would, either that or accept charity.

The CHAIRMAN. Especially in the farm areas of the country, the farmers who have very meager incomes, would be, at present, under

existing costs of medical care, absolutely deprived of adequate medical care.

They would be afraid to go to a doctor.

Mr. BAILEY. It is not the average cost, Senator, that hurts the farmer, so much as it is the sudden illness and him having a \$1,000 doctor bill and hospital bill all at once. It is loading him all at once, and not over the years.

We need a system that will spread that cost over a number of years.

The CHAIRMAN. The question is whether a compulsory or voluntary system is the best approach.

Mr. BAILEY. That is the only question we raise.

The CHAIRMAN. You admit the compulsory system is entitled to the very fullest investigation and study?

Mr. BAILEY. I think so, very much.

The CHAIRMAN. If it can be established that it is more advisable and will result in a better health-care program in the country, you would not oppose it?

Mr. BAILEY. I would go further than that, I would say we would come up here and support it 100 percent.

The CHAIRMAN. That is all.

Thank you very much.

Senator DONNELL. I understand your emphasis on this matter of compulsory insurance receiving fullest consideration, your thought was that there are so many problems and objections that you see to it that they should not plunge into it until we have first given it the fullest consideration?

Mr. BAILEY. I said here that I do not believe 1 in 100 persons understood the bill.

The CHAIRMAN. A great deal of propaganda has been sent out over the country misrepresenting the bill, distorting it, I suppose you know that?

Mr. BAILEY. There has been propaganda on both sides, there usually is.

The CHAIRMAN. I do not know about the propaganda on both sides.

Mr. BAILEY. There are some people for it and some people against it.

The CHAIRMAN. I do not know of any propaganda in support of this bill.

Mr. BAILEY. Propaganda is what the other fellow calls the remarks of another person when that other person disagrees with him.

The CHAIRMAN. Do you think I am guilty of propaganda in introducing this bill?

Mr. BAILEY. No, sir.

The CHAIRMAN. I have certainly enjoyed your testimony here today, and we will be glad to have those matters submitted to the committee for further study in connection with your study.

Mr. BAILEY. Thank you, Senator. We will be glad to have you do that, and we appreciate the opportunity of appearing before your committee.

The CHAIRMAN. The committee will recess until Monday morning, at 10 o'clock.

(Whereupon, at 12:20 p. m., Friday, May 3, 1946, the committee recessed to reconvene Monday, May 6, 1946, at 10 a. m.)

NATIONAL HEALTH PROGRAM

MONDAY, MAY 6, 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 and Donnell.

The CHAIRMAN. The hearing will come to order.

The first witness this morning is Rev. R. A. McGowan, of the National Catholic Welfare Conference.

STATEMENT OF REV. R. A. McGOWAN, DIRECTOR, DEPARTMENT OF SOCIAL ACTION, NATIONAL CATHOLIC WELFARE CONFERENCE

Reverend McGOWAN. My name is Rev. R. A. McGowan, and I am director of the department of social action of the National Catholic Welfare Conference.

Senator DONNELL. Mr. Chairman, may I ask the Reverend McGowan from what State he comes, please?

Reverend McGOWAN. It is an obscure State in the Midwest called Missouri.

The CHAIRMAN. You left that State, however?

Reverend McGOWAN. It is still my home, however.

Senator DONNELL. You have already regretted it, have you not?

Reverend McGOWAN. Yes.

The social action department of the National Catholic Welfare Conference wishes to present a statement on the bill to provide a national health program, S. 1606. We wish to speak particularly on the part dealing with national health insurance.

Our department lacks the technical knowledge to appraise fully all features of the bill. Msgr. John O'Grady, director of the National Conference of Catholic Charities and the Rev. Alphonse M. Schwitalla, S. J., president of the Catholic Hospital Association will appear before this committee and can answer such questions.

The group we represent has long manifested interest in a general health program. The bishops' program of social reconstruction, issued 27 years ago, just after World War I, urged social security not only against unemployment and old age but against sickness and disability.

REQUIREMENTS OF AN EFFECTIVE HEALTH PROGRAM

In order that any national health program can become effective the following requirements are essential:

(a) There must be an extension of hospital facilities by means of Government support or subsidy for hospital construction, particularly

in the areas sparsely settled and in the areas of low per capita income. There can be no extension of services without facilities to implement the program. This proposal is now under consideration by Congress.

(b) There must be a notable extension of public health centers for the prevention of illness. This phase of the program requires Federal appropriation and administration and is included in title I of this bill.

(c) There must be provision for adequate medical and nursing services in areas where such services are now insufficient. Private or voluntary effort will not place doctors or nurses where most needed. Some form of Government aid will be required for this purpose. We suggest consideration of this: That in such areas a policy of granting Government commissions to selected physicians for civilian service on at least a part-time basis be carefully explored and also the ideas of using services of physicians attached to the military services.

(d) There should be Federal support or subsidy to the States on a matching basis to provide care for the medically dependent who are entitled to public assistance. This, too, is in title I.

(e) There should be subsidies granted by the Federal Government to qualified colleges and universities for medical research.

We favor the establishment of a national health program which will provide both hospital and medical care for the citizens of our country. We recognize that the voluntary systems of health insurance which have rendered excellent service to our people would require some form of Government aid to achieve universal health security.

SUPPORT OF NATIONAL HEALTH INSURANCE BUT NOT S. 1666

We favor in consequence a national system of insurance supplemented by Government tax revenues by means of which all citizens can be protected in matters of health; but we consider that this bill as presently drafted is unsatisfactory because of the complicated methods of administration which it creates and because of the excessive Government control over the health services which are to be provided. This statement is directed toward improvements in the bill.

In declaring ourselves in favor of a national health program and health insurance we are not doing so because we consider that the Government has the responsibility to take over all the obligations of individuals to care for their own health or to control the doctors and hospitals whose function is to provide medical and hospital care. Just the contrary. But governmental authorities have the duty of supplementing the failures of individuals to care for their health and even compel them to live up to their own obligations and to assist the medical and hospital professions to fulfill their social functions. We maintain a real if limited freedom of both individuals and the medical and hospital professions.

The costs of a full health program will, however, be enormous. It will come ultimately from the productivity of the American people; and therefore will depend upon general prosperity, and those governmental and private policies that will secure maximum employment and maximum production. It will depend also upon the presence of doctors, nurses, hospitals, and technical people in sufficient numbers to provide the care.

These are important considerations. We trust that steps will be taken by the Government and by private organizations to get the full output which can pay for the costs of health, and that governmental and private efforts will produce the people who can furnish the technical knowledge.

In a well-conceived and soundly administered program of national health insurance, we regard the following elements as essential:

(1) There must be universal coverage of all citizens against the hazard of illness.

(2) If the program is made compulsory in fact, it should at least be voluntary as to method. By this we mean that the voluntary element in health care should be conserved and strengthened. Our citizens should be given the option of making their own health plans provided that there is both universal coverage and prepayment by some form of insurance.

FEDERAL ADMINISTRATION NECESSARY

Such a program requires a national system and Federal administration. Federal administration allows, if properly constructed, far more flexibility in arrangements with the medical profession and the hospitals than does the Federal-State system, while it provides also uniform, good care of patients. This bill establishes Federal Administration. As we shall note later, however, the method of administration should be greatly improved.

We are particularly interested in details of the law and the methods of administration. One indication of our long-standing interest in this matter is found in the bishop's program of social reconstruction referred to before. Asking for a social-security program for labor against illness and invalidity, as well as unemployment and old age, the bishops' program was insistent that the administration of the law interfere as little as possible with the individual freedom of the worker and his family.

S. 1606 extension of social security to health is not limited to labor. Yet the same principle of freedom remains important to everyone.

SAFEGUARDS IN THE BILL

Three devices in this bill seek to prevent violations of rights.

One is the writing of guarantees of rights into the bill, including rights of appeal by patients and physicians and hospitals. See sections 205 and 206 and 207.

The bill tries to incorporate into the health-insurance system all the public and private health and health-insurance organizations. That is clear in 203 (c).

The bill also provides for an advisory committee to help the administration of the law so that the administration will get the aid of doctors, hospital administrators, and the public. That is provided in section 204 and, along with the lesser advisory committees, form a most important feature of the bill.

Rights of patients, doctors, nurses, hospitals, and private health insurance organizations must be protected for the success of the program. We do not doubt the intention of the writers of this bill to protect these rights. We think that they have gone far in stating these rights. But we are still dubious.

We are dubious about the method of administration. In a law like this, a great deal of discretion is necessarily left to the administrators. They work out the fees of doctors, the standards and fees of hospitals and specialists, regulations regarding patients, the methods of appeal and many other matters, including arrangements with private and public health-insurance organizations. These cannot all be written in the law in detail. Necessarily they are decided by the administrators of the law. These administrative regulations are of far-reaching importance.

And without reflecting on the present Surgeon General, or indeed anyone who under the bill would have the sole power of decision within the general terms of the law, we wish to propose a different method of administration.

HEALTH INSURANCE SHOULD BE ADMINISTERED BY A BOARD

We are proposing that the administration be directly in the hands of a board rather than lodged in one person, and not any kind of a board, but a board selected in part from the lay public but in large part from panels of names presented by the recognized medical and hospital associations.

This method preserves freedom better and keeps the administration in closer touch with the patients and with the doctors and hospitals that will care for the sick under the bill. Congress, thus, would pass the general law. A board then would work out the details. The executives would be responsible to the board under the general law.

We know the argument advanced in favor of a one-man administration. It is that one person can administer a law better if he has full personal authority. In many things, and health insurance seems to be one, a better administration comes from a policy-making board under the law made up of representatives of the people affected to which the executives are responsible under the board and the law.

S. 1606 gives some recognition to this principle. It provides for a national advisory board and local advisory boards appointed from the medical and hospital associations and the equipped lay public. Whether these boards will be an adequate protection only time will tell, should the bill pass. Certainly, these advisory boards are relied on in this bill, but only as advisory.

We suggest that this committee consider the advisability of relying upon them still more and of having administration by a board rather than by one man, and that the board be chosen in part from panels of names presented by the medical and hospital associations, and the rest from the informed public.

We suggest also that the committee consider ways of strengthening the position of hospitals in relation to the administration of the law. The bill specifies, within limits, the costs of hospital care that the system will pay for; yet it does not specify the costs of doctor's services which are to be determined otherwise. The bill also gives to the administrator of the law the sole power to name the hospitals that can participate; but it accepts the licensed doctors of medicine and dentistry.

We suggest, if this bill is not changed to provide the type of administration we recommend, that a special committee on hospital standards, listing, costs, and appeals be set up made up of persons chosen

from panels presented by the hospital associations, and that this committee serve also as an appeals board for the hospitals.

We wish to note, in connection with the fact that S. 1606 does not provide a method of collecting the money for the health service benefits, that we are in favor normally of employer-labor joint contributions. However, the Government should probably pay an increasing amount out of its general funds for public health.

But we wish to add the suggestion that Congress try to work out a way through which all employers who do not pay the minimum wage established by Federal law—itself an inadequate wage, even if the proposed increase to 65-75 cents should go through—will pay their employee's costs of health insurance and all forms of social security. The bishops' program of 27 years ago strongly argued that employees who do not make a living wage should have their social security costs paid by the employers.

The CHAIRMAN. Father, am I correct in my understanding of Catholic social thinking in saying that the key thought is the importance and dignity ascribed to the human personality?

Reverend McGOWAN. Yes, Senator.

The CHAIRMAN. And that applies to each and every individual?

Reverend McGOWAN. Yes, Senator.

CHARITY MEDICINE UNDESIRABLE

The CHAIRMAN. Do you believe that a means test, making people dependent upon public charity, would detract in any manner from that dignity of the human personality?

Reverend McGOWAN. Yes, I think it would. Under this bill, which is quite extensive, that is not provided.

The CHAIRMAN. You think there should be some way of protecting that?

Reverend McGOWAN. Yes.

The CHAIRMAN. You think that any system which would provide for any section of our population to take a pauper's oath would not be in accordance with good, sound Catholic thinking?

Reverend McGOWAN. Not for health purposes at all; no.

The CHAIRMAN. Has the church taken any stand during the past century, when these problems were being agitated in other parts of the country, with reference to systems of insurance; health insurance?

Reverend McGOWAN. I do not think there has been any formal statement, but there certainly has been great encouragement of the private health insurance systems.

THE BISHOPS' PROGRAM ON HEALTH INSURANCE

I made the statement in here, however, on the matter of advocacy of public health insurance by the bishops' program years back.

The CHAIRMAN. Will you tell us about that? That is, the bishops' program.

In their pronouncement they said that the States should make comprehensive provision for insurance against illness, invalidity, unemployment, and old age; is that not true?

Reverend McGOWAN. Yes. That is on pages 22 and 23.

The CHAIRMAN. Twenty-two and twenty-three of the bishops' program.

Reverend McGOWAN. Yes.

Senator DONNELL. Do you have an extra copy of that, Father?

Reverend McGOWAN. I will give you this one.

Senator DONNELL. No. That is all right.

Reverend McGOWAN. I will give it to you in a minute.

Senator DONNELL. All right.

The CHAIRMAN. When was that program issued, Father?

Reverend McGOWAN. In 1919; February 12.

During the other war and for a short time after the other war there was an organization called the National Catholic War Council, which was formed by the archbishop of the country to provide additional services to soldiers, sailors, marines, and their families, and after the other war, they issued this program of social reconstruction.

The committee that was in charge of the National Catholic War Council, and which issued this program, was made up of four bishops who had been appointed by the archbishop to administer it.

Their names are not given here, but they were Bishop Muldoon, of Rockford, Ill.; Bishop Schrembs, then of Toledo, later of Cleveland; Cardinal Hayes, of New York, when Cardinal Hayes was an auxiliary bishop; and Bishop Russell, of Charleston, S. C.

This particular edition is the twentieth anniversary edition, which has an introductory statement by the chairman of the administrative board of the National Catholic Welfare Conference, the successor of the National Catholic War Council, now Cardinal Mooney, of Detroit.

The CHAIRMAN. That contains this language:

The social insurance provided in the Social Security Act is by no means perfect. To say nothing of other defects, it fails to provide for workers' insurance against sickness.

That is found on page 8.

Reverend McGOWAN. Page 8, that is in the new introduction.

The CHAIRMAN. Yes. I believe that this document should be made a part of the record.

The CHAIRMAN. Pope Pius XI, in his encyclical on atheistic communism, dated March 19, 1937, gave his approval and encouragement to a system of insurance against illness, did he not, Father?

Reverend McGOWAN. Yes. In paragraph 52 of that encyclical he has something on it. I will read the whole sentence:

But social justice cannot be said to have been satisfied as long as working men are denied a salary that will enable them to secure proper sustenance for themselves and for their families; as long as they are denied the opportunity of acquiring a modest fortune and forestalling the plague of universal pauperism; as long as they cannot make suitable provision through public or private insurance for old age, for periods of illness and unemployment.

That is the sentence involved.

HEALTH INSURANCE AS A WEAPON AGAINST COMMUNISM

The CHAIRMAN. Do you think, or do you believe that socialism or communism would be stimulated by the passage of such a bill as we have proposed here.

Reverend McGOWAN. Oh, I think just the exact opposite. The cause of communism in a country, or socialism, either, I think is widespread poverty among people, and if we can prevent some of that poverty we to that degree fight communism.

I might add that in this encyclical on atheistic communism, there is probably over half of it dealing with positive constructive programs of prevention of poverty.

The CHAIRMAN. And that is as a basis of stopping the advance of socialism or communism?

Reverend McGOWAN. Yes, sir.

The CHAIRMAN. You think, then, this kind of legislation would have the direct opposite effect?

Reverend McGOWAN. Yes.

The CHAIRMAN. I knew Monsignor Ryan very intimately during his lifetime, and I remember he has zealously expressed himself on these questions, and especially this question of health insurance.

Can you recall, from your association with him, Father, any of the ideas that he has expressed on this subject?

Reverend McGOWAN. After this bishops' program of social reconstruction was issued, he delivered a series of lectures in New York which were published in book form under the title "Social Reconstruction."

It was published by Macmillan, I think, and in that he has one of the lectures, or one chapter of the book, on the question of social insurance. Favoring, of course, the position taken in the bishops' program.

The CHAIRMAN. Yes. Monsignor Ryan was a strong foe of the advance of communism and socialism in this country, was he not?

Reverend McGOWAN. Yes. A pioneer in the fight.

The CHAIRMAN. And he was taking the stand that he took as a means of preventing the advance of communism and socialism in the country?

Reverend McGOWAN. Yes; in part that, and also because of the value of the measures themselves in the prevention of poverty and the establishment of more justice in the country, apart from communism and socialism.

The CHAIRMAN. You see no sound objections to a system of national health insurance in this country?

Reverend McGOWAN. Not in itself; no.

The CHAIRMAN. Do you think it would be the more effective way of providing for the spread of health care to the people of this country than through voluntary system?

Reverend McGOWAN. If the voluntary systems could extend quickly enough to cover everybody, why, we would normally prefer that.

The CHAIRMAN. Yes; everyone would.

Reverend McGOWAN. Yes.

VOLUNTARY PLAN CANNOT GIVE COMPLETE COVERAGE

The CHAIRMAN. But the present situation seems to indicate that the average worker in the country would find it extremely difficult to get insurance under the voluntary system that would give him complete coverage.

Reverend McGOWAN. Yes; I think that is true, and in time of unemployment it would be even more difficult.

The CHAIRMAN. More difficult. A sound national insurance system would cover the entire field and would make it possible to greatly

reduce the cost of medical care and hospitalization to the average person, because of the widespread coverage that it would give?

Reverend McGOWAN. I had not thought of that, but that is probably true, Senator, by the use of insurance methods and distribution of costs.

The CHAIRMAN. Yes. And there could be no sound objection to the National Government providing such a system. We have provided a system of workmen's compensation in this country that has worked very satisfactorily, have we not?

Reverend McGOWAN. Yes. That is on a State basis.

The CHAIRMAN. On a State basis, yes.

And at first that was thought to be objectionable, and it was opposed, was it not?

Reverend McGOWAN. By a great many people.

The CHAIRMAN. By a great many people. And since it was put into operation, it has been found to be of great benefit to the American people.

You believe, do you not, that any industry that employs working people should make some contribution toward protecting them from the hazards of disease, industrial diseases brought on by their work in such plants?

Reverend McGOWAN. Yes. We believe that an industry should not only do that, but ought to support its people against all the normal contingencies of life, and that is included in the idea of the living wage that we advocate almost continuously.

The CHAIRMAN. And that applies generally to business and industry in this country?

Reverend McGOWAN. Yes.

The CHAIRMAN. Conditions have changed tremendously in this country in the last 50 years, have they not, Father?

Reverend McGOWAN. Yes, sir. I might say that we, in this bishops' program of social reconstruction 27 years ago, advocated the family living wage. For example, as a matter of law, we advocated the protection of the right of labor organization, advocated the social-security program, advocated a great many different things, all for the establishment of as much justice and social justice as possible in the country.

Neither the Federal Government nor the State governments have yet caught up with the bishops' program of social reconstruction.

The CHAIRMAN. These conditions in the country under which people in the lower-paid brackets of the Nation have found it difficult to get medical care, these conditions have existed for quite a long while, have they not?

Reverend McGOWAN. Yes, Senator. We have known about the conditions for years, and those conditions were part of the inspiration or part of the motive that drove Doctor Ryan on in his work for years and years, and also the motive for the establishment of our department in the National Catholic Welfare Conference.

The CHAIRMAN. Monsignor Ryan devoted practically his entire life to that fight?

Reverend McGOWAN. Yes.

The CHAIRMAN. And he was regarded by some as extreme at that time; when he started?

Reverend McGOWAN. Yes.

The CHAIRMAN. But before he died, he found that his teachings were gaining universal acceptance.

Reverend McGOWAN. Many of them.

The CHAIRMAN. Yes. And you do not believe, then, that the sponsors of this legislation are encouraging socialism or communism in this country by introducing a bill of this character?

Reverend McGOWAN. No, Senator, not at all.

The CHAIRMAN. You think that we are justified in making an effort to do something about this serious problem which confronts the American people?

Reverend McGOWAN. There are a few points in the bill beyond those which I mentioned that I think are objectionable, but apart from the method of administration, the bill, in addition to these few points, seems to me to be very good.

The CHAIRMAN. Well, of course, you have had considerable experience, Father, in connection with legislation.

Reverend McGOWAN. Some.

The CHAIRMAN. Yes. Well, you have observed that it is very difficult to file a bill of such a complicated character as this which would be perfect in all its details?

Reverend McGOWAN. Well, I hope that this committee will correct it so that it will be a completely satisfactory bill.

The CHAIRMAN. You would like to see some of those who oppose the bill offer amendments that would be constructive?

Reverend McGOWAN. Yes.

The CHAIRMAN. I have never seen a bill, since I have been in Congress, which, upon its filing, covered the situation perfectly. I have always found that it was necessary to make changes in it based on studies and hearings such as we are holding here.

I am very pleased to have you here, Father, because of your connection with this institution which has been doing so much good for the country, this National Catholic Welfare organization; and I am sure that your contribution to this hearing will be greatly appreciated by every member of the committee.

Reverend McGOWAN. Thank you, Senator.

PROGRESS OF VOLUNTARY PLANS

Senator DONNELL. Father McGowan, in your statement, at page 2, I observe that you say, among other things:

We recognize that the voluntary systems of health insurance which have rendered excellent service to our people would require some form of Government aid to achieve universal health security.

I take it from that, that your judgment is that voluntary systems of health insurance have rendered excellent service already to the people?

Reverend McGOWAN. Yes. Very good service.

Senator DONNELL. Are you familiar with the Blue Cross organization?

Reverend McGOWAN. Somewhat; yes.

Senator DONNELL. Father—

Reverend McGOWAN. Yes?

Senator DONNELL. Do you know as a matter of general knowledge that something over 20,000,000 of our population have thus far availed themselves of the services of the Blue Cross?

Reverend McGOWAN. So I have heard.

Senator DONNELL. And is it your understanding, generally speaking, that the Blue Cross organization has rendered good service so far as it goes?

Reverend McGOWAN. That is my understanding; yes.

Senator DONNELL. It does not contain complete coverage?

Reverend McGOWAN. No.

Senator DONNELL. I think we all understand that to be true; but you have heard but little criticism of the Blue Cross in its operations; is that right?

Reverend McGOWAN. In its operations; yes. There has been some difficulty with some hospitals, because of the low amounts that are allowable under the insurance system.

Senator DONNELL. Yes.

The CHAIRMAN. Well, the Blue Cross system would not be a satisfactory solution of the problem of a family, of a workingman and his family?

Reverend McGOWAN. Not always, although I would like to say, and I feel pretty sure that it was the intention of the writers of this bill, that that private insurance system, as well as others, be incorporated in some way in the functioning of the administration of this bill.

Senator DONNELL. Father, I did not get the first part of your sentence. What did you say you understand?

Reverend McGOWAN. I understand from the terms of this bill, that the private health insurance systems can be incorporated into the administration of the bill.

The CHAIRMAN. As well as other group plans?

Reverend McGOWAN. Yes.

The CHAIRMAN. That could be brought entirely into this thing?

Reverend McGOWAN. Yes.

The CHAIRMAN. So the work of building them up would not be entirely lost?

Reverend McGOWAN. No, sir.

Senator DONNELL. Father, did I understand you to say that there has been some instance, or that there have been some instances in which, because of the low amounts payable to hospitals for their services, that there have been some complaints?

Reverend McGOWAN. Yes; I have heard about that. We do not know of it, personally.

Senator DONNELL. You do not know of it personally, but as a general proposition, the Blue Cross has rendered good service?

Reverend McGOWAN. Very good, sir.

Senator DONNELL. I observe on pages 67 and 68 of the bill—do you have a copy of the bill?

Reverend McGOWAN. Yes.

Senator DONNELL. At the bottom of 67 and the top of 68, that there is a limitation placed upon hospitalization benefits under the terms of this bill.

(Reading part of it as follows:)

The term "hospitalization benefit" means an amount, as determined by the Surgeon General after consultation with the advisory council: Not less than \$3 and not more than \$7 for each day of hospitalization, not in excess of 30 days, which an individual has had in a period of hospitalization; and not less than \$1.50 and not more than \$4.50 for each day of hospitalization in excess of 30 in a period of hospitalization; and not less than \$1.50 and not more than \$3.50 for each day of care in an institution for the care of the chronic sick.

Senator DONNELL. Do you care, Father, to make any observations as to whether those figures are sufficiently high, in your judgment?

Reverend McGOWAN. They might be high enough now, but maybe a year from now they might not be high enough.

I do not like to see those figures written into a permanent law. It was partly because of that, and because of other elements in the bill, in relation to hospitals, that we recommended that the whole question of hospital standards, working costs, and appeals, be turned over to a special committee.

Senator DONNELL. Yes, sir; and you favor a board, I understand—

Reverend McGOWAN. Yes.

Senator DONNELL. From your statement, rather than the ultimate authority in any one individual?

Reverend McGOWAN. Yes.

Senator DONNELL. As I understand it, then, referring to these figures on page 67 and 68, that I have referred to, you are inclined to favor some elasticity rather than a rigid maximum prescription by statute; is that right?

Reverend McGOWAN. Yes, sir.

Senator DONNELL. Father, I wanted to ask you also, in connection with this matter of the authority being vested in an individual or a board. Have you given attention to the question, under this bill, as to who it is in, the ultimate authority, whom that rests with under title II of the bill?

Reverend McGOWAN. Well, the ultimate authority rests, I suppose, in the Federal Security Administrator.

Senator DONNELL. Yes.

Reverend McGOWAN. The immediate authority rests in the Surgeon General.

Senator DONNELL. Yes. But I presume you are referring now to the terms of section 203 (a) at pages 35 and 36, reading in part:

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.

Reverend McGOWAN. Yes.

Senator DONNELL. And then it proceeds, "and after consultations with the advisory council."

The advisory council, under this bill, as its name implies, is advisory solely and does not have any ultimate legal power. That is correct, is it not, Father?

Reverend McGOWAN. Yes.

Senator DONNELL. I want to ask you also this question:

I had not seen the bishops' program of social reconstruction until this morning, and I have hastily sketched portions of it while you were testifying, although, of course, I could not assimilate it all in the few moments I have had.

I observe at page 8 this language:

'The social insurance provided in the Social Security Act is by no means perfect. To say nothing of other defects, it fails to provide for workers' insurance against sickness.'

Do you understand, Father, that that language necessarily means an advocacy of compulsory health insurance of the type under which

services, medical and surgical services, are provided as distinguished from insurance benefits in cash?

Reverend McGOWAN. No. I do not believe that a person could get from that advocacy of either method.

Senator DONNELL. No. There are, of course, as I take it, Father, and I believe we would agree, two distinct types of insurance. That is to say, you or I go down and buy insurance policies, and we get payments in cash. That is one type.

Another type would be the Blue Cross variety, where we get services.

We would agree that there are those two types, are there not?

Reverend McGOWAN. Yes.

Senator DONNELL. And this language in the bishops' program of social reconstruction, in which it states that the Social Security Act is by no means perfect, and says: "To say nothing of other defects, it fails to provide for workers' insurance against sickness"—that does not define which type of insurance the program is referring to.

Reverend McGOWAN. No.

Senator DONNELL. I am correct in that; am I not, sir?

Reverend McGOWAN. Yes; that is my understanding.

The CHAIRMAN. But right there, the bishops' statement on social reconstruction, on page 22, contains this language:

The State should make comprehensive provision for insurance against illness, invalidity, unemployment, and old age.

Reverend McGOWAN. Yes.

Senator DONNELL. Of course, Mr. Chairman and Father, that, as I see it, is subject to the same question I have raised. This does not say whether the insurance to be provided shall be in cash or in medical and surgical benefits; does it?

Reverend McGOWAN. That is my understanding of it; yes.

Senator DONNELL. Father, referring to page 22, I quote this language also:

Hence all forms of State insurance should be regarded as merely a lesser evil and should be so organized and administered as to hasten the coming of the normal condition.

That is the language in there; is it not?

Reverend McGOWAN. Yes. This particular passage on social insurance in the bishops' program comes in connection with another passage, which I think is just before it, advocating the general family living wage.

Yes; it follows immediately, and a general family living wage established by law.

Senator DONNELL. Yes, sir.

Reverend McGOWAN. And failing the passage of such an act, which would be completely satisfactory as to minimum wages, it advocates social security as a means of supplementing the other failures.

Senator DONNELL. Yes, sir. I think your statement is entirely correct as to the sequence, and as to what it advocates, and in support of that statement, although it needs no support, I will read this one sentence:

Until this level of legal minimum wages is reached the worker stands in need of the device of insurance.

So I take it, Father, that the ideal as set forth in this bishops' program is the establishment and enforcement of a legal minimum-wage provision?

Reverend McGOWAN. That is correct, a legal minimum wage that would allow the individual to take care of all the contingencies of life.

Senator DONNELL. Where I quoted exactly, and your memory is extremely accurate, the last sentence of the paragraph is:

"That is, they"—they are speaking of the workers, possibly male workers, I am not certain.

That is, they should be ultimately high enough—

I beg your pardon. They are talking about the wages.

That is, they should be ultimately high enough to make possible that amount of saving which is necessary to protect the worker and his family against sickness, accidents, invalidity, and old age.

Reverend McGOWAN. Yes.

Senator DONNELL. And immediately after that is the paragraph on social insurance which starts out:

Until this level of legal minimum wages is reached the worker stands in need of the device of insurance.

Reverend McGOWAN. Yes.

Senator DONNELL. In other words, it is the thought of the writer or writers that there should be endeavored to be procured a legal minimum wage, that that should be the permanent situation, and until that time the worker stands in need of the device of insurance; that is correct, is it not?

Reverend McGOWAN. And in that connection, may I add that the part that I read in the last paragraph of mine, in which it was advocated that employers should pay the social-security cost of their employees when the employees do not get the living wage, is drawn from that paragraph.

Senator DONNELL. Yes.

And then the paragraph in the bishops' program on social insurance contains, after an intermediate discussion, following that opening sentence:

Until this level of legal minimum wages is reached the worker stands in need of the device of insurance.

Following that language is this language:

Hence all forms of State insurance should be regarded as merely a lesser evil, and should be so organized and administered as to hasten the coming of the normal condition.

Reverend McGOWAN. Yes.

Senator DONNELL. And that "normal condition" is one under which a minimum wage enabling the worker to make his own provision against sickness, accidents, invalidity, and old age; that is the normal condition to which you refer, is it not, Father?

Reverend McGOWAN. Yes.

Senator DONNELL. Yes, sir.

The CHAIRMAN. Right there, Father, I would like to ask: How long do you think it will take us to get to that normal condition in this country?

Reverend McGOWAN. Considering the sad fate that the wages-hours bill has met, I am afraid it will take a long time.

The CHAIRMAN. Yes. Even if that bill met with favor and was adopted and approved, would it provide that normal condition?

Reverend McGOWAN. No. Our department presented a statement on the amendments to the wages-hours law some time back to this committee, and in that we advocated the 65-75 amendment, but stated that that was not sufficient for normal family support.

The CHAIRMAN. There is a powerful opposition in this country to the development of a normal condition such as you have envisaged?

Reverend McGOWAN. Yes, Senator.

The CHAIRMAN. And that opposition seems to be so strong that it would be many, many years to come, perhaps not in this century. Is that not true?

Reverend McGOWAN. I am not quite so pessimistic.

The CHAIRMAN. Well, do you not think monopolies are on the growth in the United States?

Reverend McGOWAN. Yes. I think that is true, but I think on the other hand there are other legal and private measures being taken that have made the monopolies less powerful than they were earlier.

The CHAIRMAN. My understanding is that monopoly is on the growth, and monopoly lobby here in Washington now is stronger than it has been since the last war.

Articles are being written in the papers about it, and the growth of monopolies is continuing, and the growth of big business is continuing in the United States. It seems to me that the opposition to this normal condition is so powerful that it will not be accomplished in this century, short of some change that I just cannot see.

Do you not think that is true?

Reverend McGOWAN. I am a little more hopeful than you are, Senator.

The CHAIRMAN. Well, you know the tremendous opposition to programs for the development of river valleys in the United States which bring about a huge expansion of industry and opportunities for employment, and raise the standards of living in the country tremendously, and you know that the opposition to that is so powerful that it is very difficult to pass laws of that kind?

Reverend McGOWAN. At any rate, we do have a wages-hours law on the statutes that we did not have before, and we have a much stronger labor movement than we have ever had.

The CHAIRMAN. Well, the minimum wage laws that we have on the books make practically no contribution whatever to this program that we are confronted with here, this need for bringing adequate modern medical care to the average family of the country.

Reverend McGOWAN. The wage in the present law is utterly inadequate, and the wage provided in the amendments 65-75—

The CHAIRMAN. Would be inadequate also?

Reverend McGOWAN. I think it would be.

The CHAIRMAN. And the present law, and the law that has been contemplated, would hardly take care of the necessities of life for these families?

Reverend McGOWAN. No, it would not.

The CHAIRMAN. It would not. So that with that kind of opposition in mind, you are fearful, are you not, that this normal condition that we would like to see in this country will not be reached during our lives?

Reverend McGOWAN. It will be a long time, and anyway, this measure will help.

The CHAIRMAN. This measure will help?

Reverend McGOWAN. Yes.

The CHAIRMAN. Yes. This measure will help to increase the standards of living of the country, increase the incomes of people, and will defeat the inroads of communism in this country?

Reverend McGOWAN. Yes, Senator.

The CHAIRMAN. Thank you.

Senator DONNELL. Mr. Chairman, I was not in this questioning primarily addressing myself to the probabilities of economic development in the country, but rather to undertake to determine what is exactly the theory of the bishops' program, and, as I understand it, to quote again this sentence:

Hence all forms of State insurance should be regarded as merely a lesser evil, and should be so organized and administered as to hasten the coming of the normal condition.

I think that indicates the thought of the writer or writers not that State insurance is itself a positive good, but that as it is stated here, it should be regarded as merely a lesser evil.

Reverend McGOWAN. Yes.

Senator DONNELL. Under temporary conditions.

Now, Father McGowan, you are not as pessimistic as the chairman as to the arrival at an improved condition which would obviate the necessity of this type of insurance?

I am correct in that, am I not, Father?

Reverend McGOWAN. Yes.

The CHAIRMAN. I understood you were.

Reverend McGOWAN. Not so pessimistic.

The CHAIRMAN. You think it may come within the next century?

Reverend McGOWAN. Well, I hope so.

Senator DONNELL. At any rate, Mr. Chairman, the point that I am addressing myself to—

The CHAIRMAN. I do not think it will come at all as long as we have the system that we have here where monopolies and big business are on the growth and the wealth of the country and the industries of the country are in the hands of a few hundred corporations. I do not think, as long as that condition exists in this country it will ever be obtained.

Senator DONNELL. Of course, it is to be observed also, Mr. Chairman. I think the fact that labor unions, one of whose representatives was here a few days ago, have many millions of adherents, and in the particular union Mr. Carey testified that the CIO had 6,000,000 and 24,000,000 people, I believe, whom he considers as members of the families, including the members of the union.

The CHAIRMAN. That is a very small minority, of course.

Senator DONNELL. Of course, that is only one union. We have also the American Federation of Labor and the Brotherhood of Railroad Trainmen, and other organizations.

However, the point I am addressing myself to in this connection, Mr. Chairman, is not that prophecy as to which opinions may differ, but as to an interpretation of the bishops' program, and I understand Father McGowan has established two facts:

First, that this language "to say nothing of other defects, it fails to provide for workers' insurance against sickness," does not itself affirmatively define whether that insurance is a cash insurance or whether it is compulsory medical insurance consisting of services.

I am right in that, Father?

Reverend McGOWAN. Yes.

Senator DONNELL. And in the second place, that it is established very clearly, I think, from what the Father said and from the language on pages 22 and 23 of the bishops' program, to quote again:

Hence all forms of State insurance should be regarded as merely a lesser evil, and should be so organized and administered as to hasten the coming of the normal condition.

That that is during a temporary condition.

The CHAIRMAN. Do you consider this a temporary condition, Father?

Reverend McGOWAN. The—

The CHAIRMAN. This lack of having a normal condition.

Reverend McGOWAN. I hope it is temporary. I am working to try to make it as temporary as possible.

The CHAIRMAN. When you say "temporary" I wish you would define the meaning of "temporary" there for me as applied to this situation.

Reverend McGOWAN. Well, I should think we ought to be able in 25 years to get everybody at a family living wage.

The CHAIRMAN. You think we could in this country 25 years from now?

Reverend McGOWAN. I think we ought to be able to.

The CHAIRMAN. With the present trend toward big business and monopoly, you think that 25 years from now we will have a situation where everyone will earn sufficient to take care of all of the needs and vicissitudes of life?

Reverend McGOWAN. If we do not, we are going to tailspin, I think.

The CHAIRMAN. Well, I believe you are right on that.

Erie Johnston, at the convention of the American National Chamber of Commerce the other day, warned them on that and pointed out the need of this social legislation and if they did not support it, that they would be in the dog house pretty soon, and he meant way back in the back end of the dog house; is that not true?

Reverend McGOWAN. Yes; I read that.

The CHAIRMAN. Do you think it is fair to the American people to ask them to wait for 25 years for a system of adequate medical care for our people?

Reverend McGOWAN. Oh, I think it is utterly unfair.

The CHAIRMAN. That is all.

Senator DONNELL. Now, Father, the chairman, I appreciate, holds certain very well defined and clearly stated economic views, and I have great respect for his views and powers of prophecy, as well, but may I mention this also:

You come from the State of Missouri.

The CHAIRMAN. That is the reason he is testifying.

Reverend McGOWAN. Yes, Senator.

Senator DONNELL. You are familiar with the fact, are you not, Father, that—just to illustrate the other side of this monopoly ten-

dency, that the Chairman believes exists—one of our largest utility corporations in the State of Missouri is the Union Electric Co. in St. Louis, is it not?

Reverend McGOWAN. Yes.

Senator DONNELL. And it was a component part of the North American Co., was it not?

Reverend McGOWAN. Yes.

Senator DONNELL. Did you not see in the newspapers just a few days ago that in compliance, I think, with an order of the Supreme Court of the United States, that the North American Co. was being dissolved, and as I remember it, only the Union Electric and possibly some other one company were being retained.

That is an illustration in which a great block of public utilities were being decentralized.

Reverend McGOWAN. I read something of it, and I might add that the president of that company is from my own home town in Missouri.

Senator DONNELL. What is his name?

Reverend McGOWAN. Judge McAfee.

Senator DONNELL. J. Wesley McAfee.

The CHAIRMAN. Right there, Father, I want to ask you if it is not true that there is pending in Congress now a bill to amend that act which would practically nullify it?

Reverend McGOWAN. I have heard of that. I am not familiar with it.

The CHAIRMAN. Yes. A desperate effort is being made from the very commencement to destroy that act and propaganda is on foot right now to bring that about.

That is true, is it not?

Reverend McGOWAN. So I have heard.

Senator DONNELL. But the act has not been passed, has it, Father, so far as you know.

Reverend McGOWAN. So far as I know.

I thought we were talking about the national health program.

Senator DONNELL. Just one other illustration, and I will pass from this point.

In going back home, if we use a berth, we go in the Pullman cars. Now the Pullman Co. is another illustration, is it not, of a company which was ordered to be dissolved and its component parts separated; that is true, is it not?

Reverend McGOWAN. Yes.

Senator DONNELL. Yes.

Now, Father, enough for that.

At the moment, however, may I ask you this: In your testimony, at page 3, you have stated this, as I understand it, and I read from it:

If the program is made compulsory in fact it should at least be voluntary as to method.

You believe, then, in some voluntary situation being retained, do you not?

Reverend McGOWAN. Yes.

Senator DONNELL. You say:

By this we mean that the voluntary element in health care should be conserved and strengthened.

You believe in it to that extent, and you say—

Our citizens should be given the option of making their own health plans provided that there is both universal coverage and prepayment by some form of insurance.

That is right, is it not?

Reverend McGOWAN. Yes.

Senator DONNELL. Now, Father, you were asked something about this matter of the means test a while ago.

Now, I do not know just which portion of the bill it was that the chairman or you were referring to, but if you will turn, please, to pages 26 and 28 of the act, that being a portion of title I of the act which refers to grants-in-aid to States for health services, I call your attention to the fact that in section 132, it is provided that:

A State plan for medical care must—

And then going over to page 28:

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

You are familiar with that portion of the bill?

Reverend McGOWAN. Yes.

Senator DONNELL. That, of course, I take it, does contemplate that so far as this portion of the bill which pertains to grants to States for medical care of needy persons, that it has been deemed practicable and in fact it is deemed practicable by the authors of the bill to require, before a State plan should be approved, that plan must provide for the taking into consideration of the requirements of the individuals, and the income and resources of the individual.

That is right, is it not?

Reverend McGOWAN. That is true in that particular section.

Senator DONNELL. Yes. Very well.

The CHAIRMAN. Does that contemplate a means test, a pauper's oath, or is that intended to inquire into the income of the people in the State and provide a method of care that will enable them to get the necessary care they need?

Reverend McGOWAN. That is it. It does not make them, so far as I can see, unless the State law is such, it does not make them take a pauper's oath.

Senator DONNELL. I think there is nothing in the bill that says anything about a pauper's oath.

Reverend McGOWAN. No.

Senator DONNELL. But the bill does provide that before a State can obtain any of this \$10,000,000 referred to in part C, title I, the State must prepare a plan included in which is a provision that the State agency shall, in determining need for medical care, take into consideration, quoting:

The requirements of individuals claiming medical care under the plan, and any income and resources of an individual claiming medical care under the plan, which must be taken into consideration with regard to an individual claiming assistance under a State plan approved under the Social Security Act, as amended.

That is in there?

Reverend McGOWAN. Yes. That applies to just one section.

Senator DONNELL. Yes. I understand, but the point I am getting at, insofar as this bill pertains to the administration of funds by States, which funds are derived from the Federal Government under this paragraph about needy persons, it has been deemed practically to require what we may term "a means test." That is correct, is it not?

Reverend McGOWAN. Yes.

The CHAIRMAN. It has reference to the situation in every State in the Union where there is bound to be a certain section of the population that are not capable of working, are unemployable, they are deformed, or they are unable to work because of disease or illness?

Reverend McGOWAN. Yes.

The CHAIRMAN. And it means that they should provide some system of care for that part of the population, but it does not mean, as I understand it, that this proposes that in every instance a person desiring medical care who is unable to get it because his wages are insufficient must take a pauper's oath?

Senator DONNEL. I do not know just where the chairman finds "pauper's oath"—that requirement in the bill.

The CHAIRMAN. A means test. We can call it what you wish. I do not insist on the term "pauper's oath," but I mean to say, take a means test.

Senator DONNELL. I call your attention, Father, to the fact that according to the bulletin issued by the Social Security Board in March 1946, volume 9, No. 3, in January of 1946, there were receiving old-age assistance in the United States, 2,059,312 persons; that there were receiving aid to dependent children 279,881 families, and 716,669 children; that there were of the blind receiving public assistance 71,654; that there were 274,000 cases of general assistance being granted at that time.

Now, Father, in all of this that I have referred to, old age, dependent children, blind, and general assistance, it has been found practicable to administer those funds under what we may term "a means test"; has it not?

Reverend McGOWAN. I do not like it. I do not like its use, Senator.

Senator DONNELL. Maybe not, but that is what the Government does use.

Reverend McGOWAN. Yes.

Senator DONNELL. Yes, sir.

The CHAIRMAN. Do you mean from each individual they require a means test? That is to say, that they require them to sign an instrument declaring that they are unable to pay?

Reverend McGOWAN. No. That is not it. But just the practice of the Government.

The CHAIRMAN. That is, to study the situation?

Reverend McGOWAN. Yes.

The CHAIRMAN. And determine whether or not they have in their community certain classes of people, because of illness or deformities, or physical defects of any kind, that are unable to make a living, they are to be taken care of?

Senator DONNELL. Well, Father, it is a fact, is it not, that for instance, in your State and mine, the old-age assistance is administered

there, by the Department there of which Mr. Banta was the head and Mr. Carter is now the head?

Reverend McGOWAN. That is my memory.

Senator DONNELL. And that Department, in determining whether you or I would be entitled to assistance, has a corps of investigators over the State investigating the needs of the particular individual. That is right, is it not?

Reverend McGOWAN. We are getting away from that, I think, through the method of insurance.

Senator DONNELL. Well, I am not passing on that, but today, the way that is being operated is just as I have described?

Reverend McGOWAN. That is my understanding.

Senator DONNELL. So that in these various programs—I am not saying anybody has to sign a pauper's oath, I do not recall that—but my understanding, the Department of which those two gentlemen have been respectively the head, is administered by a series of investigators who determine in each individual case whether the person, either himself or herself, would be in need of assistance granted. That is correct, is it not?

Reverend McGOWAN. Yes, I think that is correct, but I think it is a temporary situation and we can overcome it through the device of insurance.

Senator DONNELL. That may be, but I am saying that for the present that is the way those programs are being administered. That is correct, is it not?

Reverend McGOWAN. That is my understanding.

Senator DONNELL. Yes, sir.

Now, Father, may I ask you also whether or not on page 22 of this Bishops' Program, you have observed this language—and I will hand this back after I read this—

The industry in which a man is employed should provide him with all that is necessary to meet all the needs of his entire life. Therefore, any contribution to the insurance fund from the general revenues of the State should be only slight and temporary.

You are familiar with that language?

Reverend McGOWAN. Yes. I think that time has passed, though, and that there probably will have to be more public moneys given for health.

Senator DONNELL. Well, possibly so, but I wanted to get it just in what the bishops' program says.

Reverend McGOWAN. Yes.

Senator DONNELL. That was the view at that time?

Reverend McGOWAN. Yes.

Senator DONNELL. In the bishops' program; is that right?

Reverend McGOWAN. Yes.

Senator DONNELL. Father, I wanted to ask you this also: May I have this document back?

Reverend McGOWAN. All right.

Senator DONNELL. Whether or not you have investigated the terms of S. 1050, from which this S. 1606 is substantially, as I understand it, taken.

Reverend McGOWAN. Largely, yes.

Senator DONNELL. Yes, sir. Now, you know, therefore, I take it, Father, that the bill S. 1606, is intended to be a part of a much more

comprehensive program which likewise bears the name of our distinguished Chairman, Senator Wagner, and Representative Dingell?

Reverend McGOWAN. Yes.

Senator DONNELL. And is represented now by S. 1050. You are familiar with that?

Reverend McGOWAN. Somewhat.

Senator DONNELL. I am wondering whether or not you have examined into the correctness of a book issued by the American Enterprise Association, Inc., containing a monograph by Earl E. Muntz of New York University, in which he has referred to the entire program of S. 1050, which reads as follows:

The social security program as set up in this bill would require a Federal subsidy based on the most conservative estimates in excess of 50 percent of the total annual expenditures.

I am wondering, first, whether you have seen that particular language, and in the second place, whether you have studied the program to ascertain whether or not the facts are substantially as Professor Muntz thinks they are.

Reverend McGOWAN. No, I have not seen that, and I would not want to pass on that.

The CHAIRMAN. You never heard of that organization before?

Reverend McGOWAN. No.

The CHAIRMAN. You do not know Dr. Muntz?

Reverend McGOWAN. No; I do not.

Senator DONNELL. Father, are you familiar with the organization in California, known as the California Physicians Committee?

Reverend McGOWAN. No; I am not familiar with that.

Senator DONNELL. You are not familiar with that.

Do you know, from general knowledge, as to whether it is administering a health program of quite comprehensive nature?

Reverend McGOWAN. I have heard of it doing so, but I do not know about that.

Senator DONNELL. Do you know whether or not under the auspices of the American Medical Association it has recently formed a corporation, under the laws of the State of Illinois, not a profit corporation, I assume at any rate not, but a corporation the ultimate purposes of which are to develop a voluntary health insurance system throughout the country?

Reverend McGOWAN. I have heard so.

Senator DONNELL. You know that to be true?

Reverend McGOWAN. Yes.

Senator DONNELL. And you know, do you, Father, generally, that the American Medical Association comprises over 125,000 of the physicians and surgeons of our country?

Reverend McGOWAN. I have heard so.

Senator DONNELL. And do you know that that organization, through its house of delegates, has gone on record very specifically in opposition to the compulsory health insurance administered by the Federal Government?

Reverend McGOWAN. That is my understanding.

Senator DONNELL. It is.

Now, Father, you are located here in Washington and have been for some years, have you not?

Reverend McGOWAN. Yes, sir.

Senator DONNELL. And you are the director of the department of social action, National Catholic Welfare Conference?

Reverend McGOWAN. Yes.

Senator DONNELL. I note in your statement you say—

Our department lacks the technical knowledge to appraise fully all features of the bill.

Reverend McGOWAN. Yes. There is a good deal in the field of hospitals and charities and particularly that our department is not equipped to speak on.

Senator DONNELL. Yes, sir. And you have no person who has been an expert, in your judgment, upon the technical phases of compulsory governmental insurance?

Reverend McGOWAN. Oh, that is different. I think we are equipped to speak on that, but there are many details of this bill that I would not, for example, wish to speak on.

Senator DONNELL. That is, you are not here today to speak personally upon the technical phases of the bill insofar as it relates to compulsory health insurance?

Reverend McGOWAN. We are in favor of compulsory health insurance.

Senator DONNELL. I understand.

Reverend McGOWAN. And the details I have in mind are more details in the field of the relationship between the administration of your law and private charities, for example.

Senator DONNELL. I see.

Reverend McGOWAN. There are some of the details of the hospital administration in relation to this bill.

Senator DONNELL. Yes.

Reverend McGOWAN. But I think we are fairly well equipped to speak on and in favor of compulsory health insurance.

Senator DONNELL. But so far as this technical knowledge to which you refer, "The technical knowledge to appraise fully all features of the bill"; your department lacks that technical knowledge. That is right, is it not?

Reverend McGOWAN. Yes.

Senator DONNELL. That is all, Father.

The CHAIRMAN. In order to accomplish this idea of providing a universal system of voluntary insurance in this country, it would be necessary to first witness the coming of that normal condition that we have been talking about?

Reverend McGOWAN. Yes; we would have to have practically everybody, and that would be in the case of men, getting a family living wage, and in the case of women getting enough to support themselves; and by that I mean support themselves in all normal contingencies of life, including old age and sickness and so on.

The CHAIRMAN. And that means to be able, also, to pay the high cost of modern medical care and hospitalization?

Reverend McGOWAN. Yes.

The CHAIRMAN. That is all, Father.

Senator DONNELL. Thank you, Father.

The CHAIRMAN. Thank you very much, Father.

The next witness is Mr. John H. Hayes.

STATEMENT OF JOHN H. HAYES, PRESIDENT-ELECT OF THE AMERICAN HOSPITAL ASSOCIATION, ACCCOMPANIED BY GEORGE BUGBEE, EXECUTIVE DIRECTOR OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. HAYES. For the record, I am John H. Hayes, president-elect of the American Hospital Association, and superintendent of Lenox Hill Hospital, New York City.

I hope you will permit me to introduce also Mr. George Bugbee, the executive director of the American Hospital Association, who is here to assist me in this testimony.

The CHAIRMAN. Will you state again your residence?

Mr. HAYES. New York City.

The CHAIRMAN. And you are connected with what institution?

Mr. HAYES. The Lenox Hill Hospital.

The CHAIRMAN. I see. Thank you.

Mr. HAYES. I hope you will permit me to introduce Mr. George Bugbee, executive director of the American Hospital Association, who is here to assist me in this testimony.

The CHAIRMAN. Will state your address in New York City?

Mr. HAYES. I am connected with Lenox Hill Hospital, New York City.

The CHAIRMAN. Proceed.

Mr. HAYES. On the invitation of the chairman of your committee to send a representative, the American Hospital Association has designated me to appear before you. We appreciate the opportunity to discuss Senate bill 1606 and the sweeping recommendations embodied in that proposed legislation.

THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association represents approximately 3,500 hospitals comprising about 85 percent of the civilian general hospital bed capacity of the Nation. We also have as members a substantial number of city, county, State, and Federal hospitals. We do not appear before you as a commercial group with a vested interest in any present organization for distribution of hospital care. We are not under this bill threatened with taxes, increased costs, or great financial losses. Hospitals occupy a unique position in the social structure of America. Nearly every hospital performs a substantial amount of charity work, and by far the majority of hospitals are operated by organizations who do so for the sake of rendering service, and not for making a profit.

We appear, rather as a group having the greatest fund of experience in the administrative aspects of making hospital care and thus medical care available to the sick. Hospitals are organized as representatives of the public to provide the skilled personnel and technical facilities needed by physicians and surgeons in rendering care to their patients. We who administer hospitals for the benefit of society do so with a strong sense of our responsibility as public servants.

We do not claim to have solved all of the problems incident to the proper distribution of hospital and medical service. But hospitals have carried a large part of the development of the present high

quality of such care in America, and it is, therefore, our duty to be in the forefront in supporting any program which might bring progress in our field; and to lend our voice in opposition to any program which might imperil such progress or impede its further development.

ENDORSEMENT OF TITLE I

As a group, we endorse the aims of a program of Federal grants in aid to the States to make hospital and health care available to those who cannot pay for it. In previous appearances before your committee, The American Hospital Association has advocated such measures for indigent care, and to this extent, we endorse in general the aims of that part of title I which would make such provision. However, were any portion of such legislation to be recommended for passage, it should be carefully studied, bearing in mind the need for State participation and responsibility, decentralization of authority, and proper limitation of Federal authority.

OPPOSITION TO TITLE II

But we vigorously oppose the provisions of title II of this legislation, which would place the Federal Government in such a dominant position in the health field as to lead inevitably to Federal control and operation of the entire health system of the Nation. This bill would give a Federal agency complete control of practically all of the funds needed to pay physicians, hospitals, nurses, dentists, and others who render care to the sick. Control of the purse strings means control of the program, and we think this is highly dangerous.

We shall not discuss the details of the legislation embodied in S. 1606. Certainly the major issue before your committee is the question of compulsory health insurance, and it is to that point that we shall address our remarks.

PROGRESS OF HEALTH CARE IN UNITED STATES

The development of health care in this country has not followed any fixed pattern. Yet nowhere in the world has it made greater progress. Literally billions of dollars have been donated by churches, philanthropic organizations, public-spirited citizens, and various community groups to build hospitals to provide care for the people of this Nation. Benjamin Franklin was one of the trustees of the first voluntary, non-profit hospital in the United States, and the hospital he helped to found is still in operation as a monument to the civic interest of this great American genius. Since that time, outstanding citizens in every section of the country have been members of boards of trustees of hospitals in their local communities, in recognition of the importance of the hospital to the people of the area. These tens of thousands of trustees are the representatives of the general public, organized to supervise the policies of the hospital with respect to the needs of the individual community, and to see that the institution renders its fullest measure of service to its citizens. Representatives of our various church groups have fulfilled a similar purpose in operating hospitals in areas where they were needed.

Within the walls of hospitals in every part of the Nation, thousands of physicians, nurses, hospital administrators, and other personnel have individually and collectively contributed to the development of a system of hospital and medical care which draws very little criticism except that there is not enough of it. The strength of this system is that it has grown and is continuing to grow according to the needs of the people it has served. It is rooted in many soils, and has developed along various lines. Today's health care system is a living, growing organism which is instantly adaptable to the latest scientific discoveries, or to the needs of the community, or to the individual patient.

We are keenly aware of the fact that the amazing development of hospital services over the past two generations has been the result of those incentives which are found only in a free and independent professional group devoting their whole attention and interest to their efforts to be of service to society.

DANGERS OF FEDERAL CONTROL

If control of the funds of a compulsory health insurance system be placed in the hands of the Federal Government, the continuing growth of our present system which has brought such progress will be seriously affected, because, administratively the Federal Government will have to adhere to a single pattern of providing care. If our present system had been developed in a single pattern this might be less difficult. But it has not; and we have no reason to believe that the Federal Government will be able to determine such a pattern. Nevertheless, if this legislation be enacted, those who administer the law will be obliged to establish some pattern at once. And they will be in position to enforce that pattern—right or wrong—through complete control of funds. The terrible inertia of Government regulation could easily retard further development of health care in America.

Therefore, as a group, on the basis of our experience, we are opposed to the legislation which you are considering, because it would put the Federal Government into the position of controlling the whole health field. We regard this legislation as a dangerous violation of all that has been learned in the administration of hospitals. In a nutshell, hospital and medical care is a personal service, and the more remote the control, the worse the service. Please understand that we do not condemn all Government activity in the hospital field, for Government has had an important part, both on Federal and local levels. But we cannot believe that the answer to the health problem of our country is to place the Federal Government in the position of collecting and dispensing practically all of the funds needed to pay physicians, hospitals, dentists, nurses, and others who supply care to the sick.

COSTS WOULD RISE

We are further opposed to this legislation because it has been our experience that Government in the health field is seldom able to control its cost of service, and on the other hand is likely to promise greater benefits than funds will permit. Between a steadily rising cost of benefits, and an increasing demand for more of such benefits, the Government would soon begin to operate under tremendous financial pres-

sure. We do not believe that the potential demand of this program upon the taxing power of the Federal Government has been fully evaluated. Certainly, this may become one of the most expensive programs the Federal Government has ever undertaken, and the responsibility to be imposed upon the Federal Government for meeting such broad promises to the American people is not easily comprehended.

The whole problem of purchasing hospital and health service is still developing. Under S. 1606 the Federal Government would be almost the sole purchaser of such service. We do not believe it is realistic to assume that the system proposed by this legislation would long continue. Steadily increasing costs, arguments as to various methods of rendering such care in different hospitals, would lead to such criticism of the program that the Federal Government would be constantly taking steps to meet such criticism. However, these pressures would be such that before very long the Government would be controlling the whole system by regulation, and Government operation would be inevitable.

State and local governments in their operation of hospital facilities have found no easy answer to these financial pressures. In most cases, such Government institutions offer only minimal and impersonal service. The Federal Government itself has been subjected to much criticism for faulty operation of its own hospitals. Its experience in hospital operation is not such as to encourage us to believe that Government operation of hospitals will improve the quality of hospital service or reduce its cost.

QUALITY WOULD DETERIORATE

The sponsors of this legislation do not believe that its compulsory health features will lead to Government operation, and they have repeatedly so stated. Nevertheless, we firmly believe that the pressure for increasing benefits, coupled with rising costs of such benefits, will not only lead to Government operation, but will further result in serious deterioration of the quality of service, because of the inadequacy of funds.

Government control of funds will greatly change present incentives for high quality of medical and hospital service. Quality, under such conditions, will be sacrificed for quantity. This financial pressure will require detailed control of those to whom funds are paid. There is grave danger that imposed standards and sweeping regulations may supersede the present cardinal rule which places the welfare and comfort of the individual patient above all other considerations. This control by regulation will have to be established within the range of the average hospital. The process of averaging may result very logically in improving the services of substandard hospitals, but it will also almost certainly result in the elimination of our present higher cost hospitals. This will strike directly at our teaching hospitals and those which now render distinctive service. Will this not mean the elimination of leadership in the hospital field? The sponsors of this measure completely overlook the sources of hospital progress.

We are fearful of this legislation, too, because it makes promises which are impossible of fulfillment. For example, there are now in this country approximately 130,000 active physicians. These men, as you know, seldom work regular hours. However, it is reasonable to

assume that under a federally controlled administration these physicians, like other Government employees, would fall back into a 5-day 40-hour week. Allowing for the usual 2 weeks' vacation, we find that 50 weeks of such service would make 2,000 hours of medical service available from each physician in a year, and a total of 260,000,000 hours per year from the whole profession. Since we have a population of over 140,000,000 people, this is less than 2 hours of medical service per year for each individual. In other words, there are not enough physicians in the country right now to provide even two complete physical examinations per year for each citizen. The normal output of our medical schools is approximately 5,000 physicians annually, which is barely enough for replacement needs. If the output were increased to 10,000 per year, it would require 26 years to double our physician census. In the meantime should this bill suddenly become a law, the overwhelming load thrown upon our medical profession would result in the lowest standards of medical care this country has ever known. It is our feeling that the proponents of this legislation have not taken these facts into consideration in their discussion of the vast benefits to be afforded the Nation immediately upon passage of this bill.

As a matter of fact, in all the years we have had a social-security system in operation in this country, a large portion of the employed population is still not covered by present benefits. Yet here is proposed a much more complex program which is being promised to the entire population. In view of the still partial acceptance of social-security provisions, we are unable to envision the establishment of a universal compulsory health program which would even in the distant future accomplish all of the things which are promised.

We are fully sympathetic with the aims of those who would like to have more medical and hospital service available to more people. That is also one of our aims. However, we do not believe it can be widely and effectively accomplished in one bold stroke. Rather, we believe it requires an orderly, intelligent program which will be more closely integrated to the needs of our people. It takes 8 years to train a physician. Hospitals can be built more rapidly, but it also takes time to develop the highly trained personnel necessary to provide our citizens with the high quality of hospital service they have come to expect and desire when they are sick. Enactment of S. 1606 as it is presently drawn would not correct our basic shortages in facilities and personnel. Rather it would intensify the existing shortages in facilities and personnel. Rather it would intensify the existing shortage, and create confusion by its unrealistic approach to the whole health problem. Indeed, we believe that the assignment of ultimate authority in the health field to the Federal Government might well retard its further development because of the stultifying effects of remote control and administration by regulation.

THE GOVERNMENT SHOULD ENCOURAGE THE BLUE CROSS

The American Hospital Association takes great pride in the progress that has been accomplished by the Blue Cross hospital prepayment plans in protecting more than 21,000,000 people in 45 States against the unexpected costs of hospital care. The expansion of this prepayment system, which has been sponsored by the association, has been one of the greatest examples of voluntary public cooperation in the

world. We believe that our Government should be actively supporting this program instead of criticizing it because it has not yet covered the entire population. Blue Cross has been a dramatic development and its success has been much dependent on pay-roll deduction. The Federal Government, the largest employer in the country, has not taken the simple step necessary to offer this protection to its employees through such pay-roll deduction. Instead, high officials criticize Blue Cross because no greater a proportion of the population is covered. Cooperation from the Federal Government would be an easy step and most helpful in this voluntary movement to offer hospital benefits to the employed population and their dependents. Blue Cross has merited such Government cooperation—certainly not its criticism.

Blue Cross is low in cost, and its costs of operation are low. Only those who are now employed would contribute to the program under S. 1606, and these are all eligible to enroll with Blue Cross. In our opinion, it would be far better that these voluntary plans with their broad coverage for the employed and their dependents be further extended before we consider compulsory insurance as the easy answer to the whole problem of distributing hospital and medical care. The "magic of averages" is not the complete answer to all of our problems.

Incidentally, I wonder if you have considered the probable attitude of the veteran to this program of health insurance on a compulsory basis. Under present circumstances, you know, the veteran is already receiving extensive health services without cost to himself. Yet, if you enact this bill, you are going to have to tax these veterans, along with the rest of us, to pay for benefits they are already receiving for nothing. The veterans are a substantial group who have little to gain and a great deal to lose by the passage of this compulsory health bill.

As I have said, the American Hospital Association has as one of its primary aims the better distribution of hospital services to our people, and the continuing development of better standards of quality and service. With this in mind, we have actively supported the Hospital Survey and Construction Act, which was studied by your committee last year, and passed by the Senate last December. That bill is now being studied by a committee of the House of Representatives, and if it is enacted we believe it will go far toward relieving the present shortage of hospital facilities in this Nation. We wish to compliment your committee for the fine work that was accomplished in the development and passage of S. 191.

However, the construction of additional hospitals and the extension of Blue Cross will still leave one area which requires the attention of the Federal Government. We believe that all citizens, irrespective of their ability to pay, should obtain medical and hospital care according to their needs. Such a program requires acceptance by the Federal Government of the responsibility of helping to meet the basic costs of care to the needy. We believe this is a primary responsibility of State governments to be administered on a local basis, but with Federal aid to equalize this assistance among the various States.

With Blue Cross plans for those who can pay, Federal aid to the needy, and a program for construction of additional hospitals in areas where they are most needed, we believe adequate and excellent health service can be made available to the whole Nation without seriously disrupting the American system of voluntary health care, which is,

admittedly, one of the finest in the world. This broad distribution of care could be achieved without the vast drain on Federal resources, and without taking the grave risks that are inherent in the program you are now considering. Such a program permits orderly development of demand for more hospital and medical services, and these steps will in themselves stimulate an increased supply of competent professional workers required to staff expanded facilities. Hospital progress in this country has not been surpassed elsewhere. It has come about by voluntary action of the American people, and without Government control or interference. It is continuing to grow and will improve at an ever-increasing rate if it is not so controlled. Humane care of the sick has been based upon local effort, and has been developed upon an individualistic basis. It could not be standardized or regulated by government without losing much, if not all, of its value.

In closing, let me remind you of Aesop's famous fable of the dog and the bone. This dog, crossing a bridge with a large bone in his mouth, looked down into the water and saw another dog with a larger bone. He very logically reasoned that he might improve his position if he could have possession of both bones, so that in his enthusiasm for more he dropped the bone he had and ended up with neither.

We are anxious that the American people should have the very best of hospital and medical service, and that it should be available to all. But we do not believe they should be induced to jeopardize what they already have, in order to obtain something that is, as yet, impracticable and of lesser value.

The CHAIRMAN. Mr. Hayes, do you recognize the fact that in this country there is a large number of people who, for financial reasons, are unable to pay for modern medical care and hospitalization?

Mr. HAYES. Certainly; everyone in hospitals realizes that and we take care of them for nothing in practically all of our hospitals.

The CHAIRMAN. Do you take care of all this vast section of our population who do not earn enough to enable them to pay for hospital expenses?

Mr. HAYES. We take care of charity patients, too.

The CHAIRMAN. I want you to answer my question. You say that you recognize that in this country there is a large section of our people who earn insufficient income to pay for the best modern medical care.

Mr. HAYES. Yes, sir.

The CHAIRMAN. Then you state that the hospital associations of this country are prepared to take care of all of that vast section of our country, without requiring them to pay the full cost.

Mr. HAYES. With Government help; we have approved of title I.

The CHAIRMAN. Please answer my question. I am not asking about Government help. I am asking if you are prepared to take care of all that section of our population who, by reason of insufficient earnings, are unable at the present time to pay for the best modern medical care?

Mr. HAYES. No, we are not able to take care of all of it.

The CHAIRMAN. Your hospitals have found that the increasing cost of hospital care has made their situation somewhat precarious during the last 10 or 12 years?

Mr. HAYES. That is right.

The CHAIRMAN. And in order to assist the hospitals in meeting this situation, the Blue Cross plan has been a very great aid to the hospitals?

Mr. HAYES. Yes, sir.

The CHAIRMAN. Of course, you know that the Blue Cross plan does not give complete medical care, office care, and home care to the people that subscribe to that system?

Mr. HAYES. That is right.

The CHAIRMAN. Then that system would not take care of this section of our population that I am talking about that earn insufficient funds to enable them to pay for full care?

Mr. HAYES. That is right.

DESCRIPTION OF BLUE CROSS PLANS

The CHAIRMAN. Will you describe to us what the Blue Cross plan covers in the way of hospitalization and medical care?

Mr. HAYES. With very little variations, there are something like eighty-odd Blue Cross plans in the country. The aim of all of them, and the aim which they accomplish in most cases, is to provide complete care in the hospital. That is, they provide everything that is needed, the operating room, X-rays, even oxygen and penicillin have been included in these plans.

In other words, a patient may come into the hospital and go out of them without owing a penny or paying a penny for his case.

The CHAIRMAN. Can you furnish for the record a Blue Cross plan that offers that kind of service?

Mr. HAYES. New York City is one instance.

The CHAIRMAN. Will you produce for me, please, and put it in the record, something to that effect?

Mr. HAYES. I will, sir.

The CHAIRMAN. And you say that covers everything, including penicillin and other expensive things?

Mr. HAYES. Yes, sir, but not special nursing. That is the employee and the patient.

The CHAIRMAN. In addition to that, it does not give medical care, home medical care, or office medical care to its members?

Mr. HAYES. No, there is another organization that does that, the United Medical Service. That is growing rapidly.

The CHAIRMAN. That would require additional contributions on the part of people who joined that organization?

Mr. HAYES. That is right.

The CHAIRMAN. Would that cover complete and adequate medical care?

Mr. HAYES. That is a medical question. I am not familiar with all that.

The CHAIRMAN. You have never seen them?

Mr. HAYES. I have reason to believe that it is practically complete. It is the United Medical plan in New York.

The CHAIRMAN. What gives you that belief?

Mr. HAYES. I have seen circulars on it.

The CHAIRMAN. Have you seen the plan itself?

Mr. HAYES. No, I have not, not in that field.

The CHAIRMAN. You have read the circulars of the National Physicians Committee in which they say this is socialized medicine and regimentation, and so forth?

Mr. HAYES. All medicine is socialized as far as that goes. I would say it is federalized medicine.

The CHAIRMAN. Is it federalized medicine, or socialized medicine? It is nothing more than undertaking to give to the people of this country an opportunity for the medical care that they may need?

Mr. HAYES. They have an opportunity now, Senator, in commercial plans, and otherwise, that I would believe to be much less than the 3 percent of \$3,600, or whatever the percentage might be. There are opportunities for every one to enter into these medical plans on an indemnity basis.

The CHAIRMAN. I would like to have you furnish for the record any indemnity plan that would furnish the extent of care—medical care and hospitalization—that is proposed under this bill.

Mr. HAYES. I shall send them to you.

The CHAIRMAN. Will you have it available shortly?

Mr. HAYES. I will have it as soon as I get back; yes, sir.

The CHAIRMAN. We will have it incorporated in connection with your testimony, into the record.

Will you also send to me the Blue Cross plans which you say give complete and adequate hospitalization as a service, and furnish all the drugs that are necessary in connection with such hospitalization?

Mr. HAYES. Yes, sir.

THE COST OF HOSPITAL CARE

The CHAIRMAN. Now, you say that there is a steadily rising cost of hospitalization in this country?

Mr. HAYES. Yes, sir.

The CHAIRMAN. Do you expect that to continue?

Mr. HAYES. Yes; I do; because hospitals are now obliged to meet the wages of industry, and we formerly did not do it.

The CHAIRMAN. Do you refer to that steadily increasing cost all through your testimony?

Mr. HAYES. That is right.

The CHAIRMAN. Of course, that in turn makes increasingly difficult the opportunity of people in this country, who do not earn sufficient funds, to take care of themselves at the present time. It makes it increasingly difficult for them to secure this hospitalization and medical care because of the constantly rising costs?

Mr. HAYES. Unless they come in as free patients. You must remember that we take care of a great deal of them as free or part-paid patients.

The CHAIRMAN. Would you prefer to see a system where people would come in and have their care paid for by the Government in preference to a system whereby they could be enabled under the national insurance plan to pay for it themselves?

Mr. HAYES. Not if the Federal Government controlled that system; no, sir.

The CHAIRMAN. You would not be against the Federal system, as I understand it?

Mr. HAYES. I say, under this system, that to my mind represents Federal control, which I am certainly opposed to.

The CHAIRMAN. What is the Federal control in this system that you are so opposed to?

Mr. HAYES. It is written throughout the bill. The Surgeon General would determine which hospitals could serve the public. We would be obliged to take a maximum rate of \$7.

The CHAIRMAN. I wish you would point that out in the bill for me. I know of no such provision. It provides that the patient should have the choice of the doctor and of the hospital in which he wishes to be cared for.

Mr. HAYES. We are not approved by the Surgeon General. It mentions "hospitals approved." He determines the standards to be applied to the hospital and to the establishment and maintenance of the list of participating hospitals. That is included in page No. 44.

The CHAIRMAN. The patient would be entitled to any of those hospitals?

Mr. HAYES. The Federal Government would approve; that is right.

The CHAIRMAN. Do you not think it would be advisable to have the Government investigate these hospitals and determine the character of their personnel and their ability to give the kind of service that would be needed in our modern conditions?

Mr. HAYES. On a local or State basis, I believe that is all right.

The CHAIRMAN. You think the investigation and study of those conditions should only be on a local or State basis?

Mr. HAYES. That is right.

The CHAIRMAN. Is that not exactly what this bill provides?

Mr. HAYES. I do not think so.

The CHAIRMAN. I think, if you examine the bill, it provides for the State to set up methods of operating these hospitals in the various States of the Union, and to provide the qualifications for them and the kind of care they have to give.

Mr. HAYES. The final approval comes through the Federal Government, does it not, according to this paragraph [indicating]?

The Surgeon General determines which hospitals are to participate.

The CHAIRMAN. He determines whether or not they qualify, but they qualify under the State plans. You say:

In view of the still partial acceptance of social-security provisions.

What do you mean by the—

still partial acceptance of social-security provisions?

Mr. HAYES. Well, only part of the population is covered. For instance, all of our employees are not covered. We have asked for that coverage a number of times.

The CHAIRMAN. Well, the system, though, is acceptable to the people. You mean that it does not at the present time provide full coverage in the country?

Mr. HAYES. It does not cover all of the population, Senator.

The CHAIRMAN. Proposals are now pending to extend it and make it cover it.

Mr. HAYES. We have asked for that ourselves, that is right.

The CHAIRMAN. Do you approve of that?

Mr. HAYES. I approve of that for hospital employees.

EFFECT OF S. 1606 ON VETERANS

The CHAIRMAN. You were talking about the veterans under this bill. You say, if you enact this bill, you are going to have to tax the

veterans along with the rest of us to pay for the benefits they are already receiving for nothing.

Mr. HAYES. Yes, sir; that is right.

The CHAIRMAN. Why is it necessary to do that? Cannot there be some provision made there to prevent the veterans from paying for the benefits they are alredy receiving?

Mr. HAYES. That would eliminate fifteen or twenty million of the working population, would it not? There are about that many veterans and most of them are wage earners.

The CHAIRMAN. But they would still come in under the plan for their general care and the care of their families for nonservice connected injuries.

Mr. HAYES. They are entitled to that now in veterans' hospitals.

Senator PEPPER. They are not entitled to it unless they are unable to provide for it out of their own need, which means practically they have got to come into the charity basis?

Mr. HAYES. They are entitled to free medical care.

Senator PEPPER. You do not mean as a factual matter that any veteran is entitled to free medical care from any disease at the present time?

Mr. HAYES. He is if there is a bed for him.

The CHAIRMAN. There is a shortage of them, but at the present time there have been no opportunities for the veterans to get that care that they should have, because there are no beds for them at the present time?

Mr. HAYES. There are bedding hospitals, and it is something which they are credited with earning, and to which they are entitled.

Senator PEPPER. No; they are not; and they have never been entitled to it as veterans of the first war, all through the years, unless there were vacant beds and they were able to show they were practically impecunious, which most of them do not want to do.

Mr. HAYES. Was that not recently taken away, that requirement, as to swearing they were indigent?

Senator PEPPER. When I conferred with the Veterans' Administration about a week ago, General Hawley definitely informed the delegation and myself that it is only service-connected disability that they are trying to take care of.

Mr. HAYES. They are taking care of them in our hospitals to some extent.

Senator PEPPER. If a veteran received care for non-service-connected disabilities in this system contemplated by this bill and if his family received coverage and care, it would be appropriate for him to pay some kind of a compensation, would it not?

Mr. HAYES. Yes; if his family derived benefit from it.

Senator PEPPER. And if he received benefits from it, which were not covered by the law relative to veterans, it would be appropriate for him to pay?

Mr. HAYES. It would, if they were not covered.

Senator PEPPER. So it would not seem to be difficult to find some kind of diminution in the amount that the veteran should pay to give him full credit for what he gets free under the Veterans' Administration.

Mr. HAYES. We are calling attention to that fact.

The CHAIRMAN. Your associations are considering making agreements and contact with the Veterans' Administration for the care of veterans?

Mr. HAYES. We are for service-connected disabilities.

The CHAIRMAN. And under those agreements, the Veterans' Administration will pay the hospitals for the care that they give?

Mr. HAYES. That is right; the hospital's cost and the doctor's will be paid.

The CHAIRMAN. Is there any reason why similar arrangements under an insurance plan could not be entered into with hospitals?

Mr. HAYES. Well, Senator, if you did it on the basis that the Veterans' Administration is doing it, paying for the cost, that is considerably more than \$7 a day in the average voluntary hospital.

My hospital is rather economically conducted and our costs in ward patients went up over \$10 per patient last year for the first time.

The CHAIRMAN. Do you say that the Blue Cross hospital plans now have about 20,000,000 members?

Mr. HAYES. We have over 21,000,000.

The CHAIRMAN. Not more than two or three million persons are members of insurance plans that provide comprehensive medical care?

Mr. HAYES. I do not know the figures on that. That is a more recent development. That is on a nonprofit basis. Of course, there have always been commercial plans.

The CHAIRMAN. You do not know of any single Blue Cross hospital plan that offers full insurance coverage against the hazards of ill health?

Mr. HAYES. It is impossible for them to do it in practically all the States. One has to be a medical plan, and the other a hospital plan.

The CHAIRMAN. You are not a doctor, yourself?

Mr. HAYES. No, sir.

The CHAIRMAN. I notice you have discussed the effect of this bill on the medical profession.

Did you prepare this entirely by yourself?

Mr. HAYES. I prepared the statement and sent it out to members of my council and asked for their suggestions, and they scarcely changed a word.

The CHAIRMAN. They scarcely changed a word, but you had their advice and suggestions in the matter?

Mr. HAYES. I merely followed the policy of an officer of the association of letting the officers and trustees know what I was going to say.

The CHAIRMAN. You did not let the Medical Association know what you were preparing this statement for?

Mr. HAYES. No; we are not permitted to speak for the medical profession. We speak of the effect on medical care.

The CHAIRMAN. Did you talk it over with the staff in your hospital?

Mr. HAYES. No, sir.

The CHAIRMAN. You never mentioned it to the staff in your hospital or the surgeons, the fact that you were preparing this?

Mr. HAYES. I told them I was coming down, but I did not tell them what I was going to say, and I have not shown it to anyone in my own hospital.

The CHAIRMAN. You say that the Government control of funds under this national health-insurance system will greatly change present incentives for quality of medical and hospital service?

What do you base that on?

Mr. HAYES. Well, I base it on the fact that if the Government is to pay on the quantity basis for hospital care, it is going to get that type of care rather than individual care that the patients get now.

The CHAIRMAN. Who introduced the word "quantity"? The statement here is—

control of Government funds will greatly change present incentives for quality of medical and hospital service.

Mr. HAYES. That is right. You fixed a limitation on how much you would pay and it certainly would be foolish to go beyond that and incur losses.

The CHAIRMAN. But the plan undertakes to pay for whatever essential modern medical and hospitalization is necessary?

Mr. HAYES. Senator, you cannot do that on \$7 a day.

The CHAIRMAN. I am not talking about \$7 a day. I am talking about this program that we have here that will provide modern medical care of the best quality for the people under the insurance system.

Mr. HAYES. That would cause a varying rate.

The CHAIRMAN. Why should there be any varying rate for the best quality of medical care?

Mr. HAYES. Because one patient might cost us \$50 for 1 day, and another merely his meals.

The CHAIRMAN. That is true; but that does not prevent having a system set up that will enable everybody under the insurance plan to go to a hospital and get the best quality of modern medical care and hospitalization. Some will get little and others more, according to their needs.

Mr. HAYES. Under the Blue Cross plan, we are paid the identical amount for each patient and they all get the ultimate in medical care.

The CHAIRMAN. They get the highest character of medical care?

Mr. HAYES. That is right, but the Blue Cross starts off by paying \$15 in New York City, \$10 for the second, and \$9 for the third.

The CHAIRMAN. So you would get much more under the voluntary system than the Federal system?

Mr. HAYES. The hospitals get more than is proposed in this law.

The CHAIRMAN. That is a very important item, of course, that you would make more profit under the voluntary system than you would under the Federal system.

Mr. HAYES. Senator, we never make a profit. We always suffer losses.

The CHAIRMAN. You are familiar with the workmen's compensation laws, are you not?

Mr. HAYES. Yes, sir.

The CHAIRMAN. You know that under that system, the costs of medical care are paid by the Government, and the people in industry, and the men in industry that are injured or need medical care get it under that system of workmen's compensation.

Mr. HAYES. Did you say "paid by the Government," Senator?

The CHAIRMAN. Yes. They are paid under the workmen's compensation.

Mr. HAYES. They are compelled to have the insurance but the insurance can be a mutual company, or where they exist, a State fund.

In other words, the employer has his choice or he can be a self-insurer. The requirement of law is that he do cover his employees.

The CHAIRMAN. It is under a Government plan which makes it possible for every employee who is injured and needs medical care to get it when he needs it.

Mr. HAYES. It is the Government edict that he must have that insurance.

The CHAIRMAN. The hospital is paid through that kind of system?

Mr. HAYES. It is different from this.

The CHAIRMAN. But there is no deterioration in the quality of service or the character of medical care that was accorded to these people under that plan?

Mr. HAYES. That is right.

They pay costs.

The CHAIRMAN. Yes; under the system which deducts from their wages and from the employer, the cost of such a plan is deducted?

Mr. HAYES. That is right.

The CHAIRMAN. That is the kind of a system which we envisage with this bill, that the working people of the country are going to pay a part of their wages into a fund and the employers are going to contribute a fund to it.

That makes up the national fund under which the medical care that is needed will be paid for.

Do you think that is not an advisable system for us to have in this country?

Mr. HAYES. That is not the real question, Senator, in our minds.

The question is Federal control of hospitals. That is what we are worrying about. The man who controls the purse strings has the control.

The CHAIRMAN. I do not see where you get the basis for your fear against Government control of the hospitals.

My understanding is that this bill does not undertake to control the hospitals or the medical profession. It merely provides that the hospitals must prove that they are able to give the standard of service that is necessary and that they must maintain their hospital and everything in a condition which would enable them to give this service.

Mr. HAYES. Of course, we all do that and the States and local communities supervise us.

The CHAIRMAN. That is not any great burden on the hospitals, that they are examined and investigated to determine whether or not they are giving a high degree of care?

Mr. HAYES. It would establish a pattern, a pattern by the Federal Government based upon the maximum that it would pay. That would limit it.

The CHAIRMAN. Are there any other questions?

Senator PEPPER. Yes. I have some questions.

Mr. Hayes, I notice from your statement that there are some 3,500 hospitals that are members of the American Hospital Association.

Mr. HAYES. Yes, sir; that is right.

Senator PEPPER. These comprise about 85 percent of the civilian general hospital bed capacity of the Nation?

Mr. HAYES. That is right.

Senator PEPPER. Generally speaking, who owns those hospitals?

Mr. HAYES. They are owned by church organizations.

Senator PEPPER. What percentage is that?

Mr. HAYES. That is about a third.

Senator PEPPER. Who else owns them?

Mr. HAYES. The balance of them are community enterprises.

Senator PEPPER. They are owned by communities?

Mr. HAYES. We have in our membership municipal and State hospitals. I am talking about the average voluntary hospital. It is difficult to say who owns an organization of that sort. It definitely has no ownership. It has a control in the board of trustees. It is built with philanthropy.

Senator PEPPER. You said about a third of the hospitals composing your organization are owned by church organizations.

Can you give me a general idea as to what percentage of the whole number is owned by public bodies; that is, municipalities, counties, States, or public bodies of any sort, and what percentage are owned by private bodies where public funds do not enter into them?

Mr. BUGBEE. I can give you an exact break-down, Senator Pepper. I think the third is high. There are about 1,000 church hospitals in the country. Of our membership, I think it is 700 church hospitals and 500 of municipal, county, and of that type. Then there are several hundred proprietary, which are, by and large, a small percentage of the bed capacity of the country as a whole, and the balance of this nonprofit type of corporation.

Senator PEPPER. What do you mean by "proprietary"?

Mr. BUGBEE. They are owned by physicians.

The CHAIRMAN. Or are they owned by a group of physicians?

Mr. BUGBEE. Yes; they are.

Senator PEPPER. You say about 500 are publicly owned by counties and that sort of thing?

Mr. BUGBEE. That is right.

Senator PEPPER. And the others are owned by nonprofit organizations, the funds for which are derived by private contributions?

Mr. BUGBEE. They are at least nonprofit as to any payment of dividends.

The building may have been built by philanthropic gift or some of their funds for support of free care may be currently given each year, or the majority of the patients may, in certain instances, pay the costs themselves, or indigent patients may be paid by the local community out of tax funds. They are nonprofit.

Senator PEPPER. Already a considerable portion of the hospitals of the country serving civilian needs are supported by public bodies and by public funds?

Mr. BUGBEE. If you take all beds, men of tuberculosis and others, that is certainly true by a great majority. We are not referring to general hospital beds.

Senator PEPPER. But even with respect to the general hospitals where general care is rendered, you say that 500 out of the 3,500 were owned by public bodies and the funds were provided by public sources. They are in good standing in the association?

Mr. BUGBEE. That is correct.

Senator PEPPER. They are run in the same general manner and on the same general standards as the others?

Mr. BUGBEE. There is no quality of membership as a requirement for membership.

Senator PEPPER. Hospitals can be owned and operated by public bodies out of public funds and still meet hospital standards.

Mr. BUGBEE. That is correct.

Senator PEPPER. So that the fact that the United States Government had something to do with it would not mean that they are sub-standard and not satisfactorily operating institutions?

That would not be so, per se?

Mr. BUGBEE. No; that would not be so per se.

The CHAIRMAN. Then, out of the remaining hospitals a great many of them are recipients of contributions and donations from people, and a large part of their funds, in some instances, are received in this way?

Mr. BUGBEE. That is correct.

Senator PEPPER. As a matter of fact, in a great many, as the Senator suggests, are there not many patients maintained out of public funds?

Mr. HAYES. They are partially maintained.

Senator PEPPER. Well, you do not give a lower standard of care, do you, to a patient just because the bill happens to be paid by the county or State?

The fact that you happen to get the funds from the city and they have to pay it does not give a lower standard of care to those people?

Mr. HAYES. That applies to everyone.

Senator PEPPER. Well, if the Veterans' Administration has made a contract with your hospital to pay you for service-connected disability benefits, I mean for service-connected disability required hospitalization, just because you send a bill to the Government, the Government pays it, do you give a lower standard of care to those veterans?

Mr. HAYES. We do not; certainly not.

Senator PEPPER. So the source of the money in the payment of the bill does not determine the quality of the hospital care that you give?

Mr. HAYES. No; it does not.

Senator PEPPER. Mr. Hayes, could you give me some idea as to how much charity the hospitals of your association give every year to the patient?

Mr. HAYES. Well, I have not the percentage. Of course, a good many of the hospitals are city or county institutions that are all charity. Every voluntary hospital does a certain percentage of charitable work, a little bit less in recent years.

If people had a little more money, it would be different. My own hospital averages over the year about 60 percent of the patients as charity patients.

The CHAIRMAN. Then your hospital is tax exempt?

Mr. HAYES. Yes.

The CHAIRMAN. You qualify, then, as a philanthropic institution?

Mr. HAYES. Yes, sir.

Senator PEPPER. It is a nonprofit organization supported by private philanthropic grants?

Mr. HAYES. Yes, sir; it is.

Senator PEPPER. Now, Mr. Hayes, have you got some statistics as to how many hospital beds are required for so many people to give decent hospital care to the people of the country?

Mr. HAYES. There are varying statistics on that.

We realize there are too many beds in some areas and not enough in others.

Senator PEPPER. Taking the needs of the United States, what is the deficiency at the present time in the number of hospital beds required?

Mr. BUGBEE. There is variation as to the standards required. The Hospital Survey and Construction Act suggested a maximum of four and one-half beds per thousand for general hospitals. I believe the census of hospitals in the country is something over three, with wide variation by areas on some above and some below.

Senator PEPPER. Well, the American knows of, and has heard of, the Hill-Burton bill?

Mr. HAYES. Yes; it has.

Senator PEPPER. I believe they are to be built by public funds under that bill?

Mr. HAYES. That is right.

Senator PEPPER. You do not object to the Federal and State funds providing facilities for you, do you?

Mr. HAYES. No, sir; I do not.

Senator PEPPER. In fact, you advocated this plan because this private philanthropy was not meeting the needs?

Mr. HAYES. Yes, that is correct, in certain areas and that philanthropy would never meet it in those areas.

Senator PEPPER. Can you say that all the people of New York City get all the hospital and medical care that they deserve and should have for their health?

Mr. HAYES. If they come for it, we have certainly more than sufficient beds to take care of them in the city.

Senator PEPPER. You reported that part of your patients paid and 60 percent get charity?

Mr. HAYES. That is right.

Senator PEPPER. What do they have to show to be classified as a charity patient?

Mr. HAYES. The admitting clerk asks them where they live, their earning capacity, and the rate might be determined as nothing, a dollar, or \$1.50 a day. We are required to have experienced and diplomatic people to ask those questions, but no one ever signs any oath that he is entitled to it.

Senator PEPPER. Every man's word does not have to be buttressed by an oath. They have to meet a means test in order to be classified as a charity patient. That is what they are.

Mr. HAYES. That is right.

The CHAIRMAN. The reason you can give that service there in New York is because already the hospitals there are on a public basis.

HOSPITAL COSTS

Mr. HAYES. No, sir, New York has about the poorest record of any large city in the country as to what it pays the voluntary hospitals for care.

For instance, in the hospitals in New York City, New York City pays a maximum of \$3.25 per day for a case in the voluntary hospital, and that has to be strictly an emergency case, unable to go to a city hospital before they accept that.

If a man comes in with pneumonia, if it is not very acute, they would not even pay for that.

New York has a very bad record in that respect, and we have made several pleas. We are still hopeful that beginning with the 1st of July, we will get a little more assistance.

The CHAIRMAN. You would like to see a system where the hospitals are paid?

Mr. HAYES. I would like to see them paid more than they are paid now.

The CHAIRMAN. That bill proposes to make payment for all of the services that a hospital would render under the provisions of this bill?

Mr. HAYES. Well, as far as title I is concerned, the indigent and the crippled children and those other items under that are concerned, yes, sir. We think that is a Government function to take care of them.

Title I limits us in what we can collect and an insured person can be a man earning \$20,000 a year and paying tax on \$3,600 of that earning, and asking us for ward care at \$7 a day, which we do not think he would be entitled to.

Senator PEPPER. Mr. Hayes, if I should go to a hotel and ask for a room and they give me a room and I ask for meals, they do not check my income tax and charge the rich man one rate and a poor man another rate, do they?

Mr. HAYES. No, but hospitals do.

Senator PEPPER. I know that. That is the reason that millions have not had the hospital care in this country. Is that not a compulsory insurance scheme that the hospitals are imposing when you do that?

Mr. HAYES. No. We treat a person according to his means. Lawyers fix their fee in the same way, and doctors fix their fees.

Senator PEPPER. You are a service institution. If you render "A" a given service and "B" the same service, why should you charge more for one than the other?

Mr. HAYES. We charge only on his ability to pay. Remember, Senator, we are not asking for a profit. When we take in a private patient, we are still getting only our cost.

Senator PEPPER. Who gave you the right to impose any compulsory insurance system on the people who come to your hospital for medical care?

I do not know, but I thought you were in the medical care business.

Mr. HAYES. We are not exercising any compulsion of that kind. When we charge a private patient for his room, we are hoping to break out even without even charging for the depreciation of the building or anything else.

Are we not privileged to give the semiprivate patient a lower rate? We are not imposing on anybody in doing that.

Senator PEPPER. I think you will have to admit you are making the rich man contribute to an equalization fund so you can charge the poor man the lower rate.

Mr. HAYES. The rich man is paying costs.

Senator PEPPER. You do not mean it costs any more to provide a bed for one than the other?

Mr. HAYES. It may cost a few cents. We charge him costs.

Senator PEPPER. You could not charge the way a hotel does. You charge one for a bed and one for something else.

They do not say, "We are going to make the rich man pay \$100 for his bed so we will give a beggar a bed if he comes in here;" and what is that except that you elect to exercise the power to provide an equalization fund out of the payment of the rich so you can take care of the poor. Is that what it amounts to?

Mr. HAYES. Your argument would be very sound if we were making a profit in the private room, but we are not.

Senator PEPPER. It is not a question of charging for a profit. It is charging a man for what he gets. You have heard of Henry Ford and the hospital in Detroit? Did he not set up a hospital in Detroit in protest against that very system of yours, saying that he had been imposed on and other rich men were being imposed on by hospitals and that he was going to establish a hospital where you paid according to the service you got?

Mr. HAYES. He was not imposed on by hospitals. He started a hospital with an entirely different scheme.

Senator PEPPER. Is that the principle of his hospital in Detroit?

Mr. HAYES. That is a primary institution where he charges fees according to what will bring him out even or better.

In our institutions, we are not charging for a profit. We are not hurting the rich man. We are charging what it costs in that private room.

Senator PEPPER. Taking into consideration the service you gave away; is that correct?

Mr. HAYES. We do not break even. My hospital lost over \$300,000 last year.

Senator PEPPER. It would have lost more if you had charged the rich less.

Mr. HAYES. I would have had a greater loss.

Senator PEPPER. You tried to make up your deficit by charging the rich more than they would otherwise have to pay.

If everybody that received service in that hospital paid the fair value of it, you would not have to charge the rich man any more than the fair value of the service?

Mr. HAYES. I would have to charge the poor man more.

Senator PEPPER. If the poor man paid for the service he got, then you would not have to charge the rich man more?

Mr. HAYES. He would pay what he is paying for and receiving.

Senator PEPPER. Then you would make a profit?

Mr. HAYES. I would not lose as much.

Senator PEPPER. I know, if you did not give away as much care. Now, down in a given town, you will find a rich man's son and a poor man's son sitting side by side in a public school. Now, there is the rich man paying taxes, and perhaps the poor man does not pay anything, but the school children get the same service.

What I was going to ask you was, because the Federal Government here sets up a plan under which people may pay into a given fund out of which you may be paid for the service you render anybody, yet you come in here and say that you represent the hospitals of this country and are violently opposed to that.

Mr. HAYES. Are you not still putting these insured people in ward beds? The rich man does not go in a ward bed.

Senator PEPPER. I will thoroughly agree with you if the effect of this bill is to put the insured people in wards instead of in private

rooms and to give them less than the best medical care then what I think you and I both ought to do, and if you will give me the suggestion, I will, as a member of this committee, and I am pretty sure the chairman will join us, try to remove that restriction, because we are not contemplating that they will be stuck over in a ward as compared to a private room unless the facility there, unless it is the kind of a case where it might be appropriate.

Another thing, I agree with you if they have got a flat standard a day of hospitalization of \$7 a day, and you, out of experience know that you can run a loss on that, my suggestion is that you give us the figures that ought to be inserted instead of that seven.

I agree with you. We want these people to have the best medical care.

Mr. HAYES. So we do.

Senator PEPPER. If \$7 a day is not fair to the hospital, you tell us what we should recommend, and I will give you assurance that you will get one vote on this committee that will support you.

Not only that, but if this plan goes into effect and you will come back here and say: "Gentlemen of this committee, the Federal agencies that are paying us these fees are pushing us down to a figure which is diminishing the quality of our care," I will guarantee you that if I am here, and if I am not there will be some other people who will give you a sympathetic hearing, because all we want to do is to make it possible for the people of this country to be able to buy out of the funds to which they contribute, the kind of hospital care that you would like to give every patient that needs hospitalization in this country.

Mr. HAYES. The matter of the payment is a minor matter, Senator.

I do not know whether you were here during the entire reading, but our chief objection on the part of the hospitals is Federal control.

Senator PEPPER. Well, there again, Mr. Hayes, that is a matter of opinion. If the Federal Government were going to run your hospitals, that would be one thing, and I will agree with you in opposing that proposal. But if all they are going to do with your hospital is, first, to elect whether you want to come under the plan or not, you do not have to.

Mr. HAYES. If everybody is insured you just have to.

Senator PEPPER. Everybody will not be insured. Unfortunately, we have not been able to devise a system that will cover everybody. There will still be a number of people who will not be covered.

In the second place, there will always be the rich man who would prefer, although he has to pay for it, he has to pay in the way of taxes, to go to the kind of hospital he prefers and get the service of people he can pay for privately, just as there are a certain number of rich men who, although their children can go to public schools, prefer to pay their taxes as a citizen and yet in addition pay a fee to the private school.

Are there not a lot of private schools that are getting along already, in spite of the fact that we have public education available to everyone?

Now, if they give you the alternative to come in or not to come in, and if, instead of trying to run your hospital for you, they simply pay the bills the way the Blue Cross pays it now, or the way certain

industrial concerns will pay a bill if one of their employees goes into your hospital, does that mean that the quality of your medical care has got to be diminished and that you have to oppose this opportunity for some people to get hospitalization that could not otherwise get it?

Mr. HAYES. We feel that way.

Senator PEPPER. May I ask you this? Are you not thinking more of how it will affect you and your pleasure and your interests in the matter than you are of those people out there in this country to whom this offers the only hope of getting the kind of medical and hospital care that they should?

Mr. HAYES. I think that is an unfair statement. I have been 20 years in the hospital business and I could have earned an easier living elsewhere.

Senator PEPPER. I do not say that you have no right to think of it from your point of view, but every time we think of the balance of good it will do to the one group as to the detriment of another, we have to consider those things.

When we ask for taxes for a public purpose, we are balancing interests against one another.

Now, that is what we have concluded, some of us, in respect to this legislation. There may be a certain amount of inconvenience until we can learn by experience a better method. It may have faults in it, and I am sure it will. We are saying that when you balance up the inconvenience it may cause somebody in the hospital, or maybe even the bad effects it may have, with the fact that it will give life and health to millions of men, women, and children in this country who cannot otherwise get it, then we feel that we are entitled in that balance of interest to side with the needy rather than maybe somebody, who from his particular experience, may not think it is a good thing.

Do you see our point of view?

Mr. HAYES. Yes, I see it very clearly, except that we believe in evolution.

This bill is entirely too much in the nature of being revolutionary, without sufficient people to carry out its purposes.

Senator PEPPER. Well, we have to progress by experience and by experiment. If we had waited for private schools, or private voluntary plans to get all the children of this country in schools, how long do you think it would have taken us to get the effect we are now getting by compulsory education in the United States, and if we had waited for voluntary associations to cover everybody against unemployment, how long do you think it would have taken us to provide as many people with unemployment compensation benefits as are being provided for under the law of social security?

I am afraid that you gentlemen, seeing because of your personal closeness to the bill some of the bad things that might ensue from it, are not evaluating those things against the multitudinous good things that will be done for the people of this country under this bill, making it possible for a citizen to budget for the first time complete hospital and medical care.

Do you think that could be possible?

Mr. HAYES. That is not by so drastic a step.

The CHAIRMAN. The witness that just preceded you said that it would take at least 25 years for that evolution to take place, under

which it would be possible for the average person in this country to avail themselves of the best modern medical care and hospitalization.

Mr. HAYES. You do not wish us to wait 25 years, do you?

Mr. HAYES. No; that is the reason we supported the Hill-Burton bill in order to get the hospitals, the clinics, the health stations to these places where they are needed.

The CHAIRMAN. But they cannot get there unless you have a program of this kind, because they would not build those hospitals in those locations.

They would not build them where they are needed unless they can show they are financially able to support them, is that not true?

Mr. HAYES. That is true.

The CHAIRMAN. How are you going to do that without a system of this kind, to make it possible for these people to pay?

Mr. HAYES. That is one step. I believe in going in these steps, that is one step.

The CHAIRMAN. We all would love to see the evolution take place, but it has not been evolving very rapidly in the last 25 years.

In fact, it has been getting worse and worse. It is worse today than it was 25 years ago, is it not?

Mr. HAYES. No, I do not think so. I noticed a vast improvement in my 20 years in the hospital field.

The CHAIRMAN. Do you mean to say there are better opportunities today for people to get the best modern medical care, the fullest and most complete modern medical care than they could 25 years ago?

Mr. HAYES. There is a tremendous improvement. You can take, for instance, the lengthening of the span of life and everything else.

The CHAIRMAN. The hospitals do not have anything to do with that. Has not that gone through social security, to a very large degree?

Mr. HAYES. That was here before social security was ever enacted. The lengthening of the span of life and certain hospitals have had a great deal to do with that and the research in hospitals has had a great deal to do with it.

The CHAIRMAN. Has not that research taken place in laboratories, and have not the greatest advances taken place as a result of experts and scientists working apart from the medical profession and apart from the hospitals in developing these modern scientific ideas?

Mr. HAYES. No, that always is with hospitals and sick patients.

The CHAIRMAN. You think that that has all been done in hospitals?

Mr. HAYES. No; not all of it has.

The CHAIRMAN. Have not the majority of those advances and improvements taken place as a result of scientific study by experts and scientists in laboratories apart from the medical profession?

Mr. HAYES. I think most of it has been accomplished in the laboratories of hospitals and in the operating rooms of hospitals.

The CHAIRMAN. Are you acquainted with what has transpired in this country and the result of laboratory research?

Mr. HAYES. Yes; I know where insulin came from and the drugs, and so forth. I know penicillin did not start in a hospital laboratory. I know that it had to be tried out in hospitals before it proved its worth and before it was found which diseases it worked on. Insulin started in a hospital to save many, many lives.

The CHAIRMAN. Nevertheless, it is true that without these research laboratories that have had an opportunity to make scientific study

of those problems, that we have made tremendous advances in medical care, in medical science?

Mr. HAYES. It has been cooperative effort of all those in any way associated with the medical and hospital professions.

Senator PEPPER. I wanted to ask one more question, Mr. Hayes.

You are willing to start with the assumption, are you not, that the people of the United States are entitled in some way or another to get an adequate amount of hospital care?

Mr. HAYES. That is in my testimony.

Senator PEPPER. Yes; you start with that assumption.

Now, this bill would provide that quantity and quality of hospital care essentially through an insurance fund to which the Federal and State Governments perhaps jointly might have to contribute because the insurance fund might not be high enough to supply all of these needs.

You understand that, that the bill may contemplate a Federal and State, or Federal subsidy?

Senator DONNELL. I should like to call attention at this point to the fact that there is not a word that indicates it will be financed by the State.

Senator PEPPER. All right; the Federal Government, then.

In addition, the bill says they authorize such funds as may be necessary to carry out the purpose of the bill. Now, then, as against that, you propose what, now, to provide the necessary hospital care to the people?

Mr. HAYES. We propose voluntary plans plus Government help for the indigent, and hospitals mentioned in title I.

Senator PEPPER. We all agree on title I, so we can leave that out of our discussion.

Do you disagree with the testimony of some members about the voluntary plans that, in spite of the fact they have been in existence several years and the country has been aware of their expansion, that only about 3 percent of the people are given the kind of actual coverage at the present time under those plans that would be provided to the insured under this bill?

Mr. HAYES. You are asking, Senator, that this thing be done overnight.

Senator PEPPER. I was just asking a question on that.

Mr. HAYES. Its growth has been slow until the last 2 or 3 years, when it has been increasing, and again I will call attention to the part of my testimony where I stated that the Federal Government has kept out of it as far as hospital care is concerned.

Senator PEPPER. I asked you whether you disputed the statistics that have been repeatedly given, that at the present time, under the voluntary insurance system of this country, that 3 percent, not to exceed 4 percent, have complete coverage of medical and hospital care that is contemplated by this bill for the insured?

Mr. HAYES. I do not know whether your percentage is right.

Senator PEPPER. Do you dispute those figures?

Mr. HAYES. I do not. My own opinion is that it is larger because of all that industry does.

Senator PEPPER. That is your opinion, but you are not informed as to the exact figures. Do you dispute the testimony given by a great

many people and the findings made by a great many more people, that the voluntary plan cannot succeed in affording medical and hospital care to the masses of the people in the lowest-income groups because they are too high?

Mr. HAYES. The cost of it is too high?

Senator PEPPER. Yes; that is right.

Mr. HAYES. I do not believe that. I think that a man who has full hospital care for himself for \$9.60 a year or for \$24 a year, has complete hospital care for every member of his family if he has 10 children. I do not think that this bill begins to approach that.

Senator PEPPER. I am speaking now about complete coverage. He cannot be treated by the hospitals.

Mr. HAYES. I am talking about that alone, which is \$24 a year on a \$3,600 basis. I do not know what your percentage will be, but let us figure 3 percent right now.

That would be \$108 a year for the hospital and the medical care, as compared with what Blue Cross now does for \$24 a year for the hospital care, which is essentially the large part of care when you go into a hospital.

Senator PEPPER. I asked you whether you disagreed with the statement of a great many people that the voluntary plans are so expensive that they afford complete medical care, medical care, and hospital care to the people, that they practically exclude the masses of the people in the lower-income groups. Do you disagree with that?

Mr. HAYES. For the complete medical care, I think this will cost them. I disagree to that extent; yes, sir.

Senator PEPPER. You understand that it is generally considered that the employee to be covered by this bill will pay 1½ percent of the pay roll up to \$3,600 a year?

Mr. HAYES. Yes, sir; that is right.

Senator PEPPER. Well, that will cover him and all of his dependents.

Mr. HAYES. Is there any reason why an employer who now provides full Blue Cross—a great many of them do—he is paying it anyway; the employer is paying the other 1½ percent. After all it is the population that is paying it.

Senator PEPPER. We were talking about the individual.

You understand, do you not, that in 1942 the statistics were published that one-half of the families of this country who had income from wages or salaries earned less than \$100 a month?

Mr. HAYES. Yes; I do.

Senator PEPPER. Let us take half of the families of this country. If a man is getting \$1,200 a year, and he pays 1½ percent of his pay roll or of the wages, would not that be \$18 a year?

Mr. HAYES. That is true.

Senator PEPPER. Under this bill that \$18 a year would provide complete, relatively complete, medical and hospital care for the wage earner and his wife and dependent children.

Do you know of any voluntary system that could provide such complete coverage at such low cost as that for that individual man?

Mr. HAYES. No; and I know of no commercial company; but, at the same time, is not he, as a workingman, or we, the people paying for it anyway?

Senator PEPPER. You propose that we pay for it, too, in your system?

Mr. HAYES. We propose it for the indigent.

Senator PEPPER. All right. Now, do you make a distinction between a man who is indigent in the sense that he has nothing and a man who is medically indigent, that he is incapable of paying?

Mr. HAYES. That is right.

Senator PEPPER. I have quoted cases where a man had to pay \$1,300 a year out of his gross income, not allowing for tax deductions, of \$4,900; do you think they were able to pay \$1,300 in medical fees out of that income that year?

Mr. HAYES. They were not covered by Blue Cross, in other words?

Senator PEPPER. No; and if they had been, have you figured up how much it would have cost that family?

Mr. HAYES. I do not know how much the doctor charged, but I am assuming that it is not your sister, but someone else's sister, and a person went in a ward in a hospital. It would not have cost him anything.

Senator PEPPER. Yes; providing her husband said he could not pay the bill.

There are a lot of white-collared workers and a lot of citizens who do not like to accept charity.

Mr. HAYES. Yes; I hope that will always be.

Senator PEPPER. They would feel they had earned the right to medical care by paying in an insurance fund.

When they buy their Blue Cross or a social insurance system, they feel they are getting what they have contributed.

Mr. HAYES. That is right.

Senator PEPPER. You take a man getting \$100 a month in this country, is he medically independent or not?

Would you cover people making \$100 a month?

Mr. HAYES. We would at today's cost of living.

Senator PEPPER. Would you at \$150 a month?

Mr. HAYES. It depends on his dependents.

Senator PEPPER. If he has no dependents at all and he is making \$150 a month, and he has any illness under the present system, could you not think it would be quite a heavy burden on him to meet it?

Mr. HAYES. It depends on the man's personal habit, whether he is of a saving nature, and that also depends on the course of the economics of the country. I mean, that might be true today and 6 months from now might not be true at all.

Senator PEPPER. Take the family that is making \$2,000 a year. There is a husband and four members.

Do you consider them medically indigent?

Mr. HAYES. In general, I would; yes.

Senator PEPPER. If about half of the families of this country make less than \$2,000 a year, then your plan would have to provide Federal subsidy for practically half of the population, would it not?

Mr. HAYES. Well, to a great extent, local and State governments help us now.

Senator PEPPER. Have you figured out how much that would cost them to do that?

Mr. HAYES. I have a rough idea of what it would cost.

Senator PEPPER. What do you think it would cost under your plan to provide such a subsidy that the medically indigent of this country could get the kind of medical and hospital care we agree they should have?

Mr. HAYES. This is a wild guess, probably a billion dollars a year.
Senator PEPPER. Do you think it could be done on a billion dollars a year?

Mr. HAYES. Yes; what is done now in the way of charity.

Senator PEPPER. Do you think Congress would appropriate a billion dollars a year?

Mr. HAYES. I think they will have to appropriate a great deal more when this gets in operation.

Senator PEPPER. You have not actual data, have you?

Mr. HAYES. No; it is from being in the hospital business as long as I have.

Senator PEPPER. Would you think it would be as desirable, Mr. Hayes?

Supposing the Congress would provide enough Federal subsidy, which added with the subsidy by the State or local communities, too, if you want to add them in, would make purchasable and possible to the people of this country who could not, by other sources, pay for it, all the medical and hospital care that they are entitled to have, assuming that you could do it that way, would you prefer that system where they had given their assistance over an insurance system to which each one pays periodically a sum of money according to the income?

ADMINISTRATION OF HOSPITALS UNDER S. 1606

Mr. HAYES. As someone who has to worry about the deficits, that would be fine, providing it did not entail Federal control of the hospital as well.

Senator PEPPER. Where do you find in the present bill the Federal control that you refer to?

Mr. HAYES. I thought I answered that.

Senator PEPPER. Just enumerate it.

Mr. HAYES. Well, the fact that you have to be approved by the Federal Administrator is proof enough.

Senator PEPPER. At the present time you are referring to the Veterans' Administration, and do you not have to be approved by the Veterans' Administration?

Mr. HAYES. That is right.

Senator PEPPER. Do you render any service for the Blue Cross? Do you not have to be approved by them?

Mr. HAYES. Yes.

Senator PEPPER. Is that hurting you?

Mr. HAYES. No, but they are not controlling us.

Senator PEPPER. You said "approved." When I asked you about that, you said "approved."

Mr. HAYES. If the entire population, Senator, is going to be paid for by the Federal Government, the Federal Government is going to determine how that is going to be done. I mean, that is human.

Senator PEPPER. Could you point that out in the bill here for me? If they have control over all the hospitals of this country, I should like to know it. I might want to strike that part of it out of the bill.

Mr. HAYES. Page 44, paragraph (4):

standards to apply to participating hospitals, to the relations or coordination among hospitals, and to the establishment and maintenance of the list of participating hospitals.

Senator PEPPER. Those are standards, are they not?

Mr. HAYES. Surely, they are. He will tell us what we have to do in order to be eligible up there.

Senator PEPPER. Only the standards of medical care that you have to get, in order to be assigned or accredited as a hospital, will be given. Is that what it means?

Mr. HAYES. Does it not mean the same thing? We always refer to standards and hospitals as approvals.

Senator PEPPER. Is there any objection to somebody who is a public authority making inquiry as to what the standards prevailing in your hospital are and see whether they insure people to be treated in that hospital?

Mr. HAYES. We do not believe that one man should have that authority.

Senator PEPPER. Who is the one man who has it under the bill?

Mr. HAYES. The Surgeon General has it.

Senator PEPPER. Is he assisted by anybody?

Mr. HAYES. He is assisted by an advisory committee.

Senator PEPPER. That is an advisory committee of how many?

Mr. HAYES. That does not make any difference. They have no authority. The advisory committee can merely advise.

Senator PEPPER. Do you know any reason why they could not get up and make a speech on the radio, or why they could not make a statement in the press?

Mr. HAYES. Do you think this is a good way to bring this about?

Senator PEPPER. No, I have seen instances in the Federal Government where Advisory Commissions have had some influence in getting the executives to pay attention to them and to follow their suggestions.

For example, not long ago, Justice Byrnes was economic converter and mobilizer and he was not calling in his advisory council, and those gentlemen went to the press and protested that they had not been called and the Secretary called them to a conference the second day.

Mr. HAYES. Did he follow their advice?

Senator PEPPER. I do not know whether he did that.

The CHAIRMAN. May I interrupt for a moment?

Under your hospital organization, are you not required to pass on the standards and qualifications of the hospitals that want to join your organization?

Mr. HAYES. No; we are not.

The CHAIRMAN. Can any hospital in the country, regardless of its standards, belong to the American Hospital Association?

Mr. HAYES. Yes; our effort is to help all of them.

The CHAIRMAN. Do you not think to maintain a high standard of service in the hospitals and do you not recommend high standards to the committees of your organization?

Mr. HAYES. That is right. That is why it is helpful to take those not so high and break them in.

The CHAIRMAN. Your idea is to raise those standards by calling attention to their deficiencies, and that is exactly what this would accomplish under this bill.

An investigation would be made and it would determine whether or not the hospitals are up to the standard to supply the proper quality of medical care and hospitalization.

Is that not true?

Mr. HAYES. That is still one man's opinion, Senator.

The CHAIRMAN. Let me ask you another question: I understand in 1942 the representatives of these hospital associations in this country had a conference with the Social Security Board? Is not that true?

Mr. HAYES. That is right. This gentleman was there. I was not.

The CHAIRMAN. I understand that without agreeing to the principle of national health insurance these representatives advised the Board as to what would be the best method of providing hospital benefits under such a system. Is that not right?

Mr. BUGBEE. I believe so.

The CHAIRMAN. Well, the approved summary of those discussions is contained to committee print No. 3, pages 109 to 119. It certainly is gratifying to know that the hospital associations took so constructive a position and gave really valuable help to the Social Security Board in its studies in this direction, and I should like to ask at this time to have that report made a part of this record here.

I want to ask you also, at this time, whether or not the bill—S. 1606—relating to the payment of hospitals, does not substantially comply with the requirements of the report that was made at that time?

Mr. BUGBEE. I believe it does.

Might I make one comment about that report?

I have not read it recently, but it is my memory from those who were there that the conference started by a statement that they were discussing the recommendations by the President, which included compulsory health insurance, and there was not to be any discussion of the basic issue at that conference.

The CHAIRMAN. But you did make these recommendations?

Mr. BUGBEE. I believe on the basis that that was not subject to discussion, we did discuss methods of payment.

The CHAIRMAN. I should like to have this report incorporated into the record at this point.

(The report is as follows:)

IV. HOSPITALIZATION PAYMENTS UNDER OLD-AGE AND SURVIVORS INSURANCE

APPROVED SUMMARY OF THE DISCUSSION AT A MEETING OF MEMBERS OF THE STAFF OF THE SOCIAL SECURITY BOARD WITH THE SPECIAL COMMITTEE OF THE BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION, AND THE JOINT ADVISORY COMMITTEE OF THE AMERICAN HOSPITAL ASSOCIATION, PROTESTANT HOSPITAL ASSOCIATION, AND CATHOLIC HOSPITAL ASSOCIATION, SEPTEMBER 3 AND 4, 1942, WASHINGTON, D. C.

LIST OF PERSONS PARTICIPATING IN THE CONFERENCE

On behalf of the special committee (board of trustees, American Hospital Association) and the joint advisory committee of three hospital associations:

Dr. Basil MacLean, chairman.

Mr. M. R. Kneifl, secretary.

Representing the American Hospital Association:

Dr. Basil MacLean, president; director, Strong Memorial Hospital, Rochester N. Y.

The Rt. Rev. Msgr. Maurice F. Griffin, senior trustee; pastor, St. Philomena's Church, Cleveland, Ohio.

Dr. Claude W. Munger, chairman, council on Government relations; director, St. Luke's Hospital, New York City, N. Y.

Dr. Bert W. Caldwell, executive secretary, 18 East Division Street, Chicago, Ill.

Mr. E. A. van Steenwyk, commission on group hospital service; director, Associated Hospital Service of Philadelphia, Pa.

Representing the Protestant Hospital Association:

Mr. John Olsen, president; administrator, Richmond Memorial Hospital, Prince Bay, Staten Island, N. Y.

The Reverend John Martin, chairman, legislative committee; administrator, St. Barnabas Hospital, Newark, N. J.

Representing the Catholic Hospital Association:

The Reverend Alphonse M. Schwitalla, S. J., president, 1402 South Girard Boulevard, St. Louis, Mo.

The Reverend John W. Barrett, second vice president, 31 East Congress Street, Chicago, Ill.

Mr. William F. Montavon, director, legal department, National Catholic Welfare Conference, Washington, D. C.

Mr. M. R. Kneifl, executive secretary, 1402 South Grand Boulevard, St. Louis, Mo.

From the staff of the Social-Security Board, Federal Security Agency, the Department of Labor, and the Public Health Service:

Social Security Board:

Mr. I. S. Falk, Bureau of Research and Statistics.

Mr. W. R. Williamson, actuarial consultant.

Mr. Merrill G. Murray, assistant director in charge of the Analysis Division, Bureau of Old-Age and Survivors Insurance.

Mr. Barkey S. Sanders, Chief, Division of Health and Disability Studies, Bureau of Research, and Statistics.

Mr. Michael M. Davis; consultant to the Bureau of Research and Statistics.

Federal Security Agency: Mr. Morton Stavis, attorney, general counsel's office.

Department of Labor: Dr. Edwin F. Daily, Director, Division of Health Services, Children's Bureau.

Public Health Service: Dr. Vane Hoge, surgeon, Public Health Service.

INTRODUCTION

On the basis of an invitation extended earlier in the year by the Chairman of the Social Security Board, the members of the special committee (American Hospital Association) and of the joint advisory committee of the three national hospital associations met with members of the Staff of the Social Security Board in Washington on September 3 and 4, for the purpose of discussing, on a technical basis, various aspects of the President's recommendation to Congress, incorporated in his Budget message of January 5, 1942, to provide hospitalization payments through extension of the Federal old-age and survivors' insurance program.

The pertinent sections of the Budget message dealing with the President's recommendations in the field of social security read as follows:

"Pay-roll taxes and the social security program: I opposed the use of pay-roll taxes as a measure of war finance unless the worker is given his full money's worth in increased social security. From the inception of the social security program in 1935 it has been planned to increase the number of persons covered and to provide protection against hazards not initially included. By expanding the program now, we advance the organic development of our social security system and at the same time contribute to the anti-inflationary program.

"I recommend an increase in the coverage of old-age and survivors' insurance, addition of permanent and temporary disability payments and hospitalization payments beyond the present benefit programs, and liberalization and expansion of unemployment compensation in a uniform national system. I suggest that collection of additional contributions be started as soon as possible, to be followed 1 year later by the operation of the new benefit plans."

Attached is a list of the persons who participated in the discussions of the conference, together with their affiliations. In addition to the persons shown on the list, a few additional members of the staff of the Social Security Board attended the meetings. Also there were representatives from the Children's Bureau and the Public Health Service. Mr. Falk, Director of the Bureau of Research and Statistics, Social Security Board, acted as chairman of the conference; Dr. MacLean, president of the American Hospital Association and chairman of the special committee and of the joint advisory committee, acted as cochairman. The conference held morning and afternoon sessions on September 3 and a morning session on September 4. A brief summary of the scope and conclusions of the conference as a whole appears on pages 118-119.

GENERAL PREMISES

At the beginning of the conference it was agreed that the basic policies underlying the President's decommendation would not be discussed, that participation in the conference indicated neither acceptance nor rejection of these policies on the part of the members of the special committee, of the joint advisory committee, or of the organizations which they represent, that the discussion would be confined to technical aspects of the President's recommendation, and that, as a basis from which discussion would proceed, the following premises would be assumed.

- (1) Hospitalization payments would be provided for the persons covered by old-age and survivors' insurance;
- (2) The system would be national in operation;
- (3) The system would be financed by taxes levied upon the pay rolls and wages of workers covered by social insurance.

It was agreed also that the Social Security Board and the hospital associations as well as the individuals participating in the discussions were free to depart later from any of the views expressed at the conference if further thought and study indicated the advisability of such departure.

BACKGROUND MATERIAL

Before entering into technical aspects of plans for hospitalization payments, members of the technical staff of the Social Security Board presented to the conference a brief outline of the programs now administered by the Social Security Board under the Social Security Act: (1) The Federal-State assistance programs for the needy aged, the needy blind, and the needy dependent children; (2) the Federal-State unemployment-compensation program; (3) the Federal old-age and survivors insurance program.

For the purpose of clarification, attention was called to the difference between the President's recommendation for hospitalization payments under the Federal old-age and survivors insurance and the recommendation of the Social Security Board for a statutory amendment to make satisfactory financial provisions for meeting the medical needs of persons in receipt of public assistance. Under the terms of the Social Security Act, funds used by the States to furnish assistance can be matched by the Federal Government only insofar as the assistance takes the form of unrestricted money payments (within certain limits specified in the law) to needy individuals. Experience in administering these provisions has persuaded the Social Security Board that the act should be changed so as to enable the Federal Government to match State expenditures for medical care of needy individuals even if these expenditures are made in the form of payments to practitioners, groups of practitioners, hospitals, or by any other appropriate method.

It is explicit in the President's proposal that provision of hospitalization payments should be part of the Federal old-age and survivors insurance. Therefore, the technical staff of the Social Security Board presented information on the coverage of this insurance program, the system of wage records maintained by the Social Security Board, the financial basis on which the program operates, the types of benefits available, and the principal conditions, which must be met by insured workers and their dependents to become eligible for these benefits. The following figures were presented on the operation of the old-age and survivors insurance program:

Estimated number of workers who paid taxes at any time between Jan. 1, 1937 (the effective date of the program), and 1942-----	50,000,000
Estimated number of workers paying taxes in 1942-----	45,000,000
Estimated number of workers who had currently insured status on Jan. 1, 1942 (i. e., workers who had wages of at least \$50 in each of 6 calendar quarters within the 12 quarters preceding Jan. 1, 1942)-----	28,500,000
Total number of (old-age and survivors) beneficiaries, September 1942	600,000
Administrative expenses at present as percentage of total tax receipts (this percentage will be cut in half in 1943, when old-age and sur- vivors insurance taxes are scheduled to be doubled)-----percent--	4-4½

It was pointed out that the President's recommendations for extension of the old-age and survivors insurance program are not confined to hospitalization payments but include proposals for broadening the coverage of the program and for adding permanent disability and temporary disability benefits.

TECHNICAL DATA AND ESTIMATES

In the course of the discussion, the staff of the Social Security Board had occasion to present to the conference certain results of its technical studies. For the purposes of this summary, these data have been brought together, although they were not submitted to the conference in the order in which they appear here. The estimates are preliminary and subject to revision.

Eligibility.—On the basis of their studies, the technical staff of the Social Security Board are inclined to recommend that attachment to covered employment within a relatively brief period preceding the need for hospitalization of the worker should be required as a condition of eligibility. In accordance with the principles now incorporated in the old-age and survivors insurance law, wives and dependent children should be eligible for hospitalization payments on the same basis as the insured workers themselves. A plan for hospitalization payments may also be extended to persons in receipt of old-age or survivors benefits, even though these persons are not currently engaged in employments covered by the insurance system.

Coverage estimates.—If a plan of hospitalization payments were applied to the persons covered by the existing old-age and survivors insurance system it is estimated that in 1944 roughly about 47,000,000 workers would be paying taxes under the plan. About 40,000,000 of these would have sufficient earnings to acquire insurance status within that year. These 40,000,000 workers are estimated to have about 18,000,000 wives and 20,000,000 dependent children, i. e., children below age 16 and children between the ages 16 and 18 who attend school. In addition, there could be as many as 2,000,000 persons in receipt of old-age or survivors benefit.¹ Therefore, altogether about 80,000,000 persons may be insured against the risk of hospitalization under such a plan on the basis of employment forecasts for the year 1944. Of these, between ten and twelve million persons may become hospitalized within the following benefit year.

Coverage of the old-age and survivors insurance system extends at the present time primarily to employees in industry and commerce. If it should be broadened to include farmers, agricultural workers, domestic servants, employees of non-profit institutions and certain groups of Government employees, the total number of persons who would be insured against the risk of hospitalization is estimated roughly at about 100,000,000 on the basis of forecasts for the year 1944.

Cost estimates.—For the purposes of these discussions it was assumed that over a period of time the average taxable wage of insured workers is \$1,000 a year (it is more than that at present but was below that level from 1937 to 1939). It was assumed further that on the average there is one eligible dependent for each insured worker, that additional administrative costs would probably run about 5 percent of benefit expenditures, perhaps somewhat more but probably not so much as 10 percent, and that the specifications might be drawn so that the volume of hospitalization would average 1 day of hospitalization for all eligible persons. On these assumptions the cost of a system of hospitalization payments under which the payments average \$3 per day of hospitalization would be about two-thirds of 1 percent of the pay roll; if the per diem payments average \$4, costs would approximate nine-tenths of 1 percent of the pay roll; and if they average \$5, costs would be about 1.1 percent of the pay roll. Should the volume of hospitalization average as much as 1.2 days of hospitalization for all eligible persons (instead of 1 day), costs would be increased to 0.8, 1.1, and 1.3 percent of the payroll, respectively. And if it should be found that the number of eligible dependents exceeds the number of insured workers, costs would be somewhat higher. Thus, a system of hospitalization payments could be designed so that the costs will average, over a period of years, somewhere between 0.7 and 1.5 percent of taxable pay roll.

At the present time a 1-percent tax on pay rolls yields close to \$500,000,000 a year. In 1944, such a tax is expected to yield between five hundred and fifty and six hundred million dollars a year. The study made by the Public Health Service showed that in 1935 the total income of general and special hospitals, exclusive of tuberculosis and mental institutions, was about \$487,000,000.

BASIC BENEFIT PATTERN

The technical staff of the Social Security Board explained that either of two basic patterns might be followed in developing a program of hospitalization

¹ The number of persons in receipt of old-age and survivors benefits is expected to rise during the next few decades.

payments. Under one the insurance benefit would take the form of a cash payment for each day of hospitalization to the insured individual himself or, upon assignment by the insured, to the hospital. Under the other hospital service would be guaranteed to all eligible persons and payments would be made by the Federal insurance system, not to the insured, but to the hospital which furnishes the service. Advantages and disadvantages inherent in each of these basic patterns were discussed at length. From these discussions it appeared that neither a cash benefit plan (with a uniform cash benefit amount per diem) nor a complete service benefit plan (with a per diem payment to the hospital representing the cost of furnishing the service) was completely satisfactory to the members of the hospital committees. It was indicated that program of hospitalization payments should embody certain characteristics of each of these basic alternatives while discarding certain others. The general substance of the discussion may be summarized briefly as follows:

(1) The specifications and the administrative operation of the plan should make clear that the worker is the beneficiary of the plan;

(2) The hospital should be assured receipt of payment through appropriate provisions for the automatic assignment by the beneficiary of benefit to the hospital in which the care is received;

(3) The per diem payments should be reasonably related to the cost of providing basic services in the hospital in which the beneficiary receives care; the payments should in no case fall below a fixed national minimum nor exceed a fixed national maximum.

(4) The methods used in determining the per diem costs of basic services in the participating hospitals should be simple; and

(5) A fear was expressed that the development of such a governmental plan would imperil the continuance of voluntary hospital insurance plans.

The following sections summarize the discussion from which the five points listed above were developed:

1. *The worker to understand that he is the beneficiary of the plan.*—The hospital representatives thought, in general, that an arrangement under which the Federal insurance system deals directly with the individual would have advantages over one which the insurance system enters exclusively into a direct contractual relationship with the hospitals. The principle of the responsibility of the insurance system directly to the individual was considered of sufficient importance to warrant being embodied in the plan. It was considered possible to adhere to this principle even if the beneficiary is required to assign his interest in the benefit to the hospital in which he receives care. He should have the knowledge that for the service which he has received at the hospital the insurance plan has actually made a disbursement to that hospital on his behalf.

2. *Assurance of payment to hospital.*—The opinion prevailed that whatever benefits are provided under the plan should be paid directly to the hospitals. The individual beneficiary should have no discretion in the disbursement of this insurance benefit; payment to the hospital which renders the care should be assured.

3. *Level of per diem payments.*—The principles to be followed in determining the rate of hospitalization payments were discussed at some length. Because of the great variations in the costs of hospitalization a fixed uniform amount was considered unsatisfactory. The suggestion that the amounts be varied from region to region was rejected for the reason that even within one locality costs may differ as widely as among larger geographical areas. Another suggestion to the effect that the payments should be varied in accordance with the average wage of the insured worker according to a formula following the same principles as those used in computing old-age benefits was discussed briefly but was not found generally acceptable. In view of the magnitude of the insurance system and the accounting and supervisory operations involved, a service contract arrangement assuring the hospital of reimbursement for all services rendered the patient was considered impracticable. In general, the weight of opinion favored a rate of payment computed in such a way as to be related to the costs of basic services in individual hospitals. Such a rate would not necessarily be an exact or total reimbursement for the costs of services rendered to individual beneficiaries, but would be reasonably related to these costs and would cover all basic services that the care of the patient demands. Various members of the conference had in mind a reasonable reimbursement for the cost of furnishing essential services to ward patients in hospitals which offer various classes of accommodation.

There was a substantial consensus that it is not difficult to devise a fair basis for reimbursing the hospitals for basic service rendered, without detailed investigations of costs of operation. The plan recently adopted by the Children's Bureau under the crippled children's and the maternal and child-health programs was cited as an example of a simple and reasonable procedure for the purchase of hospital care under a Government program. This plan provides for the purchase of hospital care at a rate not to exceed the actual per diem cost of ward care. This cost is determined for a year at a time on the basis of a simplified method of hospital accounting. The opinion was expressed that for the larger social-insurance program being discussed, it would be possible to work out procedures following in general outline the Children's Bureau plan without necessarily adopting all the details of that particular plan.

4. *Simplicity of procedure.*—The opinion was general that the method of certification of payment should be as simple as possible, with suitable provisions to insure that the hospital receives the benefit amount.

5. *Voluntary insurance.*—The conference was unanimous in the opinion that the program should be designed so as to encourage the growth and development of the Blue Cross plans on a voluntary basis. The question was raised and discussed whether this purpose can be accomplished if the payment is varied in accordance with the costs of the hospital. It was argued, for example, that a variable cost system approaches, in effect, a service contract and that, therefore, no substantial function would be left for the Blue Cross plans to perform; it was contended that Blue Cross plans could continue to operate usefully only if a fixed cash-payment plan were adopted. Opinions differed, however, regarding the effect of the adoption of a variable-payment plan upon the opportunities for the development of the Blue Cross plans. According to one opinion, no room would be left for voluntary hospitalization insurance; compulsory social insurance would take its place. According to another, the new program would limit the field of operation of the Blue Cross plans but would not destroy them. According to a third, voluntary insurance could still play an important role along with the governmental program; its development might even be stimulated, for the social-insurance system would provide minimum essential services only and the Blue Cross plans could offer insurance protection to cover the difference between ward and semiprivate or private care or to cover types of service which may not be included in the social-insurance benefit. On the whole, the hospital representatives did not believe that adoption of the variable-payment basis would seriously endanger the development of Blue Cross plans. Even if it were demonstrated that such danger is inherent in a variable-payment plan, they were unwilling to have it replaced by a fixed-payment plan. In this discussion it was recognized that a social-insurance plan was intended to furnish a basic level of insurance protection to a very large number of persons, as distinguished from more complete or more extensive protection which might be afforded by a part of the population through voluntary insurance.

Other questions bearing on voluntary hospital insurance were briefly discussed. The suggestion was made, though not generally accepted, that insured workers should be given a choice of belonging either to the Government plan or to one of the voluntary hospital-insurance plans. The question was raised whether the Government payments should be made through the medium of Blue Cross plans in the case of insured workers who are members of a Blue Cross plan. The opinion was expressed that while such a provision might have some virtue if a uniform-cash-payment plan were adopted, it would serve no useful or practical purpose if the payments vary in accordance with hospital costs.

The weight of opinion favored adherence to the five principles mentioned above. However, certain reservations were expressed by individual members of the conference. According to one view, these principles should be followed only if they do not imply direct contractual relationships between the hospitals and the Social Security Board. According to another view, adoption of a variable-payment plan is inconsistent with the conference's endorsement of voluntary hospitalization insurance; in the interest of the development of Blue Cross plans, a fixed-payment basis should be adopted.

MAXIMUM-BENEFIT PERIOD

Should the proposed plan provide for a maximum-benefit period, and if so, at which point should the limit be set? While some of the conferees recognized the desirability of fixing an over-all maximum for duration of benefits, a number

of others urged that the benefit period be unlimited. It was agreed that the plan should provide for as long a benefit period as can be financed by available funds. All members realized, however, that the cost of caring for chronic cases should not be laid upon insured contributors. To solve the peculiar problem presented by chronic cases, the suggestion was offered that this cost might be borne by general tax funds; another suggestion was to the effect that the rate of reimbursement to the hospital might be reduced as soon as it is recognized that the case is chronic. Various other methods of dealing with long-continued cases were suggested and briefly discussed. It was understood that this matter requires further study.

DAY OF HOSPITALIZATION

It was agreed that confinement in a participating hospital for 24 consecutive hours should be considered as a day of hospitalization; a fraction of a day should be considered as a day of hospitalization at the time of admission, but not at the time of discharge.

PARTICIPATING HOSPITALS

The conference discussed the question how the term "hospital" should be defined for the purpose of the President's program for hospitalization payments. In its studies, the technical staff of the Social Security Board had proceeded on the assumption that the plan would be confined to care furnished in "general and special" hospitals and would not provide benefits for care furnished in tuberculosis and mental institutions; institutions devoted to the care of the chronic sick might be excluded also.

What standards would an institution have to meet in order to be eligible for participation in the program? Would it be possible to use for this purpose one of the existing lists of hospitals, for example, that compiled by the American Medical Association or the list of the American College of Surgeons? It was pointed out by representatives of the hospital associations that a number of the small hospitals fail to meet the standards of these two organizations, yet might have to be used in the President's program, because they are the only hospitals locally available.

Whether a hospital should be eligible to participate in the program should be determined according to the staff and facilities which it provides for rendering service, and the quality of service rendered, considered in the light of the hospital services that are available for the community or area of the worker's residence. None of the existing lists should be relied upon exclusively. The list of hospitals eligible for participation under the proposed program should be determined by the Social Security Board with the help of an advisory council.

Should insured persons confined in public hospitals (other than mental and tuberculosis institutions) be eligible for benefits under the plan? It was pointed out that such a provision would be necessary because in many communities public hospitals are the only ones which would be available to insured persons, and it is already a not uncommon practice for such hospitals to accept pay and part-pay patients and to charge for services.

Should the proposed plan include a provision to the effect that a hospital may be removed from the list of participating hospitals if it willfully engages in fraudulent practices as in the hospitalization of individuals who are not in need of hospital care? Representatives of the hospital associations advised care and caution in the development of such a provision. It was pointed out that, as a rule, a patient is admitted to, and dismissed from, the hospital on the recommendation of a physician rather than that of the hospital. Moreover, removal of a hospital from the list for fraudulent practices in individual cases may result in the denial of benefits to workers who are lawfully entitled to benefits. Even if fraud should occur in a considerable number of cases, the quality of care furnished by the hospital may be unaffected. Thus, various considerations should be taken into account in providing for necessary penalties.

In the opinion of the conference, nearly all cases of fraud could be dealt with effectively by denying benefits to the individual concerned and by imposing criminal penalties upon all persons guilty of willful fraud. As long as the service furnished by the hospital comes up to prescribed standards, the provision for its removal from the list of participating hospitals should not be invoked unless all other available sanctions have been exhausted.

ADVISORY COUNCIL

The conference discussed the proposal that the Social Security Board establish an advisory council to advise the Board on standards and practices relative to hospitalization payments. It was agreed that it is desirable to have a body with advisory—not administrative—powers to aid the Social Security Board in investigating professional aspects of hospital service and in formulating standards of service under which payments would be administered. The members of this body should represent the various professions that are concerned in the program and the diverse and special interests whose advice and counsel may be needed in carrying it out. The composition of the council was not discussed in detail, but reference was made to specifications developed for a similar body in connection with an earlier proposal for a hospital-construction program.

HOSPITAL CONSTRUCTION

The question was discussed whether insurance funds should be used, either in the form of grants or loans, to construct new hospitals in areas now without adequate hospital facilities or to improve the facilities of existing hospitals. According to one view, such a provision would be needed to make the proposed plan work because of the insufficiency of hospital facilities in some parts of the country and the need for improvement or modernization of existing hospitals in others. According to another, once a Federal insurance system assumes responsibility for provision of hospital care—a responsibility which in the past has been principally State and local—a Federal hospital-construction program is inevitable. However, the appropriateness of using insurance funds for this purpose, either on a grant or loan basis, was questioned. Attention was called to the fact that Government loans are available through the Reconstruction Finance Corporation, and that general tax funds are used for hospital construction under the Lanham Act and other Government programs.

SUMMARY

At the opening of the conference it was agreed that the basic policies underlying the President's recommendation for hospitalization payments incorporated in the Budget message of January 5, 1942, would not be considered, that participation in the conference indicated neither acceptance nor rejection of these policies, and that the discussion would be confined to technical aspects of the President's recommendation. It was agreed also that the Social Security Board and the hospital associations as well as the individuals participating in the discussion were free to depart later from any of the views expressed at the conference if further thought and study indicated the advisability of such departure.

It was stated that the Social Security Board had reached no definite conclusions on the details of a plan or on the rate of benefit and methods of payment, and did not intend to present specific legislation.² The purpose of the conference was to provide opportunity for frank and informal discussion which would aid the Board in its further deliberations.

Studies by the Social Security Board were reported, indicating that—

(a) Persons covered by old-age and survivors insurance and their dependents, who would become eligible for hospitalization payments if the President's proposals were enacted, would number between about 80,000,000 and 100,000,000, depending on the details of the legislation adopted.

(b) At present levels of employment and wages, a 1-percent tax on pay rolls yields close to \$500,000,000 a year. Depending upon average taxable wages, scope of the insurance system, volume of hospitalization, and the average per diem payments to hospitals, a system of hospitalization payments could be designed so that the costs will average, over a period of years, somewhere between 0.7 percent and 1.5 percent of taxable pay rolls.

The main points on which there seemed to be a consensus of opinion during the conference were as follows:

1. The workers and their dependents should understand that they are the beneficiaries of the plan.

2. The hospitals should be assured of receiving payments.

² H. R. 7534 introduced by Representative Eliot since the conference is an independent bill.

3. Payments should be on a per diem basis, reasonably related to the cost of basic services in the hospital furnishing the care.

4. Per diem rates of payment should in no case fall below a stated national minimum nor exceed a stated national maximum.

5. Simple accounting methods should be adopted for determining the per diem costs of basic services in the participating hospitals.

6. The plan should encourage the development of voluntary hospital insurance collaterally with the governmental plan.

7. An advisory council appointed by the Social Security Board, including adequate professional representation, should be constituted to aid the Board in investigating professional aspects of hospital service, in formulating standards of service, and in compiling and maintaining a list of hospitals eligible for participation.

Senator PEPPER. Now, you said, Mr. Hayes, just one man, the Surgeon General, but in saying that you did not take into account the Advisory Council, which is under the law, to advise and assist the Surgeon General.

Senator DONNELL. He did not say anything about assisting.

Senator PEPPER. All right, then to advise; did you take into account the Federal Administrator's Office over the Surgeon General, so that would be at least two men?

Mr. HAYES. No matter how high up you would go, there would still be one man.

Senator PEPPER. That would be the Surgeon General plus the Federal Security Administrator.

Mr. HAYES. If he liked what he did, that would be the Surgeon General's opinion, and if he did not like it, the Federal Security Administrator would make the decisions.

Senator PEPPER. If one man would make the ultimate decision, that is something else.

Mr. HAYES. Let us call it two men, then.

Senator PEPPER. Then there is the President of the United States.

Senator DONNELL. I do not recall there is anything in this bill that says the two men in conjunction make the decision. The ultimate decisions rest in the Federal Security Administrator. It is under the Federal Security Administrator. He is quite correct.

The CHAIRMAN. The witness that preceded you, recommended amendments to those provisions, and he suggested a board, instead of an individual, comprised of medical care and hospital men and someone representing the general public.

Would you favor that sort of a program?

Mr. HAYES. Senator, that is an improvement, but it still leaves compulsory insurance under Federal control.

The CHAIRMAN. But it would avoid that particular objection.

Senator PEPPER. May I ask, Mr. Hayes, if you did not want the Federal Security Administrator or the Surgeon General, aided by the Advisory Committee, to make the determination of these standards that you have mentioned on 44, subparagraph (4); would you suggest an amendment that the eligibility of a hospital for the plan in respect to standards, and so on, should be determined by the county medical society?

I am sure I would not have any great objection as to letting the certificate of the county medical society be determining as to whether a given hospital came up to the standards in respect to the quality of care.

Mr. HAYES. Senator, the keynote of our testimony is that it places the financial control of hospital care in the hands of the Federal Government.

Senator PEPPER. When you ask the basis of that, you give me this control. You say anybody that can determine standards will have control.

I say let us eliminate that, maybe we can put it under the county society, or the hospital association.

We might say whatever hospital is in good standing with the association will be the one.

Now, that would meet the objections as to the standards part, would it not?

Mr. HAYES. It would not entirely, sir.

Senator PEPPER. Would you not be agreeable to letting the standards be determined by the county medical society?

Mr. HAYES. If there were no other way out of it, we would prefer that to what is in the bill.

Senator PEPPER. You do not think it would be desirable to have any standards at all?

Mr. HAYES. That is not my statement at all.

Senator PEPPER. Who now passes on the standard of the hospital?

Mr. HAYES. Usually the State passes on them.

Senator PEPPER. You admit that the States have to pass on the qualifications and the standards of the hospital?

Mr. HAYES. Yes, by the State department of public welfare of our State.

Senator PEPPER. That is now required. Is that not a public body controlling you? You say this would authorize the Federal Government to do this?

Mr. HAYES. Yes, in the State, it would, sir. It passes on our standards.

Senator PEPPER. Suppose we said that any hospitals are eligible to participate that are approved by the Board of Welfare or by an agency in that State.

Mr. HAYES. That would be an improvement.

Senator PEPPER. That particular objection would be eliminated.

Mr. BUGBEE. I do not know whether you would prefer to have that answered, but in our testimony we have tried to bring out it is such things as establishing standards associated with payment of almost the entire income to hospitals that makes the determination of standards vital.

It has been suggested by the chairman that it be done by the American Hospital Association. We have also pointed out that it is a developing thing and yet, if you put that authority, which authority in itself, if associated with certain other determinations, is perfectly logical, if you couple that with payment of practically the entire income of hospitals, you have a very cumbersome combination.

Senator PEPPER. What I wanted to suggest respectfully to you gentlemen who are interested in the subject here, the thing that has been a little painful to me is that, instead of coming here to us and saying: "Now, this thing about standards in subparagraph (4) page 44" as Mr. Hayes first said, "would give the Federal Government control."

Then when we here are trying to perfect the bill, you do not say, "It would be our suggestion that there would be a dangerous control investigation had in the Federal Government unless in some way or other you could let the predetermination of standards that is being made by the State be determined in respect to the Federal Government."

Then we would feel very much impressed by that suggestion and that would meet your fear that the Federal Government would control you through fixing standards.

Mr. BUGBEE. You are taking specific items and asking us for answers aimed at something we have come to the conclusion cannot be done.

We do not think the compulsory health insurance can be controlled at the present stage of development until certain other steps have been accomplished.

Therefore, when you ask us to make suggestions for a bill providing health insurance it is difficult to do it.

Senator PEPPER. The reason I have to ask you these specific things is you come in here saying this is going to mean Federal control over our hospital systems; where in the bill is that provided for?

You say, "Well, one thing, that the money controls come from the insurance funds."

"Well," I say, "you do not have to join, all it is to pay a given fee that you may agree upon that the county medical society may agree upon."

Then you tell me the thing about standards give them control. I say let us eliminate that. We are trying, if you are not just against the bill, like a lady is sometimes said to say, "because"; if you are against things in the bill, and there is any way we can meet your objections, we want to hear of them.

Mr. BUGBEE. I think it is a more basic objection, and we have done the best and very sincerely to put it in the testimony, and it is tied in with the financing of some major proportion with commitments as to service, the difficulty of rendering and paying it, and standards are rather incidental to that, although it could be a method for a good deal of damage when they are attached for the power that goes with the service of being standardized.

Senator PEPPER. President Coolidge was said to have said "You are just agin' it"?

Mr. BUGBEE. That is not our aim.

Senator DONNELL. I should like to ask quite a number of questions of Mr. Hayes.

I wonder if you want to recess or do you want to continue?

The CHAIRMAN. I was admonished the other day by one of the members of the committee that in the interest of preserving the health of the members of the committee itself, and in the interest of preventing medicine, that I should not prolong these hearings as I have been prolonging them heretofore, so if you wish, I would be very glad to recess now until 2 o'clock.

Senator DONNELL. Would that meet the convenience of Mr. Hayes, or does he desire to get away?

Mr. HAYES. No; that suits me.

(Whereupon, at 12:55 p. m., a recess was taken until 2 p. m., this same day.)

AFTERNOON SESSION

(The committee resumed at 2 p. m., pursuant to recess.)

The CHAIRMAN. Well, gentlemen, the hearing will come to order.

I understand that we have a witness who is anxious to get away early this afternoon, because he has to catch a train, and with the consent of Father Schwitalla, I will call Rev. John Martin of the Protestant Hospital Association.

Senator DONNELL. Do you mean prior to the continuance?

The CHAIRMAN. Oh, you are going to cross-examine.

Senator DONNELL. Yes. It will take some little time.

The CHAIRMAN. Very well. We will have to take the time, that is all.

Senator DONNELL. Very well.

If Dr. Martin cared to go on in advance of the further examination, that is all right with me.

The CHAIRMAN. I will ask Father Martin if he has to catch a train, if he could wait an hour before he goes on, or would you like to go on right now?

Reverend MARTIN. No; I will wait until you are through with Mr. Hayes, Senator.

The CHAIRMAN. All right. Thank you.

Senator DONNELL. Shall I proceed, Mr. Chairman?

The CHAIRMAN. Yes.

Senator DONNELL. Mr. Hayes, you were examined at considerable length this morning on various phases of this matter, and I should like to ask you some questions also.

As I understand it, Mr. Hayes, you are the president-elect of the American Hospital Association?

Mr. HAYES. Yes, sir.

Senator DONNELL. When were you so chosen?

Mr. HAYES. Last November.

Senator DONNELL. And for how long a term is the president-elect selected?

Mr. HAYES. One year.

Senator DONNELL. One year.

Mr. HAYES. I will assume the presidency in October of this year.

Senator DONNELL. In October of this year.

Now, it was suggested by my good friend, Senator Pepper, this morning, that possibly you may be so close in to this situation that you might not see the situation from the general aspect that the public might see it.

Now, I wanted to ask you a few questions, thinking that possibly the close-in-ness may have a converse effect in enabling you to have valuable experience which might be helpful to those of us on the committee not connected with hospitals.

May I ask you, Mr. Hayes, where were you born?

Mr. HAYES. In Chicago.

Senator DONNELL. And what was your education and schooling prior to getting into the hospital work?

Mr. HAYES. Only public school up until the time I was 13, I went to work then and went to school at night until I was 22.

Senator DONNELL. Were you working in hospital lines or other lines when you were going to school at night?

Mr. HAYES. No, sir. It was the general of the arts courses.

Senator DONNELL. When did you get into the work of a hospital nature?

Mr. HAYES. Approximately back in 1917 when I became the manager of the Compress Gas Manufacturers Association and thus had in my membership the manufacturers of anesthetic gases. I stayed there until 1924, and for the next 2 years, I was with the Ohio Chemical & Manufacturing Co., a manufacturer of anesthetic gases.

Senator DONNELL. That would be 1926?

Mr. HAYES. And in 1926, I came into Lenox Hill Hospital.

Senator DONNELL. Lenox Hill Hospital in New York City.

Mr. HAYES. Yes, sir.

Senator DONNELL. Is that a large institution?

Mr. HAYES. Yes, sir; 620 beds.

Senator DONNELL. Where is it located in New York City?

Mr. HAYES. Seventy-sixth and Park Avenue.

Senator DONNELL. Was Senator Wagner, one of the authors of this bill, recently a patient at your hospital?

Mr. HAYES. Yes, sir.

Senator DONNELL. Mr. Hayes, your hospital has a variety of patients and treats a variety of ailments, of course?

Mr. HAYES. Yes, sir.

Senator DONNELL. Would you tell us, please, how long you have been connected with the American Hospital Association in any respect.

Mr. HAYES. I have really been connected with them during my entire term in the hospital, because the hospital is a member of the American Hospital Association.

Senator DONNELL. That would be about 20 years.

Mr. HAYES. Yes, sir.

Senator DONNELL. And you say there are about 3,500 hospitals in that organization?

Mr. HAYES. Yes, sir.

Senator DONNELL. Were you elected to some earlier office prior to being chosen as the president-elect?

Mr. HAYES. Yes, sir; 2½ years ago, I was made one of the trustees.

Senator DONNELL. How many trustees does the organization have?

Mr. HAYES. Nine trustees plus four officers that constitute the board.

Senator DONNELL. You referred, in response to a question from Senator Murray this morning, to the fact that after the preparation of your statement which you gave us today, you had sent a copy, I believe, of the statement, or a draft of it, to the members of the council; is that right?

Mr. HAYES. The Council on Government Relations and the trustees.

Senator DONNELL. How many persons was it to whom you submitted that copy or draft as the case may be?

Mr. HAYES. Possibly 18 or 19.

Senator DONNELL. Are they scattered widely all over the United States, or all in New York City?

Mr. HAYES. Scattered quite widely.

Senator DONNELL. Scattered quite widely.

Are any of those gentlemen physicians?

Mr. HAYES. Yes.

Senator DONNELL. Is Father Schwitalla, who is here this afternoon, one of the members of that council?

Mr. HAYES. No; but I believe Father Schwitalla had a copy of that. I know he had it last night.

Senator DONNELL. Did you furnish a copy of your proposed testimony to persons other than the members of the council and of the board?

Mr. HAYES. Only to Rev. Mr. Martin and Father Schwitalla.

Senator DONNELL. Rev. Mr. Martin is the gentleman here this afternoon?

Mr. HAYES. That is right.

Senator DONNELL. And Father Schwitalla is also here this afternoon?

Mr. HAYES. That is right.

Senator DONNELL. Another gentleman who is to testify.

Mr. HAYES. The three associations cooperate generally, naturally.

Senator DONNELL. And I understood you to say that there was only a slight change made in your draft as the result of submitting it to all these gentlemen?

Mr. HAYES. Those changes appear on the copy you have, sir.

Senator DONNELL. The only changes I have noted on this copy is the word, on top of page 4, where you put in the word "distinctive" in place of best"; and over on page 5, at line 7, you have inserted the word "voluntary."

Mr. HAYES. One more further down, where I crossed out four words.

Senator DONNELL. Crossed out the words "I wish it were."

Mr. HAYES. Yes, sir.

Senator DONNELL. Those were the only changes made as the result of the submission of this to how many, did you say, Mr. Hayes?

Mr. HAYES. Eighteen or twenty, I would say.

Senator DONNELL. Eighteen or twenty.

Mr. Hayes, some reference was made this morning to the question as to whether the hospitals have made any substantial contributions through scientific and medical and surgical professional development.

You mentioned insulin as a discovery which had been made in the hospitals.

Mr. HAYES. That is right.

Senator DONNELL. Could you offhand give us some other illustration of the contributions that the hospitals have made?

Mr. HAYES. Senator, I cannot, not being a medical man, tell you all of the various drugs that were developed actually within the hospitals, but I do know this: that every drug—and let us go further afield from drugs—actual care of patients, all those things, are research. Those things are developed in the hospitals, not outside the hospitals, and a pharmaceutical house determines upon some particular drug that they think might be useful and the first thing they do is to ask a hospital or a number of hospitals to carry out tests and carry on the actual practical research which results in that drug becoming an article of hospital commerce.

Senator DONNELL. And then the methods of treatment, as for illustration, improvements in hospital beds and facilities, have any of those originated as the result of suggestions from people in the hospital?

Mr. HAYES. Practically every surgical instrument, form of splint, is the result of some surgeon's or medical man's experience in the hospital which developed the idea. Of course, a manufacturer later on takes on the manufacture.

Senator DONNELL. I have heard from time to time the expression "cancer research hospital." Is that indicative of the fact that research takes place in the hospital as well as the actual treatment of given patients?

Mr. HAYES. Many hospitals, those of any size, research is going on continually.

Senator DONNELL. Yes, sir.

So you would say, Mr. Hayes, from the result of your approximately 20 years in connection with hospitalization work, direct connection with it as distinguished from your private connection with the companies you referred to, when you say that in that period hospitals in this country have made a very substantial contribution to the method of treatment of patients for a variety of diseases—

Mr. HAYES. I certainly would make that statement.

Senator DONNELL. Yes, sir. Reverting to your office with the American Hospital Association, I take it it is considered, and you will tell us this with modesty, but nevertheless it is a fact it is considered a mark of distinction and confidence by the hospitals to a man who is selected as the president-elect or the president of the association, is it not?

Mr. HAYES. I so consider it, yes, sir.

Senator DONNELL. Would you kindly tell us a very brief way by which the president-elect and the president are selected?

Mr. HAYES. In general, the suggestions come from the various State associations who, in general, attempt to pick the men for trustees or officerships, according to those who have been most enterprising and progressive in their own particular States.

And as a result of that, when election time comes around, some one has, in my case, for I was on the board of trustees for 2 years, and I figure that during that term I had perhaps earned the confidence which resulted in the election as president-elect last fall.

Senator DONNELL. Was that election the result of a convention, or is it handled by mail, or some other type?

Mr. HAYES. It is the house of delegates.

Senator DONNELL. The house of delegates.

Mr. HAYES. The house of delegates, consisting of about 150 representatives of the 48 States and the territories.

Senator DONNELL. Now, has the house of delegates itself passed upon this question of compulsory medical insurance?

Mr. HAYES. On several occasions.

Senator DONNELL. Would you be kind enough to tell us what expressions the house of delegates have made upon that subject?

Mr. HAYES. The house of delegates, in June—and I hope I am correct—for I believe Mr. Bugbee could better answer it—has expressed itself in favor of Federal aid to the indigent and these others, and distinctly in favor at all times of voluntary plans for hospital care.

Senator DONNELL. Has it expressed itself as being in favor of compulsory health insurance administered by the Federal or any State government?

Mr. HAYES. Never.

Senator DONNELL. Yes, sir.

Now, Mr. Hayes, this morning Senator Murray, our chairman, who has devoted a tremendous amount of time to this subject, referred

many times to what he considered to be the effort of this bill, S. 1606, to guarantee the best quality of modern medical care.

I ask you if you have found anywhere in this bill, in the first place, any such language as that, "best quality of modern medical care"?

Have you found anywhere in this bill any such language?

Mr. HAYES. I do not recall it. I have read it about three times, and I do not recall it.

Senator DONNELL. Did you find anything in there which says that it is the purpose of this bill to guarantee the best quality of medical care to the public?

Mr. HAYES. I do not recall it, sir.

Senator DONNELL. And may I call your attention, Mr. Hayes, to page 68, to the fact that there is a limitation there to which reference was made this morning of the amount of the expense which hospitalization benefits may include under the bill?

I read:

Not less than \$3 and not more than \$7 for each day of hospitalization, not in excess of 30 days, which an individual has had in a period of hospitalization; and not less than \$1.50 and not more than \$4.50 for each day of hospitalization in excess of 30 in a period of hospitalization; and not less than \$1.50 and not more than \$3.50 for each day of care in an institution for the care of the chronic sick.

Would you tell us, please, Mr. Hayes, whether or not hospitalization frequently, in order to have the highest quality, the best quality, for I will quote the Senator again, "the best quality modern medical care administered, whether hospitalization would require a greater expense per day than any of these limits specified in this bill."

Mr. HAYES. Definitely a greater expense.

Senator DONNELL. Approximately what is the cost of a single room in Lenox Hill Hospital?

I do not mean the most expensive one, but a good average room for a patient.

Mr. HAYES. The cost, or the charge we make?

Senator DONNELL. The charge you make.

Mr. HAYES. Our rates run from \$9 up to \$17 a day.

Senator DONNELL. Nine up to seventeen. So when you get down to \$3 and \$7, or as you approach the greater limit of days, \$1.50 to \$3.50, obviously those are less than the rates you would charge for a single room?

Mr. HAYES. That is right.

Senator DONNELL. I assume you do have rooms less expensive than what you have given us?

Mr. HAYES. That is right.

Senator DONNELL. And I call your attention to the fact that, and ask you if you have observed this: It is expressly contemplated in this bill that the Surgeon General has the right to enter into contracts for a type of service which I assume is not the most expensive, because it says, at page 68, line 16:

including the use of ward or other least expensive facilities compatible with the proper care of the patient.

You have observed that?

Mr. HAYES. Yes, sir.

Senator DONNELL. Of course, the least-expensive facilities would

not be as good as more expensive facilities. Am I right in that, generally speaking?

Mr. HAYES. As far as the care to the patient is concerned, Senator, that would not be so.

A ward patient receives very excellent care, and probably in some instances better care than a private patient in a hospital such as mine.

In other words, there are more people watching him. He is not alone in a private room. He has not one doctor, but the entire staff who devote their time and give their services free to his care.

In other words, he has every consultant there is in that ward. Therefore, he is very likely to have far better care in a ward bed than if he is in a private room.

Senator DONNELL. I see. I am glad to get that information. It is a fact, however, that greater comforts are available in a more expensive room.

That is correct, is it not?

Mr. HAYES. That is right.

Senator DONNELL. Mr. Hayes, may I ask you this, also:

Considerable emphasis this morning was made upon the subject of whether or not this was federalized medicine.

Also, Senator Murray called your attention to the fact that some literature has gone out calling it socialized medicine, and you would call it federalization.

You, in response to repeated questions, went over time and time again your view of that, and I shall endeavor not to go over it any more than necessary, but I would like to emphasize one or two points which I understand you emphasized.

In the first place, I take it I am correct in this, Mr. Hayes: according to your analysis of this bill, the provisions of title II; namely, that portion of it which relates, as it is entitled, to prepaid personal health insurance benefits, or what you and I may term compulsory health insurance, that is to be administered not by the States but by the Federal Government; that is correct, is it not?

Mr. HAYES. That is my understanding.

Senator DONNELL. It is true there is a provision in here to the effect that, and I call your attention to page 37 and following, that—

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

And so forth.

That is in there, all right?

Mr. HAYES. Yes, sir.

Senator DONNELL. But the fact is that the Surgeon General is the man who gives the priority and the preference and makes the decision.

Mr. HAYES. That is right.

Senator DONNELL. And the Surgeon General, as I understand it, and as we all understand it, is exclusively a Federal officer; that is true, is it not?

Mr. HAYES. That is correct.

Senator DONNELL. And I call your attention to the fact, Mr. Hayes, as was mentioned this morning, that on pages 35 and 36, while the Surgeon General, as is set forth at the bottom of page 35:

shall perform the duties imposed upon him by this act—

yet it is distinctly stated :

under the supervision and direction of the Federal Security Administrator, and after consultations with the Advisory Council—

And so forth.

That is true?

Mr. HAYES. That is right.

Senator DONNELL. The Federal Security Administrator, of course, is a Federal and not a State official? That is correct, is it not?

Mr. HAYES. Yes.

Senator DONNELL. And then it goes ahead and says:

after consultations with the Advisory Council (hereinafter established)—
the Advisory Council is established by Federal legislation, that is right, is it not?

Mr. HAYES. That is right.

Senator DONNELL. And not by State legislation?

Mr. HAYES. That is right.

Senator DONNELL. And then proceeding:

as to questions of general policy and administration and in consultation with the Board—

consultation with the Board. What Board is that? Do you know?

Mr. HAYES. I do not know unless they mean the Advisory Council.

Senator DONNELL. It is the Social Security Board, Mr. Hayes.

Mr. HAYES. The Social Security Board.

Senator DONNELL. Of course, that Board is, itself, a Federal department, is it not?

Mr. HAYES. That is right.

Senator DONNELL. So that it would appear, would it not, Mr. Hayes, that the Federal Government operates the provisions of the compulsory health insurance portion of this act.

Mr. HAYES. That is my understanding.

Senator DONNELL. Now, there is quite a difference as regards title I, which consists of grants to States, in which case, as I understand it, from pages 1 to 34, while the Federal Government makes contributions, the actual administration of those grants is done by the States?

Mr. HAYES. That is right.

Senator DONNELL. And under plans submitted by the States; is it not?

Mr. HAYES. That is right.

Senator DONNELL. Though those plans require approval of the Federal Government before the Federal Government puts up the money?

Mr. HAYES. That is right.

Senator DONNELL. That is the difference between the two sections?

Mr. HAYES. That is right.

Senator DONNELL. The first part of the bill, title I, is the matter of State operation, and title II is the matter for the operation by the Federal Government?

Mr. HAYES. That is right.

Senator DONNELL. To the extent that there is Federal operation, I should say, repeating the language substantially, that there is some weight to your view that this is a Federal operation; is there not?

Mr. HAYES. Yes, sir.

Senator DONNELL. Now, let us inquire a little further about that.

There was some statement made by the chairman this morning, or an inquiry, as to the right of the patient to select his own hospital under this bill.

Have you found anything in this bill that says that the patient has a right to select his hospital?

Mr. HAYES. There is mentioned a free choice. I think it refers only to physicians.

Senator DONNELL. I think that is right. That is on page 45, section 205 (a) and (b). That is correct, is it not?

Mr. HAYES. That is right.

Senator DONNELL. And that does contain the privilege except it says:

(except as otherwise provided in subsection (c) of this section or in subsection (f) of section 214), and this provision shall extend to any group of physicians, dentists, or nurses or combinations thereof whose members are similarly qualified.

And then subdivision (b), that—

every individual entitled to receive general medical or general dental benefit shall be permitted to select, from among those designated in subsection (a) of this section, those from whom he shall receive such benefit, subject to the consent—

And so forth.

You are quite correct, I take it, that that does refer only to the individual.

Mr. HAYES. And only those designated in subsection (a).

Senator DONNELL. Subsection (a); that is true.

Now, may I ask you again, and you have read this bill, as I understood you to say, three times, have you found anything in here anywhere from top to bottom that says that the patient has the right to select his own hospital?

Mr. HAYES. No, sir.

Senator DONNELL. Now, Mr. Hayes, here is something I have, issued by the International Labor Office, Studies and Reports. Series M. Social Insurance. No. 15, entitled "Economical Administration of Health Insurance Benefits," issued in Geneva in 1938.

Have you examined that book?

Mr. HAYES. No.

Senator DONNELL. I would like the record to show this excerpt from page 197, referring to Germany.

They have had compulsory health insurance in Germany many years, have they not?

Mr. HAYES. Yes.

Senator DONNELL. It appears here:

The attending physician must prove the necessity of hospital treatment in writing;

and then I observe, on the same page:

The consent of the sickness fund must be obtained before admission to hospital except in urgent cases. The patient's consent is not required (i) if the nature of the illness is such that treatment and nursing can not be given at the home of the patient; or (ii) if the disease is infectious; or (iii) if the patient repeatedly disregards the doctor's instructions or the rules for the conduct of patients.

I appreciate, Mr. Hayes, this is from Germany—and we shall have a good many more during the course of the hearings.

It is a fact, is it not, that in the forming of regulations for the conduct of any great hospital, that advice is taken frequently from other sources, where you have funds local in operation?

Mr. HAYES. That is correct.

Senator DONNELL. You referred to the pattern. Your thought is that in federalization of this administration of these hospitals, that is probably going to assume a pattern, which emanates from Washington. That is your thought?

Mr. HAYES. That is right.

Senator DONNELL. I was impressed with that, and I will inquire about two or three phases of that to see what this act says about it.

In the first place, I would like to ask whether or not you have observed the provisions on pages 36 and 37 that would undertake to indicate who it is that makes contracts with hospitals for the furnishing of services?

Mr. HAYES. The Surgeon General.

Senator DONNELL. The Surgeon General.

For instance, subdivision (c) of section 203 on page 36 reads:

In carrying out the duties imposed upon him by this title, the Surgeon General is hereby authorized and directed, after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator—

Let me stop there.

The Federal Security Administrator is not required, under the law, to be a doctor, is he, so far as you know?

Mr. HAYES. So far as I know.

Senator DONNELL. In fact, Mr. Miller, the present one, is not a doctor?

Mr. HAYES. That is right.

Senator DONNELL (reading):

and with the approval of the Federal Security Administrator, to negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any State or political subdivision thereof, and with other appropriate public agencies, and with private agencies or institutions—

Hospitals, generally speaking, are termed "institutions", are they not?

Mr. HAYES. That is right.

Senator DONNELL (reading):

and with private persons or groups of persons, and with combinations thereof, to utilize their services and facilities and to pay fair, reasonable, and equitable compensation for such services or facilities—

And so forth, and so forth.

And then, further down on the same section, without reading the intermediate point, or I am willing to read it if necessary, but at the bottom is the further language—

to enter into contracts for such services, facilities, supplies, and commodities (subject to the limitations specified in sec. 214 (h)).

Is that a part of the basis of your answer to the effect that the Surgeon would be the one who would make the contract?

Mr. HAYES. Yes, sir.

The CHAIRMAN. Right there, do you think that a doctor would be able to negotiate those contracts better than the Administrator of the Social Security?

Mr. HAYES. No, sir. That is not the subject at all. Our contention is that it is a one-man rule—one man who determines all this.

The CHAIRMAN. But in negotiating the contract for the service, do you not think that the proper person to negotiate the contract would be the man who is the head of the program? And he could do a better job than a doctor who was not in that position?

Mr. HAYES. On the State level that might be more advantageous. There is one man for the whole country involved here.

If his ideas do not agree with the majority of the hospitals' ideas, we would, nevertheless, be compelled to follow them.

The CHAIRMAN. I cannot quite understand.

Mr. HAYES. He would set the pattern, Senator.

The CHAIRMAN. I cannot quite understand why the fact that contracts are negotiated by the Administrator of Social Security would accomplish anything like you are talking about here.

It seems to me that in negotiating the contract he would be the better advised as to what the terms should be and the conditions of the contract, and he would have legal advice, of course, in negotiating those contracts, and it seems to me that has nothing to do whatever with the operation of the bill.

Senator DONNELL. Pardon me, Mr. Chairman, may I interpolate at this point, that the particular point I am addressing myself to at the moment is not the question of the wisdom or the unwise, but I am addressing myself to the point made by the witness this morning, and which you two gentlemen raised quite considerable question about, as you recall, is the point that this is a federalized system. As he called it, "federalized medicine."

And I wanted to inquire as to what part Federal officials take in these matters.

I understood him to have the idea that he thinks the Federal Government would largely set the pattern for operation of hospitals.

Personally, I think so, too, and I would like to develop these particular sections.

Mr. Hayes, on page 68 of the bill, if you will turn to that, please, at lines 9 and following, here again referring to the right of the Surgeon General to enter into contracts, I observe that after this specification of the maximum amount to be paid for hospitalization, it is stated:

In lieu of such compensation, the Surgeon General may enter into contracts with participating hospitals for the payment of the reasonable cost of hospital service at rates for each day—

et cetera, et cetera, et cetera.

Provided, That such payment may be included in a contract, between the Surgeon General and a participating hospital, for inclusive services of a participating hospital and its staff and/or its attending staff, as provided in sections 203 and 205—

et cetera, et cetera.

Those, I think, Mr. Hayes, justify the view that the contracts with the hospitals will be made with this Federal official, whether wisely or unwisely. I am right on that, am I not?

Mr. HAYES. Yes, sir.

Senator DONNELL. All this goes back again, Mr. Hayes, to pages 35 and 36, which say that the Surgeon General shall perform these duties, "under the supervision and direction of the Federal Security Administrator," and, indeed, in possibly some other places that I did not pay particular note to here, there may be some specific statement to that effect in parts I referred to. I am not sure of that.

Having established, then, who it is contracts with the hospital, Mr. Hayes, let us see who it is that pays the bills to the hospital.

Whom do you understand under the bill does that?

Mr. HAYES. The Surgeon General, is it not?

Senator DONNELL. The Surgeon General. I think it is. We will refer to pages 36 and 37 on that. In subdivision (c) after setting out the provisions about carrying out the duties "authorized after consultation" to negotiate these contracts and enter into them, up at the top of page 37, it says:

and to pay fair, reasonable, and equitable compensation for such services or facilities—

That seems pretty clear that it is the Surgeon General, does it not?

Mr. HAYES. That is right.

Senator DONNELL. I would like to call your attention also that over on page 39, there is a very concrete statement there at subdivision (h) :

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

So I take it that clearly means, as it says, that while the Secretary of the Treasury is the man who pays out the cash, he does so on the certification by the Surgeon General. That is correct, is it not?

Mr. HAYES. That is right.

Senator DONNELL. So it appears, Mr. Hayes, that in the first place, on this question of whether or not a pattern would be gradually brought into existence under Federal domination, first, that the Surgeon General with this subordination to the Federal Security Administrator, makes the contracts; in the second place, that he pays the bills.

May I direct your attention to the question as to who it is that selects which hospitals shall be approved.

I would like to call your attention, first, to the page 38 as a rather general statement on that, although I will come to a more particular one in just a moment.

I will call your attention to subdivision (g), page 38, which says:

The Surgeon General, after consultation with the Board, and after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, shall prescribe and publish such rules and regulations and require such records and reports, not inconsistent with other provisions of this Act, as may be necessary to the efficient administration of this title—

And so forth. You observe that?

Mr. HAYES. Yes, sir.

Senator DONNELL. May I call your attention to pages 68 and 69 of the bill?

I have already referred to the authority here under 68 to make these contracts for inclusive services.

By the way, what does "inclusive services" mean, as you understand it?

Mr. HAYES. That the patient would go out without any charge whatsoever, is my understand.

Senator DONNELL. Does it have anything, any meaning toward getting all the services of the hospital? Taking over the hospital, virtually?

Mr. HAYES. No. Inclusive rights, inclusive service, always mean the operating rooms, any X-rays needed, and so forth.

In other words, whatever is necessary to benefit the patient?

Senator DONNELL. All right.

In proceeding over to page 69, and as to the question of the selection of the hospital, which shall be approved, I call your attention to subdivision (k) which reads:

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

That is a very broad power, is it not?

Mr. HAYES. Exceedingly broad.

Senator DONNELL. So it would appear, would it not, Mr. Hayes; that in the first place, the contracts are made by the Surgeon General with the hospital; second, he directs payments of moneys over to the hospital; in the third place, he selects what hospitals meet his approval under the bill.

Mr. HAYES. And writes the rules and regulations.

Senator DONNELL. And writes the rules and regulations.

I want to ask you this, too: Considerable reference was made this morning to one point, as to the point that was suggested by Senator Pepper that there are two men, jointly operating this.

He did not use the word "jointly." He said two men who would be operating the system, and he meant, as I understood him, the Surgeon General and the Federal Security Administrator.

Now, I ask you, Mr. Hayes, if anywhere in this bill, from the beginning to the end, you found anything that says that determinations and decisions shall be made jointly by those two men?

Mr. HAYES. No, sir. Only with the approval of the Federal Security Administrator.

Senator DONNELL. In other words, it says, at page 36, as I have indicated, that the Surgeon General shall perform the duties imposed upon him, "under the supervision and direction of the Federal Security Administrator." So, while Senator Pepper was undertaking to add one and one and get two, I think he is quite correct arithmetically, the fact is there are not two persons jointly operating, but one person who has ultimate power of decision.

Mr. HAYES. That is correct.

Senator DONNELL. And, as you indicated, the Advisory Council functions, those are largely defined by the term "Advisory," and there is nothing in this bill that says they have legal power?

I am correct in that, as I not?

Mr. HAYES. Yes, sir.

Senator DONNELL. I am not unmindful that it is prescribed that each year the Surgeon General shall make a report to Congress of all the things that the Advisory Council suggested to him during the course of the year, and it also says such report shall contain a record of consultations with the Advisory Council, recommendations of the Advisory Council, and comments thereon.

I take it it is quite clear, the Surgeon General, believing in the correctness of his views, by his comments could make quite an effective case even against the recommendations of the Advisory Council.

Would you not agree?

Mr. HAYES. Yes.

Senator DONNELL. I was coming to this further point, and I discussed on Senator Pepper's arithmetic.

To state who selects the hospital to which an individual goes, have you found anything in here that says directly or indirectly that the individual is given the right to select the hospital to which he goes?

Mr. HAYES. No, sir.

Senator DONNELL. It is not in here, is it?

Mr. HAYES. No, sir.

Senator DONNELL. I would like to call your attention to a few things in this bill that might have some bearing.

In the first place, would you be kind enough to turn to page 36, subdivision (b), and I will ask you if that reads as follows:

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

The benefits include hospital benefits; do they not?

Mr. HAYES. I think so.

Senator DONNELL. According to the definition in the bill. So it would appear that the Surgeon General has the power to arrange for the availability of those benefits?

Mr. HAYES. That is right.

Senator DONNELL. Subject, however, to what the Federal Security Administrator says? That is correct, is it not?

Mr. HAYES. That is right.

Senator DONNELL. And then, of course, as your attention was called to this a little while ago, the Surgeon General, at page 38, again with the approval of the Federal Security Administrator, and after consultation with the advisory council as to questions of general policy and administration, is given authority to publish the rules and regulations, and so forth?

Mr. HAYES. That is right.

Senator DONNELL. And then the Surgeon General, also, at page 39, subdivision (i) is given the duty of appointing local-areas committees to aid in the administration of this title, is he not?

Mr. HAYES. That is right.

Senator DONNELL. And then, of course, again, the Surgeon General is still subject to the approval of the man up ahead of him. That is correct, is it not?

Mr. HAYES. That is right.

Senator DONNELL. So it would appear, Mr. Hayes, that there being nothing in the bill which says that any individual has the right to select a hospital, and this general power being given to the Surgeon General subject only to the overseership of the Federal Security Administrator, it would seem there is no power affirmatively given for an individual to decide what hospital he may go to?

Mr. HAYES. That is correct.

Senator DONNELL. And indeed there may be an advantage to that in some cases, because a given hospital may be overflowing, and the patient might want to go there, and it might not be practical.

And, at any rate, the fact is that it would appear to me reasonable, and I ask you if it appears reasonable to you, that I could make these conclusions:

First, that the Surgeon General of the United States, a Federal official, contracts with the hospital for the services;

Second, that the same Federal official pays the bill;

Third, that the same Federal official selects what hospitals shall be approved under this bill;

And, finally, by a negatively stated idea, there certainly is no authority given to the individual to select the hospital, and it would appear, inferentially, at least, that the Surgeon General, subject to the overseership of the Federal Security Administrator, has that power?

Mr. HAYES. I would add a bit more there, Senator.

Senator DONNELL. Yes sir.

Mr. HAYES. Senator Murray, and I believe Senator Pepper, mentioned this morning, if a hospital did not want to sign a contract, it would not have to, and yet a patient might prefer to enter that particular hospital that has no contract. You are not given a free choice if he cannot go there?

Senator DONNELL. I have here in my hand, Mr. Hayes, a book that consists of some 1,250 pages, I think it is, a little over that, with the index entitled: "The Law of National Health Insurance," in England, and that contains the National Health Insurance Acts of 1936-38, with explanatory notes, reported cases, decisions of the Minister of Health, and Statutory Rules and Orders.

This is gotten out by a gentleman of Gray's Inn, with a foreword by the Minister of Health.

I ask you, do you recognize that to be a book containing The Law of National Health Insurance et cetera, arisen in England?

Senator PEPPER. Mr. Chairman, I object to the witness being asked that. He has not been shown qualified as a lawyer so as to be able to recognize that book.

In the second place, that book is not a duly authenticated copy.

There is no certificate of its authenticity.

Third, it appears to have been published in a foreign country, and in case it is published in a foreign country there should be some certification by the highest authority in the foreign country, and then by the certification of the Secretary of State of the United States, and

because the witness has not been qualified as an expert in legal matters.

The CHAIRMAN. The objection will be overruled.

Senator DONNELL. Mr. Hayes, as a matter of fact, in Great Britain, there are only about 20,000,000 persons insured, are there not, under compulsory insurance acts?

Mr. HAYES. Approximately.

Senator DONNELL. I ask you, also, subject to the various objections, to identify this document of some—

Senator PEPPER. I renew my objection.

The CHAIRMAN. The same ruling.

Senator DONNELL. This is medical insurance practice in England, issued by the British Medical Association, a work of reference, which contains various things, mileage allowances, et cetera, et cetera.

You recognize that as having something to do with the British Compulsory Insurance Act?

Mr. HAYES. Yes.

Senator DONNELL. So that the power of making regulations, Mr. Hayes, aside from our pleasantries here, the power of making regulations is a vast power when it is applied to 107 to 112 millions of our persons covering the various contingencies and situations that might arise.

That is the point to which I have directed your attention.

I think, if the Government, through one individual or two, using Senator Pepper's suggestion at two, that if one individual contracts with hospitals, pays the bills, selects what hospitals are approved, and may have the power of selecting the hospital to which an individual goes, can prescribe rules and regulations, at least to a great extent, and we have a good many more people in the United States than England, that there is some basis for a view that there is a Federal administration, and whether people agree with the exact terminology of Federal medicine, that this is a great system that would be built up under Federal administration.

Mr. HAYES. Absolutely.

The CHAIRMAN. Mr. Hayes, right there—

Mr. HAYES. Yes, sir?

The CHAIRMAN. You understand, of course, that in the passage of legislation through the Congress, amendments are often made, and this morning a proposed amendment was made by Father McGowan, in which he said he thought it would be better if the control was taken away from the Surgeon General and vested in a board. You recall his testimony this morning.

Then if such a board were set up, that would remove that objection that you have reference to?

Mr. HAYES. As I stated this morning, Senator, that would be a little improvement. It would still be Federal medicine, in my opinion.

The CHAIRMAN. Yes; I know, but I am talking about this particular individual objection.

And I want you to confine yourself to that for the moment.

If a board were set up there to take the place of the Surgeon General, it would remove that objection that you have been mentioning about this one man.

Mr. HAYES. No, sir. It would not remove our objection.

The CHAIRMAN. It would not?

Mr. HAYES. No, sir; we would still object, because it is federalized medicine. Whether it is one man or two men, if you want to carry that on to a committee, it is still Federal medicine.

The CHAIRMAN. And it is a national bill, of course. It will be a national act if it is passed by Congress, but it would have to have some management, some direction. It could not operate by itself?

Mr. HAYES. That is true. If it is enacted it would have to have some management.

The CHAIRMAN. Yes.

Mr. HAYES. Of course, we are hoping that it will not be enacted.

The CHAIRMAN. The only kind of direction you could have would be the direction of the Surgeon General, or some other individual, administrator, or a board, authorized to provide these rules.

You say that as it is now the contracts are made by the Surgeon General. He makes the payments. He makes the rules.

Now, if we eliminate the Surgeon General from it, and provide, as Father McGowan has proposed here, a board, and Father McGowan says:

We are proposing that the administration be directly in the hands of a board rather than lodged in one person, and not any kind of a board but a board selected in part from the lay public but in large part from panels of names presented by the recognized medical and hospital associations.

Mr. HAYES. I am not in agreement with Father McGowan.

Father McGowan practically spoke for the bill. We are speaking against it, Senator.

The CHAIRMAN. I understand you are speaking against it. You are speaking very much against it. I appreciate that. I do not need to be told.

Mr. HAYES. I was going to show I was not on Father McGowan's side in this discussion.

The CHAIRMAN. Surely. We take sides in this kind of legislation, and we find some people in this country who are very anxious to set up some program which would remove the obstacles that people are confronted with in regard to securing adequate modern medical care, and there are others who do not wish to make it easy for them and would rather preserve the status quo and permit evolution to handle the situation.

It has been proposed that we wait until times have changed, when it would be possible for everybody to earn sufficient income to pay for everything they needed, including full payment for modern medical care and hospitalization.

That would be ideal. But Father McGowan, and I think I expressed myself, stressed the idea that that would take a century or so, the way we are progressing. Father McGowan thought it might come in 25 years. That would be the result, of course, of not only evolution, but somewhat revolutionary.

Mr. HAYES. Senator, was not Father McGowan's statement based on the thought that wages would be increased even beyond the 65-75 cents an hour?

The CHAIRMAN. Yes.

Mr. HAYES. And that by doing that everyone would be able to take care of himself?

The CHAIRMAN. Yes.

Mr. HAYES. I am not an economist, but I might ask this question: As wages go up, the cost of living keeps pace with wages. We do not change the picture.

The CHAIRMAN. So you think it would be impossible to accomplish this by a process of evolution?

Mr. HAYES. We will have indigent with us continually.

The CHAIRMAN. Your argument is very sound. It would be impossible, through a process of evolution of that kind, to meet this problem, because, as you say, as wages go up, the costs of everything go up with it, so that it would be impossible by evolution, to bring about a situation in this country where the masses of our people working would be able to go in and buy and pay for the kind of medical care and hospitalization they are entitled to in the United States.

Mr. HAYES. We made great improvement. The old hospitals, two generations ago, practically the only patients in the hospitals were the poor patients.

The CHAIRMAN. They received the care for nothing.

Mr. HAYES. That is right, or for a small amount, \$1 a day or something like that.

That picture has been changed, so that more and more as we go along, are able to pay for their care.

We will always have indigent people. We will always have people medically indigent. No matter how the salary scale might be raised, the cost of living will go along with it. It is bound to.

Senator DONNELL. Now, Mr. Hayes, I wanted to refer briefly to one or two other phases of the statute proposed, and also that of S. 1050, the parent Wagner-Murray-Dingell bill, with a view to determining whether or not there is a basis for your construction that this is a federalized operation.

In the first place, I call your attention to this language in S. 1050, section 250—

The CHAIRMAN. Senator, I think we might shorten the hearing if I would concede that the record may show that this is a federalized program.

Senator DONNELL. I would like, Mr. Chairman, to offer this in evidence, if I may, because I do not think it has been in evidence before, that the terms of section 250 state:

There is hereby created a trust fund to be known as the "National social insurance trust fund" (called the "trust fund"). The trust fund shall consist of the assets held by the Secretary of the Treasury for the State old-age and survivors insurance trust fund on January 1, 1946, which assets the Secretary of the Treasury is authorized and directed to transfer to the trust fund; contributions collected under the National Social Insurance Contributions Act paid into the trust fund; and such other amounts as may be paid into or belonging to the trust fund by virtue of any other provision of law. There is also authorized to be appropriated to the trust fund such additional sums as may be required to finance the benefits and payments of the social insurance system.

(b) There is hereby created a body to be known as the board of trustees of the national social insurance trust fund (called "the board of trustees") which board of trustees shall be composed of—

I want to call your attention to the fact that there are no doctors on this unless it is by chance—

shall be composed of the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board, all ex officio et cetera, et cetera.

You are familiar with the provisions of S. 1050?

Mr. HAYES. I have read that.

Senator DONNELL. I want to ask you this, too:

In order to administer this bill, I take it it would be necessary to have a great many persons employed all over the country to pass on the questions that might arise?

Mr. HAYES. That is correct.

Senator DONNELL. Many of these people would have to come into a hospital quickly and unexpectedly, they might be sitting in a hearing, or some place, and have to go to the hospital, struck with some illness.

Mr. HAYES. Or hit by an automobile.

Senator DONNELL. Or hit by an automobile, and somebody has to make the decision, whether the general practitioner would be sufficient.

Mr. HAYES. That is true.

Senator DONNELL. You recall, subdivision (d) page 46, contains a provision by which an individual may, in addition to being entitled to a specialist or consultant, upon the advice of the general or family practitioner, or of a specialist or consultant attending him, be entitled to other specialists or consultants provided he requests it, and provided that these are approved by a medical administrative officer appointed by the Surgeon General.

Mr. HAYES. That is right.

Senator DONNELL. If the medical administrative officer, in a case where a man gets hit by an automobile or has appendicitis, if the medical administrative officer is going to pass very efficiently, so as to save the man's life, he is going to have to be pretty close at hand.

Mr. HAYES. Yes, sir.

Senator DONNELL. I would like to have the record show, Mr. Chairman, that we have, according to the United States Department of Commerce, Government units of the United States, issued in 1942, showing Federal Government, 1; States, 48; counties, 3,050; school districts, 108,579; township, 18,919; special districts, 8,229; municipalities, 16,200. Total, 155,160.

Mr. Hayes, without attempting to determine whether we would have to have one or more in these subdivisions—

Mr. HAYES. You would have to have them there 24 hours a day, Senator.

The CHAIRMAN. Mr. Hayes, do you think it would be convenient for the attending physicians to make that decision?

Senator DONNELL. I would like—

The CHAIRMAN. I would like to ask that question.

Mr. HAYES. The attending physician now takes that decision, Senator.

The CHAIRMAN. What is wrong with having that provision here, then?

Mr. HAYES. Of course, that would speed things up. But the way it is now, it would not work out; and it would mean a tremendous number on the Government pay roll.

Senator DONNELL. This provision, as the chairman will recall, contemplates a situation in which the person may have additional services over and above those that a general practitioner might prescribe provided the medical administrative officer appointed by the Surgeon General shall approve such person.

Perhaps it might be cured by an amendment, but the point I make is, under S. 1606, as it now stands, obviously medical administrative officers in great numbers are contemplated throughout the nation.

The CHAIRMAN. I think all those matters can be simplified by appropriate measures.

Senator DONNELL. Of course, there are some of us that approach this problem on the view that this bill is based on a theory that is unsound, but I appreciate that every one has a right to his own opinion.

Now, Mr. Hayes, I want to ask you a few more questions.

The CHAIRMAN. We have two more witnesses. They would like to get away this afternoon.

Senator DONNELL. I would be glad to govern myself accordingly. I realize that the examination this morning was quite extensive, sir.

The CHAIRMAN. I am not making any objection, but just calling your attention to the fact that we have two more witnesses, and I have been criticized by the committee for prolonging these hearings, and I want to comply with the wishes of the committee as well as I can.

Senator DONNELL. I do not think my examination of Mr. Hayes has been unduly long.

The CHAIRMAN. No; but I could have entered into an agreement with you to show everything you testified to this morning, that the witness would testify to all those things which he has already testified to.

Senator DONNELL. Now, Mr. Hayes, referring to your point which you make in your testimony that S. 1606 leads to Government operation, as more fully stated:

But we vigorously oppose the provisions of title II of this legislation, which would place the Federal Government in such a dominant position in the health field as to lead inevitably to Federal control and operation of the entire health system of the Nation.

You have that as a very sincere belief, do you not?

Mr. HAYES. Yes, sir.

Senator DONNELL. I ask you whether or not you are aware, as the London Times of Wednesday, March 27, says, and I will read this article for the record:

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 every one free and without qualification or limitation, was made known on Thursday 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.

From our parliamentary correspondent

With the publication of the national health service bill, together with the white paper summarizing and explaining the main proposals, the Government gave legislative form to their plans for promoting a comprehensive health service in England and Wales. It is now presented in all its essentials. Within the main structure much is left to 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 opinion 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 interrelated. 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 poser 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 centres. The members of these councils will be nominated in equal numbers by the major local authorities and the Minister and by 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 centres in place of surgeries. The patients' freedom in the choice of doctor is not cancelled, 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 ac-

cept 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.

British Medical Association views on the plan.—The Council of the British Medical Association on Friday submitted for the information of the profession a report on the national health service bill. Some 56,000 copies of the statement have been distributed by the council. Meetings of the profession will be called in every area during the next few weeks and a report of the council on the bill will be submitted to a special representative meeting on May 1.

The statement emphasizes that the medical profession is anxious and willing to cooperate with the Government in evolving a complete health service, but is opposed to certain important features of the Government's proposals. It is insisted that the direction of medical practitioners, their payment mainly by State salary, and the prohibition of the sale of practices means a whole-time salaried service, sooner or later, under the State—that is, control.

It is stated that the taking over by the State of the ownership of all hospitals must cause a loss of local interest and the discouragement of support by contributions or service. Local hospitals command pride, resource, and initiative: help, innovation, staffing, and confidence. These must be preserved.

You knew of that?

Mr. HAYES. Yes, sir.

Senator DONNELL. Do you think that is somewhat indicative of the soundness of your view that if compulsory health insurance were put into effect under the terms of this bill, it will be a step in the same direction that the British have already taken?

Mr. HAYES. I believe it is inevitable, as it was in England.

Senator DONNELL. I want to ask you this concluding question, which I would like to address to Mr. Bugbee:

Mr. Bugbee, there was one question asked this morning, and I do not recall the exact wordage, but the general gist of it was: Does the fact that the Government would have a great deal to do with the plan here under which the hospitals would receive their payments, et cetera,—does that per se mean that the system would be operated inefficiently? And you answered, "Not per se."

Why was the emphasis placed, if there was an emphasis placed on "per se"?

Mr. BUGBEE. There is no standard pattern that applies to the operation of all types of hospitals. There are good Government hospitals and good nonprofit hospitals, and variations up and down the scale.

I think it would be accepted that the progressive development has come in the nonprofit hospitals rather than the Government hospitals.

Senator DONNELL. Yes, sir.

Mr. BUGBEE. And that the average care tends to be more mediocre.

Senator DONNELL. Mediocre in what?

Mr. BUGBEE. In the Government hospital.

Senator DONNELL. In the Government hospital. That is all, Mr. Chairman.

The CHAIRMAN. You were cross-examined at great length in reference to the right of a patient to select a hospital.

There would not be anything very difficult about providing that a person should be entitled to select the hospital just the same as a person has the right to make the selection of whom he shall patronize if he is going to a hotel?

Mr. HAYES. Not necessarily, Senator. The average person has his own private doctor.

The CHAIRMAN. Yes.

Mr. HAYES. If that doctor he had did not care for this scheme and had not joined in it, then he could not send that patient to a hospital that was Government-approved. Therefore, you would take away the free choice of physician at the same time.

The CHAIRMAN. Of course, the patient would not be going to that kind of doctor?

Mr. HAYES. What was that?

The CHAIRMAN. If this bill were enacted and in operation, then the patient would be going to one of the doctors that had already accepted him?

Mr. HAYES. Yes, sir. But let us assume that there is a doctor in the city who has a very fine reputation on a certain type of operation, and you want these people to have the best medical care, and that doctor wants to do it himself.

The CHAIRMAN. If he is on the panel—

Mr. HAYES. Suppose he is not? You have removed free choice of the physician as well as the hospital.

The CHAIRMAN. Have we not got that in existence in this country today? Is it not a fact that the average citizen is not able to select that kind of a doctor at the present moment?

Mr. HAYES. The average citizen that goes into any well-qualified voluntary hospital, into a ward, has that famous man operate on him who might a little later charge \$1,000 for that same operation that afternoon to another man.

The CHAIRMAN. If he is in that hospital, and that hospital is accepted, and the staff of that hospital is working under this plan, the patient could have the services of that doctor?

Mr. HAYES. Not if that doctor did not want to work under this plan.

The CHAIRMAN. I do not assume that that problem is going to confront us.

Mr. HAYES. And again you approach what I stated this morning—you have to go in, or you are out.

The CHAIRMAN. Of course, that is an extreme example.

Mr. HAYES. That is compulsory.

The CHAIRMAN. That is an extreme example, it seems to me, and I would think that the average person today is not able to select the doctor or the surgeon who is going to operate on him, because he does not know whom he should have.

People travel good distances to go to hospitals for operations and when they get there, they find the doctor they expected to get is not there any more, is dead, or unable to take them, and the result is they have to accept the services of some other doctor or surgeon.

Mr. HAYES. Equally as good.

The CHAIRMAN. What?

Mr. HAYES. Equally as good; no doubt.

The CHAIRMAN. Equally as good; yes.

I know in my own family, where the patient went to the hospital, expecting to be operated on by a particular doctor, but the doctor's assistant performed the operation very satisfactorily; and I think

that the medical profession today has advanced to a degree that the average doctor that is licensed to practice as a doctor, or as a specialist, is qualified to perform these operations. One is almost as good as the other.

Mr. HAYES. That is right.

The CHAIRMAN. Now, then, do you not think it would be very simple to provide in this bill that all persons should be entitled to select the hospital as far as it might be possible for him to get into that particular hospital, or that his doctor should be allowed to take him to that hospital if there is an opening there?

Mr. HAYES. That applies today, Senator. He can pick a hospital and walk off the street into the hospital and they will take care of him.

The CHAIRMAN. Walk off the street into the hospital?

Mr. HAYES. Surely.

The CHAIRMAN. I think you are mistaken. I know of cases where they have to wait for weeks, and perhaps for a month, to be accepted over here in Johns Hopkins.

Mr. HAYES. If it is a postponable operation, that is correct. If it an emergency, we put beds in the corridors.

The CHAIRMAN. That is not a very good system, where you have people in the corridors, and out in the back yard.

Mr. HAYES. You have to do the best you can.

The CHAIRMAN. Yes; but we are trying to do better than has been done in the past.

Mr. HAYES. The Hill-Burton bill might help. Give us some more beds and rooms.

The CHAIRMAN. And the Hill-Burton bill will not operate unless we have some measures of this kind to make it possible for those new hospitals to operate, because they cannot be built in some sections of the country unless they can show they are financially able to support them.

Mr. HAYES. I think title I of this bill and the Hill-Burton bill will work.

The CHAIRMAN. It will work if we have a program where everyone is entitled to get care, and where everyone is going to be paid for, and not accepted as charity, or the hospital not expected to handle patients that cannot pay.

As you said this morning, your hospitals were having a difficult time until the Blue Cross came along, and that was a great help.

Mr. HAYES. That is right. And we expect it to be a greater help.

Senator PEPPER. I have two things I would like to ask.

I believe you said this morning you would furnish for the record, if we desired it, the ownership of the hospitals that are included in your association.

Mr. HAYES. We will do that.

Senator PEPPER. You will put that in for the record?

Mr. HAYES. And the Blue Cross plan of New York and the medical plan of New York.

Senator PEPPER. How the hospitals that are members of your association are owned.

The CHAIRMAN. How many of them are publicly owned hospitals, and how the others are financially supported; how the other hospitals are financially supported.

Mr. BUGBEE. This morning the request was for the type of ownership.

There is multiple support. That is difficult to analyze.

The CHAIRMAN. We would like to have it analyzed as completely as possible, to tell us what the sources of income are.

Mr. BUGBEE. I think that study is in progress now, and there have been estimates, but there are no current figures as to how much came from county government, State government, other forms of government, and from charity.

The CHAIRMAN. You can state it in a general way, declare the support comes from the various directions.

Senator PEPPER. Mr. Hayes, you said you charge, for private rooms, \$9 to \$15 a day?

Mr. HAYES. \$17.

Senator PEPPER. \$9 to \$17 a day. What are the charges for hospitalization in a ward, just for the ward services?

Mr. HAYES. From nothing up to \$5 a day.

Senator PEPPER. Now, if every patient who came into your hospital paid a fair service, a fair fee for the service received, would it be necessary to charge anybody as much as \$17 a day to run your hospital?

Mr. HAYES. It would not be necessary, but the amount of space taken up by someone in a \$17 room is certainly four or five times as much as the fellow in the maximum \$5 ward bed.

Senator PEPPER. What I am getting at, this bill, as you pointed out this morning, contemplates there being paid out of this fund to the hospital some \$3 to \$7 a day.

And I think at first that might be grossly inadequate, when you suggest you had some rooms charging \$15 or \$17 a day, but now you tell me you have some space in the wards, where people pay nothing at all, or pay up to \$5 a day.

I can see that in the writing of this bill, they thought that in view of the fact that this scheme contemplated that the hospital would be paid for every patient who was cared for, and covered by the insurance scheme, that an average of \$7 a day might make it possible for the hospital to be adequately compensated, because you would not have charity patients.

Mr. HAYES. That is true, Senator. If we could fix the norm by dividing the patient days at the end of the year, taking 170,000 days, and the \$2,000,000 we spent, and I could tell you we needed so much in order to carry on.

Senator PEPPER. In other words, if you got \$7 a day for every patient that came into your hospital, would that be the income you get from the present system of working?

Mr. HAYES. No, it would not.

Senator PEPPER. You would not equal it?

Mr. HAYES. Nowhere near it. Figure 170,000 times 7 is about 1,200,000. Last year cost us practically \$2,000,000 to operate our hospital, without depreciation or anything of the buildings.

Senator PEPPER. In that case you must get the higher rates. The major part of your patients must be in the higher rooms.

Mr. HAYES. Seventy percent are in the wards—620 beds, only 82 private rooms.

Senator PEPPER. Most of the rooms are private rooms that you get \$17 for?

Mr. HAYES. Only four of them.

Senator PEPPER. If 60 percent of your beds are in wards and you said you get from nothing up to \$5 a day for them at the present time—

Mr. HAYES. That \$5 a day, Senator, is the ward daily charge. That is plus approximately one-third of the cost for X-rays, laboratory work, and so on.

Senator PEPPER. Well, does not this bill—

Mr. HAYES. No, sir; \$7 is inclusive.

Senator PEPPER. Of all services?

Mr. HAYES. Inclusive. Yes, sir.

Senator PEPPER. Is it not a mere matter of mathematics as to whether \$7 a day is a rate, or whether it should be \$8 or \$9 or \$10 a day?

Would you not render this committee a real service if you suggested that the figure should be \$10 a day or \$12 a day, or some amount you deemed appropriate?

Mr. HAYES. I am still a little worried about the Government going in debt, and if you went into that, the percentage you would charge on the salaries would not begin to pay that.

Senator PEPPER. The Government is going to pay it.

Mr. HAYES. Yes.

Senator PEPPER. You contemplate, I dare say, a larger amount out of the Federal Treasury by your suggestion of Federal subsidies to this bill, more than this would contemplate?

Mr. HAYES. If you are going to pay \$12 a day for hospital care in the average voluntary hospital, and in a university hospital, I know the ward rate has gone up to \$13 a day.

Senator PEPPER. What would you say is the average rate per patient per day in your hospital?

Mr. HAYES. The average rate is something over \$10.

I would say, roughly, it is around \$12, something like that.

Senator PEPPER. Well, then, you are not willing to give a figure that you think would be an appropriate figure?

Mr. HAYES. I think it would vary at various parts of the country. I do not think you could fix it. You know about the emergency maternal-care program. That is based on actual cost from the hospital statement and revised from year to year.

For instance, in my hospital now, I believe we are getting \$9.25 a day on that program from the Government, which program does not include the depreciation on the buildings or anything else of that sort.

Senator PEPPER. Mr. Hayes, I have just turned to a proposed report, prepared by the staff of a subcommittee of this committee, of which I am chairman, and the sources of this data are given in the proposed report, and the proposed report finds that under all voluntary medical plans now in existence only 2.5 percent of the population have comprehensive medical care.

Substantially all would be covered by this bill.

Ten percent have partial physician or surgeon service.

Most of them include hospitalization. Ten percent.

And hospital care, only 12.5 percent.

A total of 25 percent of the population have any kind of coverage under any of the voluntary insurance system in effect in the United States today.

Did you realize that the limitations were so severe?

Mr. HAYES. I realize that, Senator, and I also realize the fact that, thank goodness, a great proportion of the population of this country is able to take care of illness when it comes.

Senator PEPPER. You mean the great proportion of the United States—

Mr. HAYES. You must remember, we are still fortunately in a position where the majority of the people of the country can still take care of themselves.

The CHAIRMAN. Well, they are taking care of themselves now.

Senator PEPPER. And the same statistics show that in the United States, a half of the families had an income of less than \$2,000 a year, and half of the families had an income of over \$2,000 a year, and you think, without being a member of any kind of voluntary prepayment insurance plan, that half of the families of this country with an income of less than \$2,000 a year are able to purchase for themselves the kind of medical and hospital care for the families of this country which they are entitled to receive?

Mr. HAYES. I realize a proportion of them are not, and that is the reason why we have philanthropies and that sort of thing in our hospitals.

Senator PEPPER. That does a considerable amount of good, but I am sure you, with your vast knowledge of the health condition, would be the last one to contend that all these good services now available, that anything like adequate service is supplied with hospital and medical care that the people need?

Mr. HAYES. Nothing is perfect, Senator. We are striving for it all the time and doing the best we can.

Certainly, we people in the hospitals are fully cognizant of our lack, and we are doing everything we can, and I think the picture of medicine and hospitalization over the years is a part of progress.

Senator PEPPER. You are doing everything you can in your own way except favoring a national insurance plan that would make it possible for people of low-income groups to get it as this bill would allow it to them?

Mr. HAYES. We do not think it would improve medical care.

Senator PEPPER. It would give it to more people than are now getting it, would it not?

Mr. HAYES. It would, possibly.

Senator PEPPER. All right.

Thank you.

The CHAIRMAN. Thank you very much. We are sorry to have to detain you here so long.

(Subsequently Mr. Hayes submitted the following material:)

AMERICAN HOSPITAL ASSOCIATION,
WASHINGTON SERVICE BUREAU,
Washington 6, D. C. May 20, 1946.

Hon. JAMES E. MURRAY,

Chairman, Education and Labor Committee,

United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: When I appeared before your committee to testify on behalf of the American Hospital Association with regard to S. 1606, I promised to place certain information in the record for you.

One of these is the specimen contract of the Associated Hospital Service of New York, which offers hospital services which are as comprehensive as those envisioned by your legislation.

The second document is a specimen contract of the United Medical Service, which makes available a general medical expense indemnity which is very broad in its coverage, and which might be easily comparable to the benefits proposed by S. 1606.

I offer these to demonstrate that the hospital and medical fields are already working in the direction proposed by your legislation, and that they have made considerable progress in that direction. It is our belief that if we are allowed to go forward unhampered by unnecessary Government restrictions we can accomplish more through the traditional method of private endeavor than by any omnibus health legislation at this time.

Senator Pepper asked that we insert in the record an analysis of our membership as regards ownership of our hospitals. We also enclose this for the record.

Respectfully,

JOHN H. HAYES, President-elect.

[Specimen]

ASSOCIATED HOSPITAL SERVICE OF NEW YORK

A nonprofit corporation

(Hereinafter referred to as AHS)

CERTIFICATE OF CONTRACT FOR HOSPITAL SERVICE

Maternity benefits are provided only if type indicated below is "W," "X," or "R"

In consideration of the application of

Name of applicant	Certificate No.	Type	Charges	Manner of payment	Effective date		
					Month	Day	Year

as Applicant, on behalf of himself only or on behalf of himself and the members of the Family Group, if any, listed on such application for this Contract for Hospital Service, and of the payment of the charges as herein provided,

THIS IS TO CERTIFY

that AHS has accepted said application and that the Applicant and such members of the Family Group, if any, are entitled to Hospital Service in accordance with the Hospital Service Plan hereinafter set forth during the period of 12 months from the Effective Date above stated and from year to year thereafter unless this Contract is terminated as provided therein.

ASSOCIATED HOSPITAL SERVICE OF NEW YORK

370 Lexington Avenue, New York 17, N. Y.

JAMES DE SOCARRAS,
Secretary.

LOUIS H. PINK,
President.

Countersigned by: _____, *Registrar.*

EXPLANATION OF CODES

MANNER OF PAYMENT

- 1. Monthly 2. Quarterly 3. Semiannual 4. Annual

TYPE OF CONTRACT

Subscriber only K-M-V	Husband and wife L-A-U-E	Family W, X, R, or Z
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Maternity benefits included in "W", "X", or "R" contracts only

HOSPITAL SERVICE PLAN

Article I—Definitions

1. "Contract" means the agreement between AHS and the Applicant by virtue of which the Applicant and the members of the Family Group, if any, as hereinafter defined, become Subscribers, and shall consist of the application for this Contract, this certificate evidencing the acceptance of such application, and any supplemental application accepted by AHS. This Contract includes the endorsements thereon and attached papers, if any, and contains the entire Contract.

2. "Effective Date" means the date appearing on the face of this certificate.

3. "Contract Year" means the period of 12 months commencing on the Effective Date and each yearly period thereafter.

4. "Applicant" means the person who on behalf of himself only or on behalf of himself and the members of his Family Group, if any, has made application for, and with whom AHS has entered into, this Contract.

5. "Family Group" means and comprises the Applicant, his or her spouse, and their unmarried children over 90 days of age who shall not have attained the age of 18 years, listed on the application for this Contract or on any supplemental application accepted by AHS, but shall not include any person who has attained the age of 65 years prior to the Effective Date of this Contract unless such person was a subscriber under another AHS contract in effect immediately preceding the Effective Date of this Contract.

6. "Subscriber" means the Applicant and the members of the Family Group, if any. Any Subscriber, other than the Applicant and spouse, shall cease to be a member of the Family Group and a Subscriber on the anniversary of the Effective Date following either the attainment of age 18 or the marriage of such Subscriber.

7. "Remitting Agent" means any individual, partnership, association or corporation which, as agent for the Applicant, has agreed with AHS to collect and remit the charges payable hereunder.

8. "Member Hospital" means any hospital with which AHS has an agreement for the rendering to Subscribers of Hospital Service under the terms and conditions hereof.

Article II—Hospital Service Available to Subscribers

"Hospital Service" as used in this Contract shall mean and comprise the following:

Bed and board, including special diets

General nursing service

Use of operating and cystoscopic rooms and equipment

Laboratory examinations consistent with the diagnosis and treatment of the condition for which hospitalization is required

Use of cardiographic equipment

Basal metabolic examinations

Use of physiotherapeutic equipment

Oxygen and use of equipment for administration thereof

Drugs and medications for use in the hospital, including sera, biologicals, vaccines, interavenous preparations and visualizing dyes, but not including blood, blood plasma, radium therapy, or roentgen therapy

Dressings and plaster casts

Anesthesia supplies and use of anesthesia equipment; administration of anesthesia if administered by an employee of the hospital

X-ray examinations consistent with the diagnosis and treatment of the condition for which hospitalization is required and shall be available where necessary for the proper treatment of a Subscriber admitted to a hospital as a registered bed patient, to the following extent according to the accommodations occupied:

(a) *In Semiprivate Accommodations of Member Hospitals.*—A Subscriber occupying semiprivate accommodations (2, 3, or 4 beds in a room regardless of

the hospital's classification of any such room) in a Member Hospital shall be entitled to the aforesaid Hospital Service and the hospital shall make no charge therefor to the Subscriber;

(b) *In Ward Accommodations of Member Hospitals.*—A Subscriber may be admitted to ward accommodations in a Member Hospital upon obtaining the consent of the Member Hospital selected and of a physician who will attend the Subscriber in such ward accommodations. A Subscriber so admitted and occupying ward accommodations shall be entitled to the aforesaid Hospital Service and the hospital shall make no charge therefor to the Subscriber;

(c) *In Private Accommodations of Member Hospitals.*—A Subscriber occupying a private room in a Member Hospital shall be entitled to the aforesaid Hospital Service but the hospital will charge directly to the Subscriber and the Subscriber shall pay to such hospital the difference, if any, between the hospital's total charges and the amount which AHS is then paying pursuant to Paragraph I of Article XI hereof for Hospital Service under this Contract, which latter amount shall not exceed the hospital's regular charges for such Hospital Service tendered;

(d) *In any Accommodations of Nonmember Hospitals.*—A Subscriber receiving Hospital Service in a legally constituted and operated hospital which is not a Member Hospital, shall, subject to the exclusion contained in Paragraph 2 of Article V hereof, be entitled to an allowance toward but not exceeding the hospital's total charges for Hospital Service rendered of such amount as is fixed pursuant to Paragraph 2 of Article XI hereof for Hospital Service so rendered. Should, however, such hospital be a member hospital of any other hospital service corporation providing to its subscribers the same Hospital Service as is provided hereunder, and which other hospital service corporation has entered into a reciprocal hospital service agreement with AHS, the Subscriber shall be entitled to Hospital Service available in Member Hospitals as outlined in Paragraphs (a), (b) and (c) of this Article II.

Article III—Duration of Hospital Service

1. Except as the duration and extent of Hospital Service are limited under Article IV hereof, a Subscriber shall be entitled in each Contract Year to Hospital Service, on one or more admissions, for an aggregate number of days, including the number of days of Hospital Service rendered in any case set forth in Article IV hereof, not to exceed:

(a) 21 days; and

(b) 90 days after such 21 days have been provided, but during such 90 days the Subscriber shall pay directly to the hospital, for Hospital Service rendered during such 90 days, the excess, if any, of the hospital's total charges over the following allowance:

(i) In semiprivate or ward accommodations of Member Hospitals: 50% of the hospital's regular charges for Hospital Service rendered during such 90-day period; or

(ii) In private accommodations of Member Hospitals and in all accommodations of hospitals which are not Member Hospitals: the amount per day which AHS is then paying, pursuant to Paragraph 1 or 2, respectively, of Article XI hereof, for Hospital Service rendered under the Contract during such 90-day period.

2. In computing the number of days of Hospital Service rendered to a Subscriber, the day of admission and the day of discharge shall both be counted only if the admission is before one o'clock p. m. and the discharge is at or after one o'clock p. m.; otherwise, the portions of such different days shall be considered together as one day; if a Subscriber is discharged on the same day on which he is admitted, such day shall be counted as one day.

3. If a Subscriber shall remain in a hospital after he has been advised by his attending physician that further Hospital Service is unnecessary, whether or not the stipulated days of Hospital Service hereunder shall have been rendered the Subscriber shall be solely responsible to the hospital for all charges incurred after he has been so advised.

Article IV—Limitations

Hospital Service is limited in the following cases to the extents specified:

(a) For maternity cases and for any condition arising out of and during pregnancy, Hospital Service shall be available—

(1) only to the wife included in the Family Group;

(2) only if the certificate number appearing upon the face of this Contract is followed by the letter "W", "X", or "R"; and

(3) only if this Contract has been in effect for 10 consecutive months immediately preceding the hospital admission, which 10-month waiting period, however, shall not apply to premature termination of pregnancy without childbirth if otherwise childbirth would have occurred after such period. Hospital Service so available shall be limited to a period not to exceed 10 days in the aggregate in any Contract Year, but the hospital will charge directly to the Subscriber and the Subscriber shall pay directly to the hospital the excess, if any, of the hospital's total charges over—

\$6.00 per day of Hospital Service if rendered during the 21-day period referred to in Article III hereof, or

\$3.00 per day of Hospital Service if rendered during the 90-day period referred to in Article III hereof.

The foregoing limitations of 10 days, and \$6.00 or \$3.00 per day, shall not apply to ectopic pregnancies, Caesarean sections, or premature terminations of pregnancy without childbirth.

(b) FOR THE REMOVAL OF TONSILS OR ADENOIDS Hospital Service shall be available to a Subscriber only after he has been a Subscriber under this Contract or this and any other AHS Contract for 6 consecutive months immediately preceding the hospital admission, and shall be limited for Subscribers under 12 years of age to one day and for Subscribers of or over 12 years of age to two days.

(c) FOR PREEXISTING CONDITIONS: Hospital Service for any condition, disease or ailment which existed on the Effective Date of this Contract or for which medical or surgical treatment or advice has been rendered within one year prior to such Effective Date, shall be available to a Subscriber only after the first 11 months from the Effective Date of this Contract. If the Subscriber was previously a subscriber under another AHS contract, the effective date of such contract, if in effect immediately preceding the Effective Date of this Contract, shall be used in computing such 11-month and one-year periods.

Article V—Exclusions

1. Hospital Service shall not be provided for: any condition, disease, ailment, or accidental injury (1) covered by a Workmen's Compensation Act or similar legislation, or (2) for which hospitalization is furnished to the Subscriber under the laws of the United States of America or any State or political subdivision thereof; hospital admissions primarily for diagnostic X-ray or laboratory examinations or other diagnostic studies, or primarily for physical therapy; rest cures; mental or nervous disorders; pulmonary tuberculosis after diagnosis as such; or communicable diseases requiring isolation or quarantine.

2. Hospital Service shall not be provided in a hospital which is not a Member Hospital, within the area in which AHS operates, except for accident or emergency illness.

3. Hospital Service does not include the services of physicians or of private nurses or their board, or ambulance service.

Article VI—Conditions under which hospital service shall be rendered

1. Hospital Service shall be available only to a Subscriber admitted as a registered bed patient on the recommendation, and while under the treatment, of a physician in the hospital selected. However, in the event of accidental injury Hospital Service for emergency care shall be available, only during 24 hours after such injury, to a Subscriber not admitted as a registered bed patient, but the hospital will charge directly to the Subscriber and the Subscriber shall pay to the hospital the difference, if any, between the hospital's total charges and the amount which AHS is then paying pursuant to Article XI hereof for Hospital Service for such emergency care. This latter amount, however, shall not exceed the hospital's regular charges for such Hospital Service rendered and such care shall constitute one day of Hospital Service rendered.

2. Hospital Service is subject to all the rules and regulations of the hospital selected, including the rules and regulations governing admission.

3. AHS shall not be liable unless written notice of admission of a Subscriber to a hospital shall be given AHS within 30 days after such admission. Failure to give such notice shall not invalidate or diminish any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

4. As a condition precedent to the issuance of this Contract, the Applicant and each member of the Family Group, if any, agrees that any physician, nurse or hospital having made a diagnosis for, treated, attended or rendered service

to any Subscriber, or in possession of any information or records relating thereto, is authorized and directed to furnish, to such extent as may be lawful, to AHS at any time upon request any and all such information and records, or copies of records.

Article VII—Charges

1. The charges for a Contract Year shall be determined by the Board of Directors of AHS and shall be subject to the approval of the Superintendent of Insurance of the State of New York.

2. The amount of the charges and the time and manner of payment thereof shall be as specified by the Applicant in the application or any supplemental application accepted by AHS, or as set forth in any notice provided for under Paragraph 3 of this Article VII. All such charges shall be due and payable in advance—the initial charge on or before the Effective Date.

3. In the event of an increase or decrease of the charges, the Applicant shall be given written notice thereof at least 60 days prior to the date when such change shall become effective.

4. A grace period of 30 days shall be allowed within which to make payment of any charges except the initial charge.

Article VIII—Termination

1. *By Default in Payment of Charges.*—Upon default in payment of charges in accordance with the terms hereof, this Contract shall automatically terminate at the expiration of the grace period and a Subscriber shall not thereafter be entitled to any further Hospital Service.

2. At the Option of Either Party—

(a) This Contract may be terminated by the Applicant or AHS at any time by giving at least 30 days' prior written notice to the other, but this Contract may not be terminated by the Applicant prior to the expiration of any Contract Year in the event that any Hospital Service has been rendered hereunder during such Contract Year.

(b) If prior to the expiration of a Contract Year either party shall terminate a Contract which by its terms provides for the payment of charges quarterly, semi-annually or annually, AHS shall refund to the Applicant the pro rata amount of such charges, if any, which shall have been paid for any unexpired portion of such Contract Year. If such termination shall be by the Applicant, there shall be deducted an expense charge of \$2.

3. *By Failure of Remitting Agent to Make Payment of Charges.*—If the Remitting Agent fails to pay to AHS the charges payable by the Applicant or notifies AHS prior to the expiration of the grace period that the Remitting Agent will no longer make payment of such charges for the Applicant this Contract shall terminate, unless the Applicant shall pay directly to AHS within 15 days after such failure, or in the event of such notice, within 15 days after such notice or prior to the expiration of the grace period, all unpaid charges then due and shall commence to pay subsequent charges on a quarterly, semi-annual or annual basis at the then current rate of charges for Contracts the charges for which are not paid through a Remitting Agent.

4. *By the Death of the Applicant.*—Upon the death of the Applicant, this Contract shall terminate as of the date to which charges shall have been paid. However, Hospital Service shall continue to be available to the remaining members of the Family Group, if any, for the remainder of the Contract Year, if the charges then unpaid for the remainder of the Contract Year are paid directly to AHS.

Article IX—Notice

Any notice given hereunder shall be sufficient, if given by AHS to the Applicant, when mailed to the Applicant either at his address as it appears on the records of AHS or in care of the Remitting Agent, if any, at the latter's address as it appears on the records of AHS; if given by AHS to any Member Hospital, when mailed to such Member Hospital at its principal office; or if given by the Applicant or a Member Hospital to AHS, when mailed to AHS at its principal office in New York, N. Y.

Article X—Reinstatement and Miscellaneous Provisions

1. Any Contract which shall have terminated in any manner as provided herein may be reinstated by AHS in its sole discretion upon such terms and conditions as it may determine, but if default be made in the payment of charges, the subse-

quent acceptance of a payment by AHS, or by any of its duly authorized agents, shall reinstate this Contract but only to cover accidental injury thereafter sustained and such sickness as may be first manifested more than 10 days after date of such acceptance: Hospital Service for maternity cases or any condition arising out of and during pregnancy, if provided pursuant to Article IV hereof, shall not be available until this Contract has been in effect for 10 consecutive months immediately following the date of such acceptance.

2. The benefits of this Contract are personal to a Subscriber and are not assignable.

3. No statement by any subscriber in the application for this Contract or in any supplemental application accepted by AHS shall avoid this Contract or be used in any legal proceeding hereunder unless such application or exact copies thereof, are included herein or attached hereto; and no agent or representative of AHS, other than a duly authorized officer, is authorized to change this Contract or waive any of its provisions.

4. No action at law shall be brought against AHS for any claim unless brought within 2 years from date of the Subscriber's discharge from the hospital.

Article XI—AHS's Agreement With Hospitals

1. AHS shall, subject to the terms and conditions hereof, compensate Member Hospitals for Hospital Service rendered by them to Subscribers by payments in such amounts and upon such basis as shall be determined from time to time by the Board of Directors of AHS, subject to approval as to adequacy by the Commissioner of Social Welfare of the State of New York and as to reasonableness by the Superintendent of Insurance of the State of New York, but which amounts shall not be reduced until Member Hospitals shall have been given at least 60 days' prior written notice.

2. AHS shall, subject to the terms and conditions hereof, compensate hospitals which are not Member Hospitals for Hospital Service rendered by them to Subscribers. The amount of such compensation shall at all times be subject to the determination of AHS and the approval of the Superintendent of Insurance of the State of New York and shall in no event exceed either the then prevailing rate of payment to Member Hospitals adopted pursuant to Paragraph I of this Article XI or the hospital's regular charges for such Hospital Service rendered.

3. The membership in AHS of any Member Hospital and the agreement between AHS and the Member Hospital for the rendering of Hospital Service by such Member Hospital to Subscribers may be terminated by either AHS or the Member Hospital at any time upon at least 60 days' prior written notice to the other, and upon such termination, the obligation of such hospital to render Hospital Service shall cease as to Subscribers making application for admission to such hospital for Hospital Service after such termination.

(Specimen)

GROUP CONTRACT NO. _____

UNITED MEDICAL SERVICE, INC.

A nonprofit medical expense indemnity corporation

(Hereinafter referred to as UMS)

GROUP CONTRACT FOR GENERAL MEDICAL EXPENSE INDEMNITY

ISSUED TO

(Hereinafter referred to as the Employer)

In consideration of the application of the Employer, a copy of which is attached hereto and made a part of this Contract, of any application referred to in paragraph (c) or (d) of Section 3 of Article II hereof and of the payment of charges as provided in Article VVIII hereof, UMS agrees to provide Medical Expense Indemnity under the terms of this Contract for a period of one year beginning at 12:01 a. m. standard time at New York, New York, on _____ (hereinafter called the Effective Date) and from year to year thereafter, unless this

Contract is terminated as provided herein. The charges shall be due and payable by the Employer in advance, on the Effective Date and on the _____ day of each _____ thereafter during the continuance of this Contract.

This Contract is issued and delivered in the State of New York, is governed by the laws thereof and is issued and accepted subject to the terms and conditions recited by UMS on the subsequent pages hereof, which are a part of this Contract as fully as if recited over the signatures hereto affixed.

IN WITNESS WHEREOF, UNITED MEDICAL SERVICE, INC., has caused this Contract to be signed at New York, New York, this _____ day of _____, 194__.

UNITED MEDICAL SERVICE, INC.

370 Lexington Avenue, New York 17, N. Y.

ROWLAND H. GEORGE,
President.

DEWITT STETTEN, M. D.,
Secretary.

-----, *Registrar*

Article I—Definitions

1. "Employee" means an employee of the Employer.
2. "Family Group" means and includes the Employee's spouse and unmarried children over 90 days and less than 18 years of age.
3. "Subscriber" means any person covered under this Contract as provided by Article II, but any child included as a Subscriber, as a member of a Family Group, shall cease to be a Subscriber upon attaining the age of 18 years or upon marriage, whichever event shall first occur.
4. "Participating Physician" means any duly licensed physician with whom UMS shall have an agreement providing that, for any Subscriber to whom he shall render any General Medical Care, Surgical Care, Maternity Care or Specialist Care specified in Article XV, the physician shall render such care in accordance with the terms and conditions of this Contract.

Article II—Employees and Their Families Covered

1. *Eligibility.*—Every Employee within the Classification of Employees Eligible set forth below shall be eligible for coverage for himself and his Family Group if, on or after the Effective Date, such Employee shall have completed the period of continuous employment with the Employer set forth in such Classification:

Classification of Employees Eligible	Period of Continuous Employment Prerequisite to Eligibility
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2. *Election of Coverage.*—Any Employee eligible for coverage may elect coverage for himself and members of his Family Group by completing and filing with the Employer notice of such election, on a form approved by the Employer, listing thereon the names of himself and the members of his Family Group and other identifying information.

3. Commencement of Coverage.—

- (a) If an Employee elects coverage before he becomes eligible therefor, coverage shall commence automatically on the date he becomes eligible, provided his employment with the Employer shall not have terminated between the date of such election and the date he becomes eligible.
- (b) If an Employee elects coverage on the date he becomes eligible or within 30 days thereafter, coverage shall commence on the date of filing of notice of such election.
- (c) If any member of the Employee's Family Group is not covered on the date such Employee's coverage commences, coverage with respect to such member of his Family Group shall commence on receipt by UMS at its principal office of the Employee's application for such member's coverage if such application is received within 30 days after such member becomes a member of the Family Group.

(d) Coverage shall commence only an approval by UMS at its principal office of application therefor, submitted with evidence of acceptability satisfactory to UMS, under any of the following circumstances:

(i) if an Employee does not elect coverage within 30 days after the day he becomes eligible;

(ii) if an Employee again elects coverage after terminating coverage for any reason other than termination of employment; or

(iii) if an Employee does not elect coverage for a member of his Family Group within 30 days after such member becomes a member of the Family Group, as required in paragraph (c) of this Section 3 of Article II.

(e) If an Employee shall not be actively at work at his regular employment and his regular place of employment on the date coverage for himself and members of his Family Group otherwise would commence, such coverage shall commence upon his return to such active work.

* *Article III—Medical expense indemnity provided*

1. Medical Expense Indemnity shall be provided with respect to the fees of Participating Physicians for General Medical Care, Surgical Care, Maternity Care, and Specialist Care, as specified in Article XV, rendered to a Subscriber in the treatment of injury, illness or pregnancy, and shall be the Indemnity set forth in Article XV; and for such care rendered by a duly licensed physician who is not a Participating Physician, Indemnity shall be provided only under the conditions and to the extent provided in Section 7 of this Article.

2. A Subscriber may choose any Participating Physician who, if he accepts such Subscriber as a patient, agrees to render care in accordance with the provisions of this Contract. No Participating Physician shall be compelled to accept a Subscriber as a patient and nothing herein is intended to alter or change the normal relation of physician and patient.

3. The amount of such Indemnity shall be applied as a credit by the Participating Physician toward his fee for such care rendered and the Subscriber shall pay directly to the physician any difference between such fee and the amount of such Indemnity, without recourse to UMS. Participating Physicians have agreed to accept from UMS in payment of such Indemnity, such amounts, and upon such basis, as shall be determined from time to time by the Board of Directors of UMS.

4. If at the time care is rendered, the rate of aggregate income of the Employee and his Family Group shall not exceed:

\$1,800 a year for an Employee without a Family Group, or
\$2,500 a year for an Employee with a Family Group,

the payment by UMS to the Participating Physician shall constitute the physician's full fee for such care, except as otherwise specified in Article XV with respect to General Medical Care and Specialist Care.

5. In the case of an Employee with a Family Group, if the rate of aggregate income of the Employee and his Family Group is between \$2,500 and \$3,500 a year at the time care is rendered, and if the fee of the Participating Physician exceeds the amount of Indemnity provided by Article XV for the care rendered, then the Physicians' Review Committee of UMS, upon request of the Subscriber, and after notice to the physician and reasonable opportunity for him to be heard, shall review all the facts and shall determine the fair fee to be paid by the Subscriber directly to the physician above such Indemnity, and its decision shall be binding upon both the Subscriber and the physician.

6. The provision of Sections 4 and 5 of this Article with respect to the fee of the Participating Physician shall not be binding upon the physician unless the Subscriber, prior to or at the time of the arrangement for his care, notifies the physician that he is a Subscriber and the physician accepts him as a patient upon that basis.

7. When care is rendered by a duly licensed physician who is not a Participating Physician, Indemnity shall be provided only if reasonable effort was made to obtain the services of a Participating Physician and to transfer to the care of a Participating Physician as soon as reasonably possible, and shall be limited to an allowance of 75% of the amount which UMS is then paying to Participating Physicians for like care, but such allowance shall not exceed such physician's fee.

Article IV—Payment of Medical Expense Indemnity, to Whom Made

Payment of Medical Expense Indemnity shall be made by UMS to the physician who shall have rendered care to the Subscriber and filed a claim in accordance with subparagraph (b) of Section 1 of Article VII.

Article V—Limitations of Liability for Medical Expense Indemnity

Medical Expense Indemnity and the liability of UMS therefor shall be limited as set forth in Article XV and also in the following respects:

1. *When Care is Rendered by Two or More Physicians*, the amount of Indemnity provided for such care shall be the same as in the case of care rendered by one physician;

2. *When Two or More Operations or Procedures of Surgical or Maternity Care are Performed at One Time*, Indemnity shall be provided only for that operation or procedure so performed as UMS, in its sole discretion, shall determine to be the primary care rendered to the Subscriber;

3. *When General Medical Care is Rendered in Addition to Surgical, Maternity or Specialist Care*, Indemnity will be provided for such General Medical Care only if UMS, in its sole discretion, shall determine that such General Medical Care is required in addition to the care customarily rendered as a part of Surgical Maternity or Specialist Care;

4. *When Specialist Care is Rendered in Addition to General Medical, Surgical or Maternity Care*, Indemnity will be provided for such Specialist Care only if the Subscriber shall be referred to the Specialist, and Specialist Care is certified to UMS, by the Subscriber's attending physician as incident and necessary to the care of injury, illness or pregnancy;

5. *When Studies or Tests for Determining the Existence of an Allergy shall be Performed*, Indemnity will be provided therefor only if UMS, in its sole discretion, shall determine that such studies or tests are required;

6. *When Care is Rendered to a Subscriber who has Attained the Age of 90 Days but not the Age of One Year*, Indemnity will be provided for General Medical or Specialist Care only if such Subscriber at the time such care is rendered is a duly registered bed patient in a legally constituted and operated hospital;

7. *When There is No Objective or Clinical Evidence of Injury or Illness*, Indemnity will be limited to a maximum aggregate amount of \$20 for the services of one or more physicians rendering care therefor to the Subscriber;

8. *When Care is Rendered for Pregnancy or for Any Condition Arising out of and During Pregnancy*, Indemnity shall be provided for such care only to the wife and only if both husband and wife are Subscribers;

9. It shall be a condition precedent to any liability of UMS hereunder that each Subscriber covered hereunder shall be concurrently covered under a hospital service contract issued by Associated Hospital Service of New York during the entire period of his coverage hereunder; otherwise the limit of liability of UMS under this Contract with respect to any Subscriber's claim for benefits shall be the refund to the Employer of all charges paid hereunder with respect to such Subscriber for any period during which such Subscriber was not concurrently covered under such a hospital service contract.

Article VI—Medical Expense Indemnity Not Provided.

Medical Expense Indemnity will not be provided hereunder for: any condition, disease, ailment or accidental injury (1) covered by a Workmen's Compensation Act or similar legislation, (2) for which care by a physician is furnished to the Subscriber under the laws of the United States of America or any state or political subdivision thereof, (3) for which care is furnished by a medical department maintained by the Employer, or (4) for which care is furnished under any other circumstance under which the Subscriber incurs no physician's fee; medical examinations for "check-up" purposes when not incident and necessary to treatment of injury or illness; mental disorders; rest cures; alcoholic or drug addiction; surgery for cosmetic purposes; congenital anomalies; examinations of the eyes solely for glasses; or pathology, radiology, anesthesiology or physical therapy if benefits therefore are provided in the hospital service contract issued by Associated Hospital Service of New York and referred to in Section 9 of Article V.

Article VII—Conditions under which medical expense indemnity shall be provided

1. UMS shall be liable under this Contract only when:

(a) written notice that care has been rendered shall have been given to UMS within 20 days after the commencement of care; and

(b) a claim in writing, signed by the Subscriber's attending physician and also signed by the Employee or his spouse, shall be filed with UMS on its regular forms, within 30 days after the completion of Surgical or Maternity Care, or at the end of each calendar month in the case of General Medical or Specialist Care, stating the income classification of the Employee pursuant to Article III, and the full particulars of such claim. UMS may require as part of such particulars, written verified statements as to medical or surgical treatment or advice received by any Subscriber, itemized bills of the physician, and all information and records, or copies of records, of any physician, nurse or hospital, who has made a diagnosis for, treated, attended or rendered service to the Subscriber or is in possession of any information or records relating thereto; and each Subscriber hereby agrees that any such physician, nurse or hospital may and is authorized to furnish, to such extent as may be lawful, to UMS upon request such information and records or copies of records.

2. Failure to give such notice, file such claim or furnish such particulars, bills, information, records, or copies of records within said respective limited periods shall not invalidate or diminish any claim under this Contract if it shall be shown not to have been reasonably possible so to give such notice, file such claim, or furnish such particulars, bills, information, records, or copies of records, and that the same were given, filed or furnished as soon as was reasonably possible.

3. UMS shall have the right and the opportunity to make a medical examination of any Subscriber, for whom a claim is made hereunder, when and so often as UMS may reasonably require such examination.

Article VIII—Charges

1. The amount of the monthly charges shall be determined monthly in accordance with the number of Employees covered at the beginning of such monthly period and shall be at the following rates:

For each Employee without a covered Family Group----- \$1.60 per month
For each Employee with a covered Family Group----- \$4.00 per month

2. Upon each anniversary of the Effective Date, UMS may, by notifying the Employer, change the rates at which further monthly charges, including the one then due, shall be determined.

3. After the payment of the first charge a grace period of 30 days, without interest, will be allowed in the payment of subsequent charges, unless the Employer shall have given written notice to UMS that this Contract is to be terminated.

Article IX—Employer's Personnel Data

The Employer shall furnish UMS with the names of eligible Employees as they file notices of election of coverage, copies of such notices of election and such other information as required by UMS, and during the continuance of this Contract shall report to UMS every termination of employment, and change in family status according to the Employer's personnel records, respecting the Employees covered, within one month after such termination or change. Payroll records of the Employer and such other personnel records as may reasonably be considered to have a bearing on the administration of the coverage and on the determination of the future charges, shall be open for inspection by UMS.

Article X—Termination

1. *By Default in Payment of Charges.*—Upon default in payment of charges in accordance with the terms hereof, this Contract shall automatically terminate at the expiration of the grace period.

2. *At the Option of Either Party.*—This Contract may be terminated by the Employer or UMS at any time by giving at least 30 days prior written notice to the other.

Article XI—Individual Terminations

In the event any Employee fails to make any required contribution for the coverage respecting such Employee and his Family Group, if any, such coverage shall terminate automatically at the end of the period for which contribution shall have been made. In any event the coverage hereunder respecting any Employee and his Family Group shall terminate automatically at the expiration of 30 days from the death of the Employee or the termination of the Employee's employment. Cessation of active work of an Employee with the Employer shall be deemed termination of employment. However, an Employee who is absent

on account of injury, illness or pregnancy, or is temporarily laid off, granted leave of absence, pensioned or retired, shall nevertheless be considered as still employed until the end of the calendar month next following the month in which such cessation occurs, but the coverage respecting such Employee and his Family Group in force at the date of such cessation shall not be continued after the date the Employer, acting in accordance with rules precluding individual selection, shall terminate such coverage by notifying UMS to that effect or by failing to pay the charges therefor.

Article XII—Conversion Privilege

In the event of termination of employment with the Employer, UMS shall issue, without further evidence of acceptability, to the Employee and the members of his Family Group covered hereunder, a limited coverage contract, limited to indemnity for care rendered in the hospital and in the form then customarily issued by UMS to Employees converting from this form of Group Contract: *Provided, That—*

(a) Written application for the new contract and the payment of the first charge applicable thereto shall be made to UMS by such Employee within 30 days following the date of termination of his employment and the new contract shall become effective at the end of such 30 days; and

(b) Such Employee and members of his Family Group continue to maintain, and to be covered concurrently under, a hospital service contract of Associated Hospital Service for New York.

Article XIII—Notice

Any notice given under this Contract shall be sufficient, if given by UMS to the Employer, a Subscriber, or a Participating Physician, when mailed to the Employer, Subscriber, or Participating Physician at his respective address as it appears on the records of UMS; if given by the Employer, a Subscriber, or a Participating Physician to UMS, when mailed to UMS at its principal office.

Article XIV—Miscellaneous Provisions

1. This Contract, the application and any supplemental application of the Employer and any application of any Employee constitute the entire contract, and the statements made in said applications shall be considered representations and not warranties; and no statement shall be used as a defense of any claim hereunder unless it is contained in this Contract or in any of said applications. No agent or representative of UMS, other than a duly authorized officer, is authorized to change this Contract or waive any of its provisions. All sums payable by UMS hereunder shall be payable at its principal office.

2. No action at law or in equity shall be brought against UMS for any claim prior to the expiration of 60 days after a claim in writing shall have been filed with UMS, nor shall any such action be brought unless commenced within 24 months from the date of notice of claim as required according to Article VII.

3. UMS does not select a physician for the Subscriber, is not responsible for any physician's acts, omissions, or conduct and shall be under no liability in connection with care rendered by any physician other than to provide Medical Expense Indemnity to the extent set forth in this Contract.

4. The benefits of this Contract are personal to a Subscriber and are not assignable.

5. UMS will issue to the Employer for each covered Employee an individual certificate of coverage which shall not change or void any of the terms or conditions of this Contract.

Article XV—Schedule of Medical Expense Indemnities and Periods of After-Care

Medical Expense Indemnities for General Medical Care, Surgical Care, Maternity Care, and Specialist Care, and periods of after-care for Surgical Care and Maternity Care, shall be as listed in the following schedule and in the more detailed list available for inspection of the offices of UMS and the Superintendent of Insurance of the State of New York, which shall be deemed to be a part of the following schedule:

1. GENERAL MEDICAL CARE by a Participating Physician :	Indemnity
At the physician's office-----	\$2 per visit
at the patient's residence or at a hospital-----	3 per visit

If a physician receives a call between 8 P. M. and 6 A. M. to visit a Subscriber and visits the Subscriber between those hours, he may make a charge directly to the Subscriber, in addition to the above indemnity, but with respect to a Sub-

scriber coming within the income limits set forth in Section 4 or 5 of Article III said additional charge shall not exceed \$2.

Payment by UMS for more than one visit in any one day or more than 20 visits in connection with any one injury, illness, or pregnancy is subject to specific authorization by UMS.

2. SURGICAL CARE by a Participating Physician in connection with the performance of any operation or procedure listed and the rendering of after-care therefor for not longer than the period specified, including administration of anesthesia by the physician rendering such Surgical Care. For any care rendered to a Subscriber subsequent to the specified period of after-care, Indemnity shall be provided upon the basis specified for General Medical Care in Section 1 of this Article, but only if UMS, in its sole discretion, shall determine that such care is a necessary extension of such after-care.

	After Care	Indemnity
Abdomen:		
Appendectomy.....	3 weeks.....	\$100.....
Gall bladder removal.....	3 weeks.....	125.....
Gall bladder drainage.....	3 weeks.....	100.....
Bowel resection.....	3 weeks.....	150.....
Other cutting into abdominal cavity for diagnosis or treatment, unless otherwise specified.	3 weeks.....	100.....
Abscess:		
Deep cellulitis drainage.....	None.....	20.....
Carcinole, excision of.....	None.....	25.....
Deep breast abscess, boils excepted.....	None.....	25.....
Amputations:		
Thigh through hip joint or neck of femur; arm through shoulder joint.....	6 weeks.....	150.....
Thigh; leg; arm through neck of humerus; forearm through elbow joint; foot through ankle joint.....	6 weeks.....	100.....
Knee cap; foot below ankle; upper arm; forearm.....	6 weeks.....	75.....
Hand at wrist.....	6 weeks.....	60.....
Finger or toe.....	6 weeks.....	30.....
Fingers or toes (two or more).....	6 weeks.....	60.....
Coccyx.....	3 weeks.....	50.....
Breast:		
Radical amputation, single.....	3 weeks.....	100.....
Radical amputation, bilateral.....	3 weeks.....	150.....
Tumor, noncancerous.....	2 weeks.....	35.....
Chest:		
Thoracoplasty:		
First operation.....	3 weeks.....	100.....
Each subsequent operation.....	3 weeks.....	50.....
Cutting into thoracic cavity for diagnosis or treatment.....	3 weeks.....	50.....
Pneumothorax, induced:		
First induction.....	None.....	25.....
Each refill (maximum 5 refills).....	None.....	10.....
Cutting into trachea.....	3 days.....	50.....
Bronchoscopy, including biopsy, removal of foreign body, or treatment:		
First operation.....	1 week.....	50.....
Each subsequent operation.....	None.....	10.....
Dislocations: Reduction of, for an open reduction of dislocation, unless otherwise specified, increase indemnity by 50 percent:		
Shoulder, closed.....	3 weeks.....	40.....
Shoulder, open.....	6 months.....	150.....
Heel, closed.....	3 weeks.....	50.....
Heel, open.....	2 months.....	100.....
Hip joint.....	3 weeks.....	75.....
Knee.....	3 weeks.....	60.....
Knee cap.....	3 weeks.....	50.....
Ankle.....	3 weeks.....	40.....
Elbow, closed.....	3 weeks.....	35.....
Elbow, open.....	3 weeks.....	75.....
Collar bone; wrist.....	3 weeks.....	25.....
Jaw.....	3 weeks.....	10.....
Finger or toe.....	None.....	5.....
Ear, Nose or Throat:		
Mastoidectomy:		
Simple.....	3 weeks.....	75.....
Radical.....	3 weeks.....	150.....
Tonsillectomy and adenoidectomy:		
Subscribers under age 12.....	1 week.....	25.....
Subscribers of or over age 12.....	1 week.....	40.....
Sinus operations:		
Frontal, intranasal, simple.....	3 weeks.....	50.....
Frontal, external.....	3 weeks.....	100.....
Puncture for drainage or irrigation.....	None.....	10.....
Antrum, radical.....	3 weeks.....	50.....
Submucous resection of nasal septum.....	2 weeks.....	75.....

	After Care	Indem-nity
Excision or Fixation by Cutting:		
Hip joint.....	2 months.....	\$150
Joints of: shoulder; elbow; wrist; knee; ankle.....	2 months.....	100
Removal of semilunar cartilage of knee.....	2 months.....	100
Eye:		
Removal of cataract; operation for detached retina.....	10 days.....	100
Needling of cataract; removal of tear duct.....	10 days.....	75
Removal of intra-ocular or intraorbital foreign body; removal of eyeball; cutting of extrinsic eye muscles.....	3 weeks.....	100
Iridectomy.....	10 days.....	60
Fractures:		
Fractures Not Reduced by Open Operation:		
Thigh bone.....	2 months.....	150
Vertebral body, or adjacent bodies, upper arm; shafts of both bones of forearm; shafts of both bones of leg.....	2 months.....	100
Elbow (including humerus, radius and ulna); ankle; large bone of leg (tibia).	2 months.....	75
Pelvis—one bone.....	3 weeks.....	50
Pelvis—more than one bone.....	3 weeks.....	75
Forearm at wrist joint (Colles).....	2 months.....	65
Lower jaw (alveolar processes excepted); sacrum; knee cap.....	3 weeks.....	50
Shaft of one bone of forearm; carpal bones of hand (one or more); small bone of leg (fibula); heel bone.....	2 months.....	50
Collar bone; shoulder blade.....	3 weeks.....	40
Metacarpal bones of hand (one or more).....	3 weeks.....	30
Metatarsal bones of foot (one or more).....	3 weeks.....	30
Tarsal bones of foot (one or more).....	2 months.....	30
Finger or great toe.....	3 weeks.....	20
One toe other than great toe.....	3 weeks.....	15
Fingers or toes (two or more in same hand or foot).....	3 weeks.....	35
Compound Fractures (increase by 50 percent the above indemnities for "Fractures Not Reduced by Open Operation").		
Incomplete (Greensick or Chip) Fractures (decrease by 33 1/3 percent the above indemnities for "Fractures Not Reduced by Open Operation").		
Fractures Reduced by Open Operation (Increase by 50 percent the above indemnities for "Fractures Not Reduced by Open Operation", except as listed below):		
Skull.		
Open operation within duramater.....	3 weeks.....	150
Open operation not within duramater.....	3 weeks.....	100
Elbow (including humerus, radius, and ulna); forearm at wrist joint (Colles); large bone of leg (tibia); ankle.....	2 months.....	110
Heel bone.....	2 months.....	100
Carpal bones of hand (one or more).....	2 months.....	100
Metacarpal bones of hand (one or more).....	2 months.....	75
Metatarsal bones of foot (one or more).....	2 months.....	75
Tarsal bones of foot (one or more).....	2 months.....	60
Genito-Urinary Tract:		
Removal of entire kidney.....	3 weeks.....	150
Removal of entire prostate.....	4 weeks.....	150
Complete removal of uterus and both tubes and both ovaries.....	3 weeks.....	150
Other cutting operations with abdominal approach for removal of, or on, uterus or its appendages.....	3 weeks.....	100
Removal of uterine fibroid tumors, polypoid growths excepted.....	3 weeks.....	100
Cutting into bladder and removal of tumors.....	3 weeks.....	150
Other cutting into bladder.....	3 weeks.....	75
Cutting into kidney, including removal of stones or tumors.....	3 weeks.....	100
Fixation of kidney.....	3 weeks.....	100
Cutting into ureter.....	3 weeks.....	100
Cystoscopy for removal of urinary stones or bladder tumor:		
First operation.....	None.....	25
Each subsequent operation.....	None.....	10
Varicocele.....	1 week.....	25
Hydrocele with excision of tunica vaginalis.....	1 week.....	50
Orchidectomy.....	3 weeks.....	60
Epididymectomy.....	3 weeks.....	75
Dilation and curettage (nonpuerperal).....	3 weeks.....	25
Circumcision.....	1 week.....	15
Golter:		
Thyroidectomy.....	2 weeks.....	100
Ligation of thyroid arteries.....	2 weeks.....	50
Hernia, Cutting Operation:		
Single hernia.....	2 months.....	75
More than one hernia.....	2 months.....	100
Rectum:		
Hemorrhoidectomy:		
Internal, or internal and external.....	2 weeks.....	50
External only.....	2 weeks.....	25
Fistula, resection of :		
Single.....	3 weeks.....	50
Multiple.....	3 weeks.....	75
Anoplasty.....	2 weeks.....	50
Prolapse of rectum, complete procedure with abdominal approach.....	3 weeks.....	150

	After Care	Indemnity
Tendons, Suture of:		
Single tendon	3 weeks	\$35
Each additional tendon (maximum of 6)	3 weeks	10
Transfusions or Infusions, when supplemental to Surgical or Maternity Care, exclusive of cost of blood plasma or serum:		
Blood transfusion, direct from donor to recipient	None	25
Blood, plasma or serum infusion	None	5
Tumors, Cysts, etc., Removal of:		
Nonmalignant skin tumor or subcutaneous lipoma:		
Single	1 week	10
Multiple	1 week	20
Malignant tumors of face, lip, or skin, wide excision of	2 weeks	50
Pilonidal sinus or cyst	6 weeks	75
Varicose Veins:		
Saphenous vein, ligation with injection of involved tributary branches:		
Unilateral	3 weeks	50
Bilateral	3 weeks	75

3. MATERNITY CARE (including care for conditions arising out of and during pregnancy) by a Participating Physician, but only if rendered to the wife and only if both the husband and wife are covered hereunder, including pre-natal care, and after-care for not longer than the period specified, including administration of anesthesia by the physician rendering such Maternity Care. For any care rendered to a Subscriber subsequent to the specified period of after-care, Indemnity shall be provided upon the basis specified for General Medical Care in Section 1 of this Article, but only if UMS, in its sole discretion, shall determine that such care is a necessary extension of such after-care.

	After Care	Indemnity
Obstetric delivery		
Cesarean section	2 weeks	\$75
Abdominal operation for ectopic pregnancy	2 weeks	100
Miscarriage (abortion), including dilation and curettage, if any:		
Up to beginning of 4th month	3 weeks	100
After beginning of 4th month	2 weeks	35
	2 weeks	50

4. SPECIALIST CARE by a Participating Physician who is qualified as a specialist and who renders such care within the scope of his specialty, when the Subscriber is referred to such specialist by another Participating Physician and when such Specialists Care is certified to UMS by the referring physician as incident and necessary to the care of injury, illness or pregnancy. Indemnity for such Specialist Care shall be 50% of the Base Rate listed below and the Subscriber receiving such care may be charged the specialist's regular fee for service rendered, less such Indemnity, but as to a Subscriber coming within the income limits set forth in Section 4 or 5 of Article III the charge to the Subscriber above such Indemnity shall not exceed 50% of the Base Rate.

In the event that Specialist Care is obtained by a Subscriber in a manner or under circumstances other than as set forth above, no Indemnity shall be provided for physical therapy, pathology, radiology, or anesthesiology, but for other Specialist Care UMS shall be obligated to provide Indemnity therefor only at the scheduled rate of Indemnity for General Medical Care according to Section I of this Article, and any fee in excess of such amount shall be paid by the Subscriber, without recourse to UMS.

*CARDIOLOGY		
DERMATOLOGY		
ENDOCRINOLOGY		
GASTROENTEROLOGY		
GYNECOLOGY OR OBSTETRICS		
HEMATOLOGY		Base Rate
IMMUNOLOGY OR ALLERGY		
*INTERNAL MEDICINE		
NEURO-SURGERY		
OPHTHALMOLOGY (examination of the eyes solely for glasses not covered)		
ORTHOPEDICS		
OTORHINOLARYNGOLOGY		
PEDIATRICS		
PLASTIC SURGERY		
PODIATRY		
PROCTOLOGY		
SURGERY		
NEUROLOGY OR PSYCHIATRY:		Base Rate
Complete examination and treatment		\$20
Second visit		5
Each subsequent visit		3
PHYSICAL THERAPY, including any and all modalities, subject to Article VI		3
UROLOGY, complete examination, consultation or treatment, not inclusive of cystoscopy or X-rays:		
First visit		15
Each subsequent office visit		3
PATHOLOGY: Subject to a maximum Indemnity of \$50 during any one year of coverage of the Subscriber and to Article VI:		
Blood:		
Serologic:		Base Rate
Agglutination test: Typhoid		\$3.00
For syphilis:		
Wassermann		5.00
Flocculation		3.00
Both		7.50
Chemical:		
Creatinine		3.00
Nonprotein nitrogen		3.00
Sugar		3.00
Sugar tolerance (4-5 specimens)		10.00
Sulfa drug concentration		3.00
Urea nitrogen		3.00
Uric acid		3.00
Clinical:		
Hemoglobin and red cell count		3.00
White cell count and differential		3.00
Complete blood count		5.00
Bleeding and coagulation time		2.00
Sedimentation time		3.00
Malaria search		2.00
Grouping and compatibility		5.00
Rh grouping		5.00
Bacteriologic: Blood culture		5.00
Tissues:		
Biopsy		10.00
Other specimen (surgical)		10.00
Frozen section in hospital		15.00
Urine:		
Routine (chemical only)		1.00
Routine (chemical and microscopic)		2.00
Acetone, diacetic, quart. sugar		1.00
Ascheim-Zondek for tumor		15.00
Bile and urobilin		2.00
Ureteral specimens (Urea, P. S. P., microscopic)		5.00
Mosenthal concentration test		5.00

	<i>Base Rate</i>
Cerebrospinal Fluid:	
Wassermann	\$5.00
Colloidal gold	3.00
Quantitative protein	3.00
Globulin	1.00
Cell count	1.00
All or part above (maximum)	10.00
Feces:	
Occult blood—description	2.00
Ameba (warm stage, culture, cysts)	5.00
Miscellaneous:	
Concentration and film for tubercle bacilli	4.00
Smear for tubercle bacilli	2.00
Anmila (g.p.) inoculation	10.00
Basal metabolism	10.00
Pneumococcus typing	5.00

RADIOLOGY: Subject to a maximum Indemnity of \$50 during any one year of coverage of the Subscriber and to Article VI:

	<i>Base Rate</i>
Single finger	\$5
Single toe	5
Hand	8
Wrist	8
Forearm, mid third	8
Elbow	8
Humerus, any $\frac{1}{3}$	8
Foot	8
Ankle	8
Leg, any $\frac{1}{3}$	8
Knee	8
Femur, any $\frac{1}{3}$ of shaft	8
Shoulder joint	10
Clavicle	10
Scapula	10
Hip joint	15
Head and face	20
Follow up, partial	10
Nasal bones	10
Nasal sinuses	15
Mastoids	15
Spine, cervical	15
Spine:	
Dorsal	15
Lumbar	15
Pelvis	15
Sacro-iliac joint, coccyx	15
Any two spinal regions	25
Any three spinal regions	35
Bones of thorax, excluding spine	15
Lungs and heart	15
Cardiac mensuration	15
Abdomen, for acute obstruction	15
Esophagus only, including fluoroscopy	15
Gastro-intestinal series	35
Colon by opaque enema	15
Gall bladder, simple	15
Graham, oral	25
Intravenous, or Stewart concentration	35
Genito-urinary, simple	15
Retrograde pylography	15
By excretion	25
Search for foreign body in alimentary or respiratory tract	20
Foreign body in eye, Sweet	25

ANESTHESIOLOGY, subject to Article VI:

	Base Rate
Inhalation :	
First 15 minutes.....	\$10
First 30 minutes.....	15
Each succeeding 30 minutes.....	5
Spinal or epidural (not caudal) :	
First 30 minutes.....	20
Each succeeding 30 minutes.....	5
Rectal :	
First 60 minutes.....	20
Each succeeding 30 minutes.....	5
Intravenous :	
First 15 minutes.....	10
First 30 minutes.....	15
Each succeeding 30 minutes.....	5

For any Surgical Care, Maternity Care, or Specialist Care for which no indemnity is listed in the foregoing schedule, or in the more detailed list which has been filed with the Superintendent of Insurance of the State of New York and which is available for inspection of the offices of UMS and the Superintendent of Insurance, UMS reserves the right, in its sole discretion, to determine the amount of indemnity, if any, to be paid.

Analysis by type of control, for 5,982 United States hospitals with 1,278,074 beds, which include all United States institutions with exception of Army and Navy hospitals

	American Hospital Association institutional members			Not American Hospital Association institutional members	
	Hospitals	Beds	Membership percentage of beds (percent)	Hospitals	Beds
A. Institutional:					
Nonprofit voluntary.....	2,193	279,937	84.65	766	50,770
All Government.....	617	343,564	38.28	1,098	553,993
Proprietary.....	664	29,548	59.32	644	20,262
Total.....	3,474	653,049	51.10	2,508	625,025
B. Personal (administrator is AHA personal member, but hospital is not institutional member):					
Nonprofit voluntary.....	82	12,270		684	38,500
All Government.....	54	34,886		1,044	519,107
Proprietary.....	20	689		624	19,573
Total.....	156	47,845		2,352	577,180
C. Combined membership coverage:					
Nonprofit voluntary.....	2,275	292,207	88.36	No coverage	
All Government.....	671	378,450	42.16	684	38,500
Proprietary.....	684	30,237	60.70	1,044	519,107
Total.....	3,630	700,894	54.84	624	19,573

Analysis by type of service for 5,982 United States hospitals with 1,278,074 beds, which include all United States institutions with exception of Army and Navy hospitals

	American Hospital Association institutional members			Not American Hospital Association institutional members	
	Hospitals	Beds	Membership percentage of beds (percent)	Hospitals	Beds
A. Institutional:					
General and comparable.....	3,147	390,549	63.03	1,885	229,063
Nervous and mental.....	190	233,595	40.05	329	349,611
TB.....	137	28,905	38.41	294	46,351
Total.....	3,474	653,049	51.10	2,508	625,025
B. Personal (administrator is AHA personal member, but hospital is not institutional member):					
General and comparable.....	130	33,161	-----	1,755	195,902
Nervous and mental.....	9	11,399	-----	320	338,212
TB.....	17	3,285	-----	277	43,066
Total.....	156	47,845	-----	2,352	577,180
C. Combined membership coverage:				No coverage	
General and comparable.....	3,277	423,710	68.38	1,755	195,902
Nervous and mental.....	199	244,994	42.01	320	338,212
TB.....	154	32,190	42.77	77	43,066
Total.....	3,630	700,894	54.84	2,352	577,180

The next witness is Rev. John G. Martin. Have you a prepared statement?

Reverend MARTIN. Yes, sir.

The CHAIRMAN. You may proceed.

STATEMENT OF REV. JOHN G. MARTIN, PAST PRESIDENT OF THE AMERICAN PROTESTANT HOSPITAL ASSOCIATION

Reverend MARTIN. For the record I am Rev. John G. Martin, past president of the American Protestant Hospital Association, and superintendent of the Hospital of St. Barnabas and for Women and Children, of Newark, N. J., a voluntary hospital of the Episcopal Church. The invitation of your chairman to appear before you and present the views of the American Protestant Hospital Association with regard to the National Health Act of 1945 is greatly appreciated.

I think, Mr. Chairman, there can be little criticism of the motives of those who support this legislation. We can fully understand their eagerness that the fine quality of hospital and medical service which has been developed in this Nation should be made available to every one of its citizens.

S. 1606 WOULD MAKE HEALTH CARE TOO MECHANICAL

Everyone engaged in the health field is equally anxious to bring this about. However, we are not sure that this legislation is the proper way. On the contrary, we, who have had long experience in the prac-

tical administration of making hospital and health care available, have grave apprehension as to certain dangers that we believe are inherent in the methods which are proposed under this legislation. If we were to state it briefly, we might say that the psychological aspects of hospital and health care resulting from its very personal nature have been completely overlooked by the proponents of this legislation.

At the edge of a small town of which I have heard there is a large traffic sign which bears this warning: "Slow down. Do you want to become a statistic?" Gentlemen, it is our fear that under this legislation which you are now considering the American people would lose their individuality and become simply a group of impersonal units in the matter of health and hospital treatment.

It has been impossible for me to give this bill the intensive study that I should like. However, I may note two or three items which tend to support our apprehension. Section 201 (a) promises that—

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

To me that calls up a picture of a social-security card and all the red tape and Government forms that will be necessary to be filled out by each individual when he becomes insured. Even more than that I can see the complicated procedure that would be involved at the time such a person enters a hospital for treatment because of the necessity of determining whether or not that person is entitled to treatment as a beneficiary of this Government program.

Then, in section 205 (a), I note that—

any physician, dentist, or nurse legally qualified by a State to furnish any service benefits under this title shall be qualified to furnish such service—

and so forth; and then in section (b)—

every individual entitled to receive general medical or general dental benefits shall be permitted to select from among those designated in subsection (a) of this section those from whom he shall receive such benefits.

This seems to be a process of matching the beneficiaries who are eligible to the practitioners who are qualified. Both eligibility and qualification will no doubt be determined according to regulations imposed by some central authority—in this case the Surgeon General. And the administration of health service will be in danger of becoming a purely mechanical arrangement instead of being administered according to need, with the personal relationship which now exists. The participants in this system would lose their individuality and become mere units.

I do not want to become a statistic. When I am ill I want to go to a doctor because I am John Martin, a friend of his, and a patient with whom he has a direct relationship. I want him to treat me as an individual; and I want his personal attention to my personal suffering. The same is true when I enter a hospital. I want to be treated as an individual with a personality of my own—with special attention to my particular needs. I fear that this personal relationship would not exist if I entered the hospital as simply another Government beneficiary entitled to a prescribed standard of care and nothing more. As long as I pay my own bill, by financial arrangements which I control, I have a great amount of control of the situation, even if I am ill.

Under our present system as it has become developed to a degree that is not surpassed anywhere in the world, the first consideration of service is the individual welfare of the individual patient; as far as is possible in a large organization, all procedures and treatment are directed to the accomplishment not only of physical healing but also of comfort and peace of mind while ill.

We greatly fear the substitution of uniform standards in place of this motive. The very best of standards cannot provide the incentive for improvement of methods of treatment that have been developed through the personal attention which we have striven to give the people of our country when they are ill.

I believe this factor might be demonstrated by observation of any of our church hospitals in comparison with hospitals operated by Government units. The church hospitals have been founded because of the desire to render a personal service to suffering mankind. For many people care of the sick is an outward expression of deepest religious urges. These high ideals have been carried over into the actual administration of care in these nonprofit hospitals.

On the other hand, hospitals operated by governmental organizations tend to be much more impersonal in their service. In these institutions allegiance tends to be to a set of purely mechanical standards. The patients are entitled to a set measure of care, and the absence of a deep urge of personal service tends to minimize the psychological factors which are of so much importance in treatment of illness and convalescence.

From very early history, treatment of those suffering from illness has been a traditional function of the Christian church. Church hospitals today are an important segment of the hospital field. I do not believe it is the purpose of the sponsors of this legislation to find fault with the quality of service that has been rendered in any of these church hospitals.

However, it now appears that in spite of the admittedly excellent service that is now being rendered, this legislation would interject the Federal Government into a position between the hospital and the patient. There would be a strong tendency to substitute adherence to the standards fixed by the governmental agency in place of concern for the patient's welfare. If this happens, the Federal Government then becomes the dominant force in the whole health field, and will tend to squeeze out the religious influences which have contributed so much to present-day developments.

HEALTH INSURANCE WOULD DISCOURAGE PRIVATE PHILANTHROPY

We are concerned about the entry of the Federal Government into this picture in place of private philanthropy and human service which has done so much for the health of our Nation. The genius of the American people has been exercised in making good use of private wealth. At death no one may take his money with him. As a result large fortunes have been returned to the people in the form of institutions of mercy and culture such as hospitals, orphanages, schools, and colleges. Foundations and endowments have provided the means for the care of millions who otherwise would have suffered severely. Entirely apart from the compulsion of tax levies, the philanthropic

contributions to build and perpetuate voluntary hospitals have been among the outstanding features of American social progress. We have the strong feeling that legislation such as this would discourage private charity, not only with a great loss in health services and facilities, but a sacrifice of those spiritual values which have contributed so much strength to our country.

We do not mean that the health of our Nation should depend entirely upon private philanthropy. But if the Federal Government takes over the entire health field, controlling it by the inevitable series of uniform regulations and minimum standards, what place will the religious organizations have left to them in this field which has been so important a part of their work?

We are also concerned with the apparent intention of the Federal Government to establish fixed standards which would be made to apply in all parts of the country regardless of local circumstances or needs. At the present time hospital and health care have developed more or less in accordance with local circumstances or needs.

Hospitals and health service have developed to meet the special needs which they have faced. Naturally there have been variances in standards and methods of supplying this service. As long as these services could be developed independently this has worked out very satisfactorily to supply the right type of care at the right place. However, if any Federal agency attempts to take over this program on a centralized basis, it will be immediately faced with problems which may throw the program into confusion.

It will be necessary to establish these standards on a uniform basis for all areas to avoid charges of discrimination or unfairness between those areas. The different needs and circumstances of the several areas will be so difficult to evaluate that these individual considerations will not enter the picture to any great extent.

However, it may be necessary to set these standards low enough to accommodate existing hospitals in certain areas which have not been fully developed and this will have a tendency to pull back those areas where hospital and health service have made their greatest progress. This would be extremely unfortunate because progress is not made uniformly throughout the entire field. Rather, improvement comes here and there, particularly in the more highly developed areas and tends to be copied by those who have observed its beneficial result. If you reduce the whole field to an average of mediocrity you may kill off this leadership which is the incentive to our continuing progress.

In this discussion, I would not want to make the impression upon you that we do not favor Government interest in the health field. Government has had and still has a very important function to perform in safeguarding and improving the general health of its citizens. It is our point that government should do this not by destroying a soundly developing system and substituting one of its own. Instead, the Government would be wiser to take advantage of the program that has so far been so successful and improve upon it by supporting and developing further the best features of the present system. I am sure you are aware of the great strides that have been made in recent years and are still being made today in the health field.

Blue Cross hospital prepayment plans already cover more than one-seventh of the population, and their enrollment of 21,000,000 people

covers 45 of the 48 States and is constantly increasing. Commercial insurance plans have also entered the field with a considerable number of beneficiaries estimated 15,000,000. Undoubtedly Blue Cross should be as well able to take care of the employed population as this measure of compulsory health insurance. In a very short space of time it has already accomplished a great proportion of that task.

We need more hospitals, and if Senate 191, the Hospital Survey and Construction Act, is passed by the House of Representatives, a great stride for improvement of this situation will result. This is the bill which was reported favorably by your committee last fall and passed by the Senate in December.

ENDORSEMENT OF TITLE I

However, neither system would take proper care of the needy, and for that reason we believe that a program of Federal aid for indigent care which is mentioned in title I of this bill is a proper field for Government activity.

The system we have in America today has served us well and has made notable progress. It is strong and healthy and continues to grow. We believe that the answer to the health problem of our country is the further development of what we have. We greatly fear that if attempt is made to spread this present system of hospital and health care too thinly and to suddenly, great loss of essential values will inevitably result. For that reason we believe the legislation before you should have the most careful and thoughtful study before any action is taken on it.

The CHAIRMAN. Have you any questions, Senator?

BLUE CROSS PLANS

Senator PEPPER. Reverend Martin, you have referred to the Blue Cross plans, which undoubtedly have been very serviceable to the country.

Do you know the total membership of the Blue Cross system by 1945?

Reverend MARTIN. Something over 21,000,000, I believe.

Senator PEPPER. The statistics that my staff on the subcommittee, of which I am the chairman, get, is 18,400,000 were reported covered by this type of plan.

Senator DONNELL. Pardon me. I think one of the officers of the Blue Cross brought those figures down to March of this year as 21,000,000.

Senator PEPPER. Very well.

In 1944, when they had 16,000,000, our staff discovered 13,400,000 only had hospital bills covered. Two million had surgeon and obstetric fees provided. About 100,000 had physicians' care in hospitalized illness. Only 50,000 were entitled to physicians' care in the home and office, as well as the hospitals.

So that whatever good it has done, it is far from providing for the people of the country the medical and hospital care they require; is that not true?

Reverend MARTIN. I might comment on that, Senator, to the effect

that the program for medical care is much younger than that for hospital care.

In the first 5 years of hospital care by the Blue Cross plans, the progress was extremely slow. It took time to educate the people to the value of that plan, but if you compare the first 5 years with the last 5 years, you will notice a tremendous increase in the membership.

Senator PEPPER. I say, at the present time, however, it does not meet the needs of the country.

Reverend MARTIN. Not yet; but give the medical plan a chance to develop, as the Blue Cross hospitalization plan, and I think we have reason to believe that that, too, will accelerate in a similar proportion.

Senator PEPPER. How many years under voluntary plans would you say would be required to give to the people of the country the completeness of coverage which is contemplated by S. 1606?

Reverend MARTIN. When we are predicting the future, of course, we are on uncertain grounds.

But if title I of this bill is enacted, and the Government supports the Blue Cross plans in every way possible, that will provide for the people of the country, in the first place, care for the indigent, adequate care for the indigent.

In the second place, it will urge upon the employed population of this country voluntary membership, and an adequate provision for their hospital and medical care, leaving the few people who do not desire to enter these things, perhaps because they are sufficiently affluent not to need it, to pay for their own care if they do not go in.

Senator PEPPER. I want to repeat my question. My effort was to get your opinion as to how long it would take, by the voluntary plans, to get to the people of the United States the degree of hospital coverage and medical care contemplated by S. 1606?

Reverend MARTIN. Why, I would hazard a guess of 10 years to give us adequate coverage for the population of the United States.

Senator PEPPER. You would estimate 10 years?

You know at the present time that only about 2½ percent of the population has complete comprehensive medical care under all the voluntary plans put together, and that only 10 percent of the population has partial physician's or surgeon's services with hospitalization included in some cases, and that only 12½ percent of the population have hospital care only, so that all the voluntary plans put together do not provide any kind of insurance at the present time to more than 25 percent of the population.

Reverend MARTIN. Well, the hospitalization plans are only about 12 or 15 years old. Give them another 10 years with constantly accelerating increases in membership, and I believe my prediction of 10 years is not very far out of place.

Senator PEPPER. I say, you are willing to have the Federal Government contribute under title I to the States to care for the indigent, are you not?

Reverend MARTIN. Yes.

Senator PEPPER. Have you made any estimate as to how much appropriation would be required for the Federal Government to provide for the indigent the kind of medical and hospital care which S. 1606 would provide the people covered by it?

Reverend MARTIN. I have not made any computations, but contrary to the opinion of some people, the people of this country have not been without medical care.

Even the indigent have not been without medical care. They have been cared for under the responsibility of the smallest unit of Government, the township and the city, and what they have not done has been taken care of by the voluntary philanthropic efforts of individual private hospital corporations.

Senator PEPPER. Are you aware of the fact that some 40 percent of the Nation's selectees were found unfit for military duty, at least one-sixth of which had defects which were remedial, and many had preventable physical defects?

Reverend MARTIN. I have seen such figures as that; yes, sir.

Senator PEPPER. Are you aware of the fact that more than 23,000,000 people in the country have some kind of chronic disease or physical impairment?

Reverend MARTIN. I have seen those figures, too, but I believe that the program we are developing with the constantly increasing emphasis on the medical research and with the increase in hospital care as would be provided in S. 191, that we will be making a great inroad into those problems and increasing the health of the country tremendously.

Senator PEPPER. Are you aware of the fact that on any one day, at least 7,000,000 people of the United States are incapacitated by sickness or other disability, half of them for 6 months or more.

Reverend MARTIN. That may be so.

Senator PEPPER. Are you aware of the fact that sickness and accidents cause industrial workers to lose 12 days' production a year, a loss of 600,000,000 man-days annually?

Reverend MARTIN. Yes, sir.

Senator PEPPER. You direct a hospital in Newark, N. J.?

Reverend MARTIN. Yes.

Senator PEPPER. Are you aware of the fact that 40 percent of our counties do not have a full-time public health officer?

Reverend MARTIN. Those figures should be open to interpretation. There are a great many counties that do not even rate a hospital, but because of the great ease in transportation, the patients in those counties could easily have access to the existing hospitals and the hospitals created by S. 191.

Senator PEPPER. Are you ware of the fact that 40 percent of your counties, with an aggregate population of 15,000,000 do not have a single recognized general hospital?

That in 1944, 553 counties had less than one active physician per 3,000 population, and 81 had no active doctor at all?

That 309 counties had less than one active physician for 3,000 people, and 37 had no doctor at all?

Are you aware of the estimate that half of the maternal and one-third of the infant deaths could be prevented if known measures were applied to them in this country, which you say is already getting all medical care it needs?

Reverend MARTIN. I do not say it is already getting it; I say we are in the process of increasing it.

Senator PEPPER. You did not say that, Reverend Martin, if I may say so. At least, I did not understand that.

You say the people are already getting medical care, but it is being done through philanthropy.

I wanted to ask you if you thought the American people were getting the proper care, all they need.

The Maternal and Child Welfare Bureau, or the Crippled Children's Bureau of the Labor Department, have put out the figure that if all the States had provided as good medical and hospital care to mothers as is provided, I believe, in Minnesota, that 3,000 a year would have had their lives saved, and their figures were also given with respect to infant care, if the children in all the States of this country had had available to them the kind of medical and hospital care available to them in the State of Connecticut, I think there were some nearly 10,000 children of this country who would have been saved every year, and you are a minister to whom human life means more than to anybody, and I am sure that if you could save the life of a child, you would do almost anything, make any personal sacrifice.

Reverend MARTIN. Yes, sir.

Senator PEPPER. If you could save the lives of men and women and children in this country, are not you willing to make a few concessions, and a few legalistic compromises, and help the people of the United States get a national insurance system, if that will save human life?

Reverend MARTIN. My belief is that real development of our present system would accomplish that better than a compulsory system.

Senator PEPPER. Well, would you be willing to have a group of students sit down and make a factual study of that question and be governed accordingly?

If they could show you that the voluntary systems have failed, and that it will take more than you estimated, 10 years, but a compulsory national insurance system of the sort contemplated could be provided, with a fund that would pay every doctor a fair fee for the service he rendered, and enable more students to become doctors, more nurses to become nurses, and more hospitals to be built, and better staffs to be organized, if they could show you that and it would save the lives of mothers bearing children, and people that are sick, would you support this bill?

Reverend MARTIN. If all those things could be accomplished that way, I would.

Senator PEPPER. But you do not think—

Senator DONNELL. Pardon me just a minute. I know the Senator did not mean to interrupt him. I do not think he had finished his answer.

Senator PEPPER. I did not mean to interrupt your answer, Reverend Martin.

Reverend MARTIN. If all those ideals you have outlined could be accomplished better by the system of compulsory health insurance, I would certainly be convinced, but I am not convinced now that that is so.

I am convinced that the voluntary method, which has been the genius of this whole country—

Senator PEPPER. Except when we fight a big war. It has not been the genius of the defense of the country.

Reverend MARTIN. That has not been the fault of the hospitals.

Senator PEPPER. You said that the voluntary systems have been the genius of the country; except when we fight a war we do not raise

soldiers. We discard the voluntary system because it would not defend our country.

The reason I ask that, Reverend, is this: If somebody comes in here and says that there is a provision in this bill which will destroy the initiative and the integrity and the professional quality of a hospital or its staff, then we want to see that provision in the bill, because we want to get it out of here. But most of the time we have the experience of a witness coming here—as you have seen some today—they will come here, make an over-all attack on this bill, say it is going to ruin the hospitals, destroy professional character, and so on and so on.

And then when we say, "Very well, if you do not want the Federal Government to lay down standards, we will just say any hospital presently meeting the States' standards." Such as the gentleman's hospital in New York.

That is already inspected by the State board of public welfare. So we say, "We will accept the State requirement."

He says, "No, that is not really what I have in mind."

And then he turns to some other provision in the bill.

When we say, "What does that do? What would you suggest to change that provision and make it conform with your ideas?" they say, "You might amend it a little bit, but that is not the real reason we object to the bill." It looks as if it is just a sort of a general emotional attitude of opposition, just like I am a Baptist, and I do not suppose that anybody could sell me some other religion from now until my last sunset, to join the Episcopal or the Catholic or any other church. It looks as if a lot of our friends feel that way about this bill, but I was hoping you would be willing to point out to us a provision in the bill that we can correct without destroying the heart of it, which is the right of the people of this country, and the working men who have been in here—we have not had any workingmen in here, except, of course, we had labor organizations; I say, any amendment that you or anybody else would propose to me, and I am sure our chairman would be even more gracious in his response than I would, that will make this a better bill, that will remove anything wrong that is in it, but at the same time will not take the heart out of it, namely, the compulsory insurance, through which almost every man and woman in the country can have the right to participate, and most of them will be compelled to participate if they are working, so long as you will do that, I will be most glad to hear what you say.

Reverend MARTIN. I think it is the compulsory feature of it that is not agreeable to most of our hospital personnel.

Senator PEPPER. Is the hospital or the man that has to pay the tax, the one that should make the principal objection?

Reverend MARTIN. When I say the hospital, I think I am representing the hospital's clients as well as the hospital management, the people who come into the hospitals.

They believe that they pay the bills now.

Senator PEPPER. Are you any better qualified? We are all here in the Congress of the United States. We were elected by the votes of our States. And if this Congress determines that it is the will of the people, the whole people of the country, you would not blame us for giving more responsibility and attaching a little more weight to

the people who elected us than we would to somebody like yourself, who is not elected?

Reverend MARTIN. That is true.

Senator PEPPER. I do not know whether the reverend would be required to pay any of these pay-roll taxes or not.

It applies only to people earning wages or salaries.

Let us see. Where do you derive your compensation?

Reverend MARTIN. I am paid by the hospital.

Senator PEPPER. By the hospital.

Reverend MARTIN. Yes.

Senator PEPPER. Well, in that case—

The CHAIRMAN. Self-employed people.

Senator PEPPER. If you were self-employed, you would be covered.

Reverend MARTIN. I am not self-employed.

Senator PEPPER. Perhaps you would be a salaried worker.

Reverend MARTIN. According to this bill, ministers are exempt, but a lay superintendent would participate.

Senator PEPPER. I thought that would be so. You individually are not coming here as a citizen protesting against the proposed imposition of a tax upon you by somebody in your Government?

Reverend MARTIN. It does not affect me at all personally.

Senator PEPPER. And the first thing this bill does is to make people pay a tax.

Reverend MARTIN. Yes, sir.

Senator PEPPER. And the second thing it probably will contemplate is that the Federal Government shall propose a subsidy to supply the difference between the amount of money raised by taxation on employees or employers, and the amount needed to carry out this scheme?

But, Reverend, we want you to know that we, too, have some respect for the institutions of this country, and for the people, and we believe some kind of compulsory insurance plan is the best way to help your hospitals.

Frankly, I am surprised at the hospitals of this country not being here en masse and saying, "Gentlemen, if you can enact a scheme which will leave us our proportional independence, and freedom from interference in the way we administer hospitals, but at the same time will assure us that practically every man and woman who comes to us and who needs us will have a fee paid for them commensurate with the service," it would seem to me that all the hospitals of the country should be here.

Senator DONNELL. Mr. Chairman, may I interpolate? I am sure the Senator does not speak for every member of the committee.

The CHAIRMAN. Of course not.

Senator PEPPER. Of course not.

Senator DONNELL. I understood him to say "We," and the witness might think that was all of us.

Senator PEPPER. I mean some of us, particularly myself, Reverend.

Reverend MARTIN. May I make a further remark?

Senator PEPPER. I think Senator Murray and I may be on the same side. There may be a difference between us and Senator Donnell.

Reverend MARTIN. Reference was made this morning to a conference, I believe it was in 1942, of the Social Security Board technicians with representatives of the joint committee of the Hospital Associations.

I attended that 2- or 3-day conference, and at that time we were assured that we were not discussing compulsory health insurance, and we gave every possible help we could to those technicians, telling them all we knew about hospitalization and its trends, its workings, and I am sure that committee must have gained a great deal from us.

Senator PEPPER. We welcome that information, Reverend.

Reverend MARTIN. But we were assured that compulsory hospitalization insurance was not a part of the conference, and we did not discuss that matter.

Senator PEPPER. Reverend, I am not quite clear right now as to the difference insofar as it affects your hospital, between this plan as it would work—except that different people would be making the decisions—and the way your hospital cooperates with the Blue Cross plan.

Will you tell us what happens when a patient, covered by the Blue Cross plan, comes to your hospital? Does he have the freedom of choice of hospitals?

Reverend MARTIN. Yes; he has freedom of choice of hospitals.

Senator PEPPER. Of all hospitals identified with the Blue Cross plan?

Reverend MARTIN. There are two types of participating hospitals and cooperating hospitals.

Those that are members of the plan who will accept the contract, and other hospitals that will accept the money without the contract.

They will accept the payments, but not necessarily guarantee the full service.

In those cases, the hospital will give the service, receive the money paid by the Blue Cross plan, and the balance of the bill is paid by the patient.

Senator PEPPER. How many hospitals are there in your city of Newark?

Reverend MARTIN. Seventeen.

Senator PEPPER. Seventeen. Can a person covered by the Blue Cross plan in Newark go to any one of those hospitals?

Reverend MARTIN. Any one of them.

Senator PEPPER. Before he goes there, does he have to get approval from anybody to go there?

Reverend MARTIN. Only his physician.

Senator PEPPER. But he does have to have the physician's approval?

Reverend MARTIN. He has to have the physician's approval.

Senator PEPPER. Before he goes to the hospital?

Reverend MARTIN. Before he goes to the hospital.

Senator PEPPER. Is the physician paid by the Blue Cross?

Reverend MARTIN. No; that is a private arrangement. It is the patient and the physician.

Senator PEPPER. Well, I am speaking about a patient that has complete coverage.

Reverend MARTIN. Yes.

Senator PEPPER. His physician, I thought, would be covered by the plan. The plan does not cover one's own private physician?

Reverend MARTIN. There are two types of coverage.

Hospitalization, and medical care. They are separate.

Senator PEPPER. I see. All right.

He goes to the hospital, then, and what does the Blue Cross do? Does the Blue Cross have anything to do with the kind of medical care given to him, whether he is operated on, or anything like that, or the laboratory or other equipment available?

Reverend MARTIN. He gets all he needs.

Senator PEPPER. He just gets all he needs.

Reverend MARTIN. He gets all he needs.

Senator PEPPER. If he is fully covered?

Reverend MARTIN. If he is fully covered.

Senator PEPPER. Then when the patient finally leaves the hospital, does the hospital submit a bill to anybody?

Reverend MARTIN. To the hospital-service plan; yes.

Senator PEPPER. To the hospital?

Reverend MARTIN. To the hospital.

Senator PEPPER. Do they have to keep books?

Reverend MARTIN. Yes.

Senator PEPPER. About the service?

Reverend MARTIN. Yes.

Senator PEPPER. And then does the hospital have any agreement as to a standard for the fees?

Reverend MARTIN. With the Blue Cross, yes. The regular schedule.

Senator PEPPER. And there is an agreed schedule of fees between the Blue Cross and the hospital?

Reverend MARTIN. That is right.

Senator PEPPER. Just exactly as this bill contemplates, there will be an agreed schedule of fees for medical services between the hospital and the Social Security fund that will cover these patients?

Reverend MARTIN. Of course, the figures are different. The figure, of course, in this bill, may be changed, but they seem inadequate now, the minimum and the maximum.

Senator PEPPER. For the hospital?

Reverend MARTIN. For the hospital; yes.

Senator PEPPER. \$7 a day.

Reverend MARTIN. Yes.

Senator PEPPER. Maybe so, but the Federal agency is authorized to negotiate with the hospitals, so the very fact that the hospital—that a point has been made of the fact that the Federal Security Agency might agree upon a schedule of fees with the doctors; do you know whether the doctors that serve patients under the Blue Cross plan also agree to a schedule of fees with the Blue Cross?

Reverend MARTIN. I believe they have.

Senator PEPPER. And that has not lowered the quality of service they give, has it, the fact that they agreed upon a fee and did not have the same kind of a fee that they would charge a stranger; that has not impaired the quality of the service rendered?

Reverend MARTIN. No.

Senator PEPPER. So that if this plan were run right, Reverend, if it were really run right in the spirit in which it is conceived, do you think there is anything inherently of necessity that would impair the quality of hospital service or medical service rendered to the people covered?

Reverend MARTIN. If it were run right and as well as we think it can be run under the present system, it would be all right.

Senator DONNELL. But you do not think it can be so run?

Reverend MARTIN. I do not think it can be so run.

The CHAIRMAN. Reverend, have there ever been any complaints on the part of insured under the Blue Cross system as to the quality and extent of the care they have received?

Reverend MARTIN. I do not know of any complaint. Every once in a while some patient has some complaint for some minor thing.

The CHAIRMAN. Have they complained at any time with reference to the character of the services that they have received?

Reverend MARTIN. No.

The CHAIRMAN. You do not know of any such complaints.

Now, Reverend, you are familiar with the social-security system which we have established in this country?

Reverend MARTIN. Yes.

The CHAIRMAN. You have no objection to that?

Reverend MARTIN. On the contrary, the hospitals have, for 10 years, been trying to get into it, and we have not been very successful so far. We would like to have our membership covered, too.

The CHAIRMAN. Well, there is a proposal now that the coverage under that system shall be extended so as to take in everyone, as far as it is possible.

Reverend MARTIN. For old-age and survivors' insurance.

The CHAIRMAN. You feel that under a compulsory system, such as we propose here, it would make every individual what you term a "statistic." Is that your view? It would make them a statistic? An individual under such a plan as this, we would all become mere statistics?

Well, you are familiar with the Workmen's Compensation Act, are you not?

Reverend MARTIN. Yes, sir.

The CHAIRMAN. Do you not think that already in this country individuals employed in our great industrial institutions are more or less a statistic now, under the present existing situation?

Reverend MARTIN. More or less so; yes.

The CHAIRMAN. Yes. You have no complaint to make of the Workmen's Compensation Act, have you?

Reverend MARTIN. No; none at all.

The CHAIRMAN. You think that is very advisable legislation?

Reverend MARTIN. Yes. Very good legislation.

The CHAIRMAN. And yet, there, under that system, they are furnished with medical care and hospitalization and are somewhat akin to what we are trying to do here.

Reverend MARTIN. But that is done under contracts made with the hospitals and groups of hospitals which provide adequate payment for their care.

The CHAIRMAN. Yes.

Reverend MARTIN. And, moreover, those payments are made not by the patients but by the employers.

The CHAIRMAN. Yes.

Reverend MARTIN. The Government comes in, and this might be a good thing to think of in regard to this bill—the Government insists that there shall be coverage. If the Federal Government should insist that all the people shall be covered by legislation, then it is just the

method of coverage in that voluntary way, and that might be an improvement in the bill.

The CHAIRMAN. Well, you do, though, approve of the Workmen's Compensation Act and the way it works?

Reverend MARTIN. Yes, indeed.

The CHAIRMAN. You recognize the fact that working people in this country have difficulty in earning sufficient to enable them to meet all of their living expenses and all of the costs of life in this country such as attending the children, clothing and feeding them, and providing medical care and hospitalization for them when they are sick?

Reverend MARTIN. I would say that that was so before the inauguration of the Blue Cross system, but since then, the low cost of membership in the Blue Cross plan has enabled those same people, low-priced workmen, to become insured.

I have employees in my hospital who are receiving less than \$20 a week, who are members of the Blue Cross and are hospitalized, receiving benefits therefor.

The CHAIRMAN. But, of course, the Blue Cross does not provide complete coverage or all their sicknesses that may develop in the family?

Reverend MARTIN. It covers hospitalization.

The CHAIRMAN. Yes; but it does not cover the ordinary illnesses that come up in a family from day to day.

For instance, I know a family here in town who just had three children get diphtheria and all sick about the same time. That is quite a burden on a family, is it not?

Reverend MARTIN. That is provided for already in our municipal medical organizations, the township or the city takes care of the indigent, and others go to the clinic in the hospital, and receive medical advice and care from physicians who do not charge for their services, and a large segment of the population is taken care of.

Those who cannot afford to pay for their own care, as soon as they can afford to pay for their own care, then they should pay something toward their care.

The CHAIRMAN. Do you not think it is desirable that a family should try to provide in advance for sudden illnesses like that?

Reverend MARTIN. I do. That is what the Blue Cross is for.

The CHAIRMAN. Yes; but it only covers hospitalization, and does not cover the illnesses such as I have mentioned.

Pardon me. I should have said "measles" not "diphtheria."

The Blue Cross plan does not cover those ordinary illnesses that come up in a family suddenly and very frequently, does it?

Reverend MARTIN. The hospitalization feature does not. It only covers hospitalization.

The CHAIRMAN. So, do you not think it is very desirable for families that have children like that, that they should undertake to safeguard themselves from those illnesses by providing in advance for some way of caring for them if it can be done within their means?

Reverend MARTIN. Yes. The medical-insurance plan would provide that at a low cost.

The CHAIRMAN. But sometimes they find it impossible to join those plans, because it is too costly, and they are kept out of them.

Reverend MARTIN. In those cases, I would say they belong in the

indigent class and should be cared for by the agencies giving free or part-free care to such patients.

The CHAIRMAN. But some of these families are very reluctant to accept that kind of care, and they would like, if they could, to pay for the care themselves, but would like to get it at a cost within their means, and they feel that a system such as we propose here, is the only manner in which they could provide in advance for complete protection of that kind.

Reverend MARTIN. I have a very firm conviction that the system that I have outlined, care of the indigent, as the responsibility of the Government, and voluntary philanthropic institutions for one segment, and I will say that in the modern hospital, I do not think that the psychological attitude toward those patients is unfavorable. They are received in a kindly, friendly manner, and we have paid social workers, whose special duty it is to hunt up those people and not only bring them to the hospital, but go to their homes and help teach them how to live.

The CHAIRMAN. You try to make it as easy as possible upon them?

Reverend MARTIN. Yes.

The CHAIRMAN. And to relieve their minds of the feeling of being unable to pay for their expenses for medical care?

Reverend MARTIN. That is correct.

The CHAIRMAN. That is all.

Senator PEPPER. Reverend, do you know of any voluntary insurance plans that give approximately, to the people of the country, the low cost of insurance that this bill is generally assumed by any of us to make possible?

For instance, half of the families of the country are supposed to have an income of less than \$2,000 a year, roughly.

For the breadwinner in a family making \$2,000 a year, even to pay 1½ percent, it would be only \$30 per year, and that would provide all the medical care provided by this bill, hospital and otherwise, for him and all the dependents in his family, if he had 5 or 10 children and a wife. They would all be covered unless they were independent in the sense that they were their own support.

That would be \$30 a year.

A large part of the population, we will say at least probably 14 or 15 percent, probably have a family income only of \$1,000 a year. In that case, they would only pay \$15 a year. The breadwinner, for covering for himself and all the dependents in his family, would pay \$15 a year.

Even if one were receiving the maximum that may be taxed under the supporting bills with this bill, or \$3,600, 1½ percent—it would be 3 percent, that would be only a little over \$100 for him, and all dependents, for medical services and hospital services and certain dental services, and including home-nursing services for the year.

Obviously, the broad phase of the coverage is what makes those low rates possible, and the fact that the employer is required also, in case of employees, to pay 1½ percent.

In your opinion, no voluntary plan would approximate that cheapness would it?

Reverend MARTIN. May I ask a question with regard to those figures?

Senator PEPPER. Yes.

Reverend MARTIN. I believe that the 1½ percent you referred to is the amount paid by the employee.

Senator PEPPER. That is right.

Reverend MARTIN. That is also matched by the employer, making instead of \$30 for the \$2,000 man, a payment of \$60.

Senator PEPPER. That is correct.

Reverend MARTIN. You asked me the plans that supply that service for \$60?

Senator PEPPER. I asked you whether you knew of any plan that would provide that service as cheaply.

Reverend MARTIN. For \$30?

Senator PEPPER. As \$30 to the employees.

Reverend MARTIN. I am not quite sure of the figures of the medical-service plan, but a family of any size in the hospitalization plan will be taken care of for \$24.

Now, you have \$36 left to go to the \$2,000 man, and with regard to the \$1,000 man, I do not think you should tax him. He belongs in the indigent class and should not have to pay any tax at all.

Senator PEPPER. The \$24 for hospitalization; that is only for hospitals?

Reverend MARTIN. That is right.

Senator PEPPER. And that does not cover the rest of the expenses?

Reverend MARTIN. But with \$60 of payment, there is \$36 more to go to the other plans.

Senator PEPPER. But the employer does not contribute as much as the employee under the Blue Cross plan.

Reverend MARTIN. In some places, the employers are contributing the entire amount.

Senator PEPPER. Is that voluntarily?

Reverend MARTIN. Voluntarily; yes.

Senator PEPPER. No one has any objection if they wish to do that. That is all.

The CHAIRMAN. That is all.

Senator DONNELL. Reverend Martin, would you tell us, please, what is the American Protestant Hospital Association?

Reverend MARTIN. The American Protestant Hospital Association is an association of hospital personnel, administrators, trustees, and other workers who are personal members of the hospitals of Protestant denominations as institutional members.

Senator DONNELL. How widespread is the membership?

Reverend MARTIN. There are about 300 such hospitals, I believe, in membership, and perhaps another 150 that are not members.

Senator DONNELL. And they all belong to the association. How widely are they distributed geographically?

Reverend MARTIN. All over the United States.

Senator DONNELL. And you are the past president of the association?

Reverend MARTIN. Yes; I was the last president.

Senator DONNELL. Yes, sir.

How long an experience have you had in the matter of the management of hospitals?

Reverend MARTIN. It will be 23 years next September.

Senator DONNELL. And you are now the superintendent of the Hospital of St. Barnabas for Women and Children of Newark, N. J.; is that right?

Reverend MARTIN. Yes.

Senator DONNELL. How large is that?

Reverend MARTIN. A hospital of 270 beds.

Senator DONNELL. Yes, sir.

That is all.

Senator PEPPER. No questions.

The CHAIRMAN. That is all. Thank you very much, Reverend Martin.

The next witness will be Father Schwitalla.

STATEMENT OF REV. ALPHONSE H. SCHWITALLA, S. J., PRESIDENT OF CATHOLIC HOSPITAL ASSOCIATION, ACCCOMPANIED BY M. R. KNEIFL, EXECUTIVE SECRETARY, CATHOLIC HOSPITAL ASSOCIATION

Reverend SCHWITALLA. Mr. Chairman, may I introduce Mr. Kneifl, executive secretary of the Catholic Hospital Association?

In case Senator Pepper gets into another arithmetic mood, I want to have some one to show me how to add one and one.

Senator PEPPER. If I do not get above two, I do not think you will have any difficulty.

Reverend SCHWITALLA. The trouble is when you get to two.

The CHAIRMAN. I think you will be able to take care of yourself very well, Father.

Reverend SCHWITALLA. I was going to compliment you before you start complimenting me, because I think you deserve it more than I do.

The CHAIRMAN. No; I do not think I do.

I think you have made a great contribution to the studies we have been carrying on here during the years. You have appeared many times, and we have always enjoyed your presence, and not only in the hearings but outside the hearings. We have great love and regard for you.

Senator DONNELL. May I ask the witness, Mr. Chairman, from what State he comes?

The CHAIRMAN. I wanted to bring that out myself. He is from Missouri. You know this is Missouri Day. You will have to admit that.

Senator DONNELL. Every day is Missouri Day.

Reverend SCHWITALLA. What is that?

Senator DONNELL. Every day is Missouri Day.

The CHAIRMAN. But you are a citizen of the United States, and you are interested in the welfare of all the people of this country, not only the people of Missouri.

You are faring pretty well in Washington.

Reverend SCHWITALLA. I would not be too sure of that.

I think they are more or less identified and that is what we are complaining about.

I recall, Senator, the days when you and I discussed these questions, began discussing them 12 years ago.

The CHAIRMAN. Yes.

Reverend SCHWITALLA. And I recall my visits here, and when I compare the directness and the relevant A, B, C character of your questions in those days with the Ph. D. character of your questions here today, I can readily see that you have done something in the last 12 years.

The CHAIRMAN. Well, Father, you have contributed greatly to my education during those 12 years, and I think as the result of your many hearings here and my many private conversations here, I have learned a great deal.

Reverend SCHWITALLA. I am going to test that out right away.

INTRODUCTION

I am appearing before this honorable committee on behalf of approximately 1,100 institutional members.

There was no vote taken on that number, and I will be glad to describe later on how I have the right of representation of all those institutions.

Hospitals and allied agencies which constitute the membership of the Catholic Hospital Association and approximately 96 percent of the Catholic institutions of this kind in continental and territorial United States.

These institutions, as is well known, are the most compactly organized group within the voluntary hospital field, being bound together, as they are, by a common purpose, a common outlook on life, a common attitude toward the patient, a common motivation which is spiritual and religious, and by a common desire to retain in and, if it should not be there, to introduce into the care of the sick not only the highest scientific and professional, but also the very highest spiritual and religious influences.

I emphasize all this and restate it here since I wish to have it understood by all that in representing here as I do, approximately 20,000 of the Catholic Sisters and Brothers of the United States with their numerous friends, their well-wishers, and their sympathizers, together with equal numbers of other Sisters and Brothers, there are no other considerations uppermost in my mind than those worthy of the privilege that is mine to represent before this august body with its huge responsibilities for the Nation's welfare, a group of persons who have bound themselves by the most serious and uncompromising ties to work unselfishly for no other purpose than the welfare of the three million and a half patients entrusted to them in the course of each year, and to do this under the inspiration of the highest possible ideals and under the stimulus of the most completely selfless motivations.

The CHAIRMAN. I am sure we are all satisfied with that, Father. I think we are all absolutely in accord with that statement, which you have made.

Reverend SCHWITALLA. Thanks very much for your confidence, Mr. Chairman.

COOPERATION BETWEEN PUBLIC AND PRIVATE AGENCIES

The Catholic Hospital Association endorses with particular satisfaction the intent of parts A and B of title I of Senate bill 1606,

singling out for its special endorsement the authorization for appropriations for venereal-disease prevention, treatment, and control, for the prevention, treatment, and control of tuberculosis, and for the extension and improvement in public-health work.

If the Catholic Hospital Association would prefer a liberalization of the provisions throughout these parts of title I of the bill, as it does, it would like to focus attention upon the great desirability of facilitating in some way by administrative provisions, the use of private agencies in the public-health program and of explicitly providing in the bill for such cooperation with the private agencies.

The Catholic Hospital Association sees no convincing reason why the term "public-health services" should be regarded as synonymous with services rendered by public agencies in the field of health. Many of the private agencies are carrying on public-health activities of a high order of excellence, and that is true of some of our Catholic hospitals.

Hence, to give an example of what I mean. The bill provides in section 314 (2) (H) page 7, lines 6 to 13—

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

There seems to be no detectable reason why cooperation and working agreements should not be secured between the State health agency and private agencies as well as between the State health agency and "other public agencies." Hence, the Catholic Hospital Association would welcome the insertion of the words "or private" in the appropriate places in the paragraph which I have just quoted so that it would read as follows: And then in the paper you have the rereading.

Provide for cooperation and when necessary, working agreements between the State health agency and any public or private agency or agencies administering services related to the public-health services furnished under the State plan including both public and private agencies concerned, et cetera.

This rewording would harmonize the wording in the present paragraph with the wording concerning the membership of the council (p. 6, line 22) where it is provided that the advisory councils should be composed of members of the professions and agencies, "public and private."

Further insertions of the word "private" in conjunction with the word "public" are suggested in other sections of the bill so that provision may be made for securing the cooperation of the private and the voluntary agencies in the maternal and child-health services and in the services for crippled children. These amendments pertain to sections 122, page 15, lines 18, et cetera, and section 124, page 18, lines 20.

It is recognized that in accordance with recently prevailing practice, this health bill do doubt intends to continue the cooperation between the public and private agencies, but there seems every reason for insisting that an explicit statement such as we are here suggesting is not only desirable but also necessary.

Emphasis should thus be placed upon liberalizing the whole program. Conditions differ from State to State and from locality to locality and

there should be provisions in the bill permitting the use of a wide variety of cooperating organization, thus to meet the conditions and needs existing in different States and in different localities.

THE FUNCTION OF THE COUNCILS

One of the requirements for the approval of the State plan for securing grants as provided for in section 314, is that the State health agency administering public-health services—

shall have authority to make and publish such rules and regulations as are necessary for the efficient operation of such services, having special regard for the quality and economy of service.

It would seem that as far as the bill is concerned, no provision is made for submitting these rules and regulations to the judgment of the advisory councils provided for in a previous paragraph. It is suggested, therefore, that paragraph (I) should read as follows:

Provide that the State health agency (or other State agency administering public-health services under this plan) shall have authority to make and publish with the advice of the advisory council or councils, such rules and regulations, etc.

Insertions of the same words and for the same reasons should be made in those sections of the bill in which similar provision is made for the publication of rules and regulations by the State agency in matters pertaining to maternity and child welfare in matters pertaining to services for crippled children.

HEALTH CENTERS AND PLANNED PARENTHOOD PROGRAMS

The Catholic Hospital Association desires to call special attention to the possible use of the health centers authorized under various sections of part A of title I of this bill as centers for the education of the people in planned parenthood programs. Paragraph (f) of section 314 defines in its second part, already alluded to, the requirements of a State plan in order that the State might qualify for participation in the grants under the authorized appropriation.

One requirement which the State must meet is that the State plan must provide for cooperation between a public-health agency and the State health agency. Furthermore, in the division of public-health work it is said that this term includes besides other things and services—the production or procurement and distribution of therapeutic and prophylactic preparations.

Evidently, the intention of the bill is to insure the widest possible usefulness and distribution.

The Catholic Hospital Association wishes to point out that a representative of the United States Public Health Service has already expressed himself in a published statement on the significance of the grants for public-health work which are to be authorized through Senate bill 1606.

Speaking before one of the national associations specially interested in planned parenthood, this official said:

I speak of the health center as a new concept, and one with peculiar meaning to this group. For these centers would be the primary protectors of the health—physical and mental—of the entire American people. They would be located so as

to be within reach of every family, every individual. Through them, preventive medicine of every type, could be truly realized.

After having held out this hope for a future expansion of their opportunities to the members of an association specially interested in parenthood planning, and lest there be any misunderstanding of his meaning, the speaker went on to discuss the mode or operation of the health centers as part of the venereal-disease and tuberculosis-control program but also as a part of a possible planned parenthood program. He said :

In States like North Carolina, Alabama, and several others which have decided that child-spacing programs should be part of their public-health activities, these health centers would house clinics for that purpose. It is the policy of the Public Health Service to cooperate with the health departments of the State in the programs they carry on for the protection and advancement of the health of their people. Any State deciding to develop a planned parenthood program could expect from the Public Health Service the same consideration that would be given to any other proposal in connection with its State health work.

The speaker was, of course, not alluding directly to S. 1606 because at that time the bill was not in its present form, but he was summarizing "The postwar planning of the Public Health Service" which has for its purpose—

make available to every family the health services it needs and should have.

Besides, the definition of public-health work as contained in the present bill is in complete harmony with the understanding of the public-health official whom we have here quoted.

I know I am here raising extremely difficult issues. I know, too, that the Public Health Service has committed itself as a policy to cooperate with the various public health programs in the various States; so that, if in a State planned parenthood is defined by statute or regulation to be part of the State's public health program, the policy to which I have just referred in the quotation is carried out; that is:

It is the policy of the Public Health Service to cooperate with the health departments of the States in the programs they carry on for the protection and advancement of the health of their people. Any State deciding to develop a planned parenthood program could expect from the Public Health Service the same consideration that would be given to any other proposal in connection with its State health work.

On behalf of those citizens of our country who regard planned parenthood, as practiced through contraceptive procedures or preparations, as basically subversive of the moral law, as destructive of the welfare of the Nation and of individual morality, I recommend and request changes in the content and the language of the bill, so that grants from the Federal Government to the States for public health services may not be used for the furtherance of programs which, no matter how controversial the issues might be, are still condemned by the Criminal Code of the United States and are offensive to the convictions and beliefs of large percentages of the population of these United States.

Senator PEPPER. Excuse me, Father. Do you not think, having quoted the statement, you should give the author of the statement for the record?

Reverend SCHWITALLA. I would be glad to give it to the secretary and to you, unless the chairman rules otherwise.

The CHAIRMAN. That is satisfactory.

Reverend SCHWITALLA. If that is satisfactory, I do not see any special purpose in publishing the name of the author.

Senator PEPPER. If you are going to quote the statement and say that the person is within the Public Health Service, I think you should.

The CHAIRMAN. I think if he gives it to us it is all right.

Senator PEPPER. Is there any reason for that?

Reverend SCHWITALLA. I have a little feeling about that, Mr. Chairman, unless you want it done.

The CHAIRMAN. We will not insist on it.

Reverend SCHWITALLA. I will give it to you right now, and if you will give it to the secretary, he can take the name right now. It is rather a high official in the Public Health Service.

Senator PEPPER. The statement, as far as I am individually concerned, I might not have an objection to the statement, but someone might have objection to the statement.

It is attributed to the Public Health Service, and to an official, so that if it is an objectionable statement, it is the basis of a complaint against the Department, and yet who the person is or the position he had or the authority he had, is not revealed in the authorship of the statement.

I thought if you were going to use it at all, it would be fairer to the Public Health Service to disclose who the person was.

Reverend SCHWITALLA. It was not a secret quotation at all, because it was made in a public address at the Waldorf Astoria, January 24, 1945.

Mr. Chairman, I submit myself.

The CHAIRMAN. Father, you are willing that the committee should have access to it. That will be satisfactory.

Reverend SCHWITALLA. Yes. I think a lot of people probably know this gentleman.

The CHAIRMAN. Yes.

Reverend SCHWITALLA. I regard him as a friend of mine.

He knows I am going to quote him. The amenities have been taken care of. I do not believe it is wise to spread this name abroad among other people.

Some of the Sisters are in here and some of the Sisters know this man. There is no necessity of putting him into a certain category. I have a feeling that the Sisters might have a certain resentment about the statement. Why increase that?

Senator PEPPER. I cannot lend my acquiescence to the quotation of a public officer, and then a declination to give the official's name in a public discussion of the matter.

I do not want to be in any sense of the word objectionable, but I just do not think that is of propriety, to quote in the record in a prepared statement a public official of the United States Public Health Service and not disclose who the official is.

The CHAIRMAN. Well, the committee will have access to it, and it seems to me that that will be sufficient. If, after further study, I should change my mind—

Senator PEPPER. As far as an individual member of the committee is concerned, I will not agree to be bound.

If I determine that I desire to disclose the name of the person, Mr. Chairman, I shall feel free to do so, as a Member of the Senate, and a member of this committee.

I do not think this is a secret session, and unless there is some special reason, I do not see why we should do that.

Senator DONNELL. Mr. Chairman, I find myself in accord with the Senator from Florida. I do not mean to embarrass the Reverend Schwitalla, but I do believe it is a matter of public concern, and I should feel exactly as the Senator from Florida has expressed himself.

The CHAIRMAN. Well, Father, if you wish to comply with the request of the Senators, you may do so.

Reverend SCHWITALLA. Well, I certainly have no wish to stand on any constitutional rights here. I think I have them, but if the committee wants them, it was an address by R. C. Williams, M. D., Assistant Surgeon General, Bureau of Medical Services, Public Health Service.

Senator DONNELL. Thank you.

Reverend SCHWITALLA. The address was made before the twenty-fourth annual dinner meeting of the Planned Parenthood Federation of America.

The title of the pamphlet is Responsibility for the Health of Tomorrow's Family. The place was the Waldorf Astoria, New York, January 24, 1945.

I made it my business to find out whether the policy of which Dr. Williams here speaks; namely, that it is the policy of the Public Health Service to cooperate with State plans without discriminating with reference to individual phases of a public health program. I made it my business to find out whether that was or is the policy of the Public Health Service.

I understand, from several inquiries that it is, and that when funds are given by the Public Health Service to the States for the extension of public health services, it is the State's program that is accepted.

Now, that evidently is at the bottom of this whole situation, and I think it is not without some bearing upon the whole situation here that we are discussing in this committee.

THE MEDICAL CARE OF NEEDY PERSONS

The Catholic Hospital Association regards it as one of the desirable features of this bill that it actually makes provision for the medical care of needy persons. Such a provision is, of course, indispensable in any comprehensive national health program.

The question may, however, still be raised legitimately whether the indigent should be taken care of in his illness through the special provisions of a public assistance program or whether we should not rather make efforts to take care of the needy through the same program through which the contributors to the program, in this case the wage earner, is taken care of.

As a matter of fact, at the present time, if the situation is carefully analyzed, the hospitals and the physicians who are most keenly alive to their obligations draw no line of distinction between the paying patient and the nonpaying patient. Even if the sarcastic cynic or the scoffer sees that such idealism is all too rare to constitute a real factor in the health care of the Nation, it still remains true that the physician and the hospital and the nurse must treat a human being as a human being according to the basic requirements of any reasonable system

of ethics, irrespective of the paying capacity of the patient. Such has been the standard which the Catholic Hospital Association in conjunction with the other hospital associations has always held up as a basic principle for insuring proper medical care of the indigent.

It is true that our public hospitals have been the bearers of the obligations of society to give hospitalization and medical care when it is needed to the completely or partially indigent, but in doing this I wish to visualize their functioning not as agents of government but as agents of society assuming the obligations of society for its most needy members and thereby sharing with the voluntary hospitals, which are also agents of society, this prime and indispensable duty—a duty which arises from the fact that society has been inadequate to supply the needs to all its component members for food, housing, clothing, employment, recreation—this neglect, no matter how inevitable it might be, resulting in the sickness or disability of the indigent or the medically indigent.

Still, I have no quarrel with the provisions made in section C of title I, and I leave it to those more expert than myself in this field of public assistance to suggest amendments, if the need for any seems to be indicated. Of course, if the Catholic Hospital Association were to assume a favorable attitude toward title II of the bill, then I would make as strong a plea as my command of language would permit to omit part C of title I and to make the care of the indigent or the medically indigent a part of the compulsory national health program. It is unthinkable to me that if the day ever comes when we shall finance a compulsory national health program through prepaid personal health service benefits, we would be content to still segregate benefits to the indigent or the medically indigent in the special assistance program. I would have to insist that the care of all of the people of the Nation should be financed through the prepaid personal health service financial program, but, fortunately, I do not have to face a discussion on this very important point even though it is controversial in S. 1606.

BENEFITS FROM FUNDS ACCUMULATED THROUGH PAY-ROLL DEDUCTIONS

It is worthy of note that S. 1606 sedulously avoids all direct reference to compulsion. The extent of the person health service benefits are specifically defined and these consist of general and special medical benefits, and so on, all purchasable through funds authorized to be allotted to the personal health services account to which there is to be credited by the Secretary of the Treasury, amounts equivalent to 3 percent of the wages paid after a stipulated date with respect to employment but for wages only up to and below \$3,600 per annum.

While, therefore, the compulsory element is understressed, it is clear that through the tax on wages, the legislation becomes definitely compulsory and it becomes compulsory, moreover, with specific reference to health insurance as the procedure through which the contributing wage earner is to purchase his health protection.

Now, the interesting point about all of this to me is that there is really a compulsory or an obligatory feature in health care. It is man's duty to take care of his health and of the health of those who are dependent upon him and that duty is binding upon him by virtue

of the natural law which obligates every reasonable and rational human being and which exercises compulsion over man within the full limits of his financial and physical capacity to obey it. This obligation is the same kind of obligation as man's loyalty to his country, man's obligation to worship God, man's obligation to respect the rights of his neighbors. The compulsion arises from the full effectiveness and force of the natural law and from its universality. Hence, man is a trustee of his life and health and not the owner of them, a trustee for the health of the members of his family and not the owner of that health. If man willfully and maliciously or through culpable negligence disregards his own health or that of his family, he is subject to severe censures before the tribunal of God no matter what individual persons might think of him. The compulsion in this obligation, like so many of the obligations of the natural law, though binding on the individual, still leaves the individual free, leaves him free in the full enjoyment of a vast freedom because the obligation is not specific with reference to this or that method of living up to my obligation.

Man is not obligated to choose one method rather than another of safeguarding his health. Man is not even bound to use the best possible means or allegedly the best possible means of safeguarding his health. He may, as a matter of fact, choose to safeguard it at the cost of seemingly disproportionately large inconveniences or sacrifices. Moreover, the obligation of man in safeguarding his health may have to yield to higher obligations, as for example, when a man deliberately chooses to expose his life to danger in the defense of health or life dear to him or of his country. This means also that health and for that matter, even life, is not an absolute good but only a conditional and a contingent good. All of this means that the observance of man's obligation to safeguard his health, though the obligation is a compelling one, is still subject to the prudence, the good judgment, the free choice of the individual who conforms to the basic law. There is compulsion, therefore, with reference to the safeguarding of man's health; there is no compulsion arising from the natural law to choose this rather than another form of providing for his health.

Furthermore, positive law, such as the law which S. 1606 seeks to enact, may restate and reemphasize the dictates of the natural law. The moral obligation can be desirably fortified through emphatic restatement, but, be it noted, the positive law which we are dealing with in S. 1606 goes far beyond the compulsion of giving care to man's health; it seeks to compel him concerning the method by which man is to implement his observance of the natural law. It imposes upon man the obligation of seeking to fit himself into a "newly to be created" scheme of things, into a prepayment plan and not into a voluntary prepayment plan but into a prepayment plan which deducts an imposed percentage from the earnings to which man has a right; it imposes upon the wage earner, the obligation to fit into an elaborate program of controls of medical, and dental, and nursing, and hospital care.

To make sure, moreover, that controls of these elaborate systems are effective, the bill proposes coercive and compulsory features with reference to the professions, no matter how we may try to palliate these compulsions. In brief, once we begin with the imposition of a specific obligation, we necessarily are forced to adopt a long sequence of coer-

cive measures with reference to the payments by the wage earner, the professions concerned with health care, the controls and counter controls by Government officials and the whole coercive set-up of a compulsory national health program. We recognize the compulsion of the obligation but we deplore the compulsion as to the methods of complying with that obligation.

In view of this reasoning, it would seem to follow that to deprive a man of the reasonable right of choice in his compliance with a recognized obligation is a most serious matter and such privation cannot be justified unless there are solidly and acceptable reasons for doing so. Are there such reasons? Is it apparent that the system of private initiative in medicine has so completely failed as to justify this extreme compulsion? Moreover, is it apparent that a compulsory system is going to be effective in remedying the alleged or even the actual shortcomings of a system of private initiative? Is it apparent that all the individuals whose pay rolls are going to be put under contribution are so dissatisfied with the present methods of taking care of one's health that they will willingly undergo the serious inconveniences which are implied in a compulsory system such as is here projected? Is it apparent that society is so seriously endangered by the system of private initiative as to make this compulsory system immediately imperative? These are the questions which I believe, must be answered before we can justifiably pass a law such as we are here discussing.

The compulsion of which we are here speaking implies the giving up of considerable freedom and the relinquishment of considerable responsibility. We cannot create an intelligent and enlightened and a responsible citizenry unless we entrust duties and obligations to that citizenry. To remove responsibilities from man is not to elevate him but to degrade him. To take away from him the obligations of maintaining himself and his family in a state of refinement and fuller living is not to foster that man's character but to weaken it unless the removal of responsibility from him is accomplished with a clearer understanding of the reasons why that relief is given to him. To make a strong nation requires that man must be given responsibility rather than to have responsibility taken away from him.

If society could not create and could not maintain the processes by which the human being can meet this obligation of his health care, then the Government would have to give aid to society and ultimately to the individual so that society might meet this obligation. But even in that case, the Government would not be permitted in any reasonable interpretation of ethical principles to ride rough shod over the obligations of citizens but would have to respect the rights of human beings insofar as this is possible under the concrete circumstances of each given situation.

Two questions present themselves in the face of all this: First, can society create and maintain the processes by which in our present question, the health of the Nation can be safeguarded; and secondly, what particular characteristics and capacities of the individual must be protected if Government feels itself obligated to interfere in the individual's responsibility for his own health care and of his dependents.

With reference to the first question, can society really create or maintain the processes necessary for safeguarding the health of the

Nation? If our question pertains to American society, my answer is unhesitatingly and unqualifiedly an emphatic "Yes." It has done so and one by one disease entities have received mortal blows from the votaries of American medicine, from the research workers who understand the biological processes that have yielded such amazing triumphs. It is now said that through the aid of the Government our schools of medicine can be still better protected just as our research can be more emphatically fostered and the pertinent sections of S. 1606 are significant and at the same time, most valuable contributions to afford the proof that society and Government in their wisdom have realized that through Federal aid in these two important areas, much more can be accomplished than has already been achieved. It would seem therefore, that with miracles such as we are here discussing already accomplished, no one would dare say that limits have been set to the effectiveness of private initiative. Through the glorious pioneering of our American investigators, and through the discoveries and the daring aggressiveness of those who widen the horizons of man's thinking, it should certainly be possible to bring the whole American people under a voluntary health program since problems of so much greater difficulty have already been successfully solved. The proof, therefore, cannot be brought and to my thinking, will not be developed, to show that society is incompetent to cope with this problem through the processes that have already been employed in the solution of much greater problems. If we can achieve our purpose through the encouragement of voluntary initiative, we shall strengthen the sense of responsibility of the individual, we shall safeguard the dignity of the individual as that of a person who is intellectually and emotionally competent to make his own choice concerning the manner in which he obeys the natural law to which he is subject. From all of this it becomes apparent also what features must be preserved in the re-emphasis upon the importance of each one's obligation to fulfill this basic responsibility.

ADMINISTRATION OF A NATIONAL HEALTH PROGRAM

Once it is admitted that a compulsory national health program is to be initiated, then it can easily be seen that such devices as are contrived in S. 1606 for the administration of a national health program become all but necessary. If there is to be, as S. 1606 contemplates, a compulsory national health program, I for one would have to insist that responsibility for it should be centralized, that there should be drafted rules and regulations which would ensure a measure of uniformity in the whole program, that these rules and regulations should be such as to be more or less universally applicable and that the rules and regulations be written so as to simplify administrative procedure. I can easily understand that routinization, mechanization, standardization of the procedures should be effected so that the costs of the program may thus be minimized and so that, furthermore, the most easy approach be made to the generality of the people whom the program is devised to protect. Hence, I can see why so much power should be entrusted into the hands of the Surgeon General and why there should be the special kind of an Advisory Council which the bill creates and why there should be certain kinds of appeal bodies and why the

Surgeon General should himself be the arbiter, legally constituted, of controversies which his own actions may have evoked and why all the other numerous provisions of the Bill should follow as necessary corollaries from the necessary concentration of administrative power.

But think of what all of this is doing. First of all, to the insured person; secondly, to the professions of medicine, dentistry and nursing; thirdly, to our hospitals; and fourthly, to society at large. It has been said, and we must pay our respects to the writers of the bill for at least thinking of this concept, that the methods of administration should be drafted so as to ensure—

the prompt and efficient care of individuals; promote the personal relationship between physician and patient; provide professional and financial incentives for the professional advancement of practitioners and encourage high standards in the quality of services.

But frankly, I cannot help but wonder whether the personal relationship between physician and patient can possibly be promoted through such a system as S. 1606 proposes. I would seem to me that at ever so many steps in the contact between patient and physician, there would be injected into the patient-physician relationship, extraneous considerations of the most diverse kinds. The physician would be expected to make reports to his government; to maintain records quite different from the case histories which he now maintains and which would be prescribed for him; he would lose a great deal of contact with his patients through the fact that he receives a stipulated sum from Government sources. Since he is being paid on a service basis and on the basis of a fee schedule, he would be bound to lose the proper attitude toward professional remuneration which in any true concept of medical care is regarded only as a token payment and not in any sense as a wage or salary or stipend but only as an honorarium. All of these consequences would be found to follow as I see it and from all of them, there would also necessarily be bound to result a deterioration in the character of medical practice. There would almost of necessity be a commercialization and the material outlook upon practice which would thus be fostered might actually result in serious consequences to the whole concept of medical care for the American people.

As for the professions, I wish again to express my appreciation of the fact that the hope was formulated in the bill that there would be no enslavement of the medical profession or of the other health caring professions through S. 1606. I wish I might be able to share this optimism, but as I see it, centralized control would be inevitable and that means control through regulation and control through regulation means a curtailment of freedom of action and such a curtailment in turn means a loss of interest in one's professional activities. And so a chain of successive causes and effects would be initiated, the end of which, taking human nature as it is, would lead to nothing else but what has been eloquently envisaged by others who have testified before this honorable committee.

With specific reference to the hospitals, I wish to join others who have expressed to this committee their gratitude for the committee's success in dealing with S. 191. We entertain the fondest hopes for the success of this forward-looking, constructive and socially minded legislation. We know, however, from experience how difficult it is to

operate hospitals under a rapidly increasing multiplicity of rules and regulations. The voluntary hospitals will react with a generosity, effectiveness, and enthusiasm once it becomes clear to them that the Government really wishes to enter into a whole-hearted partnership with them and once it is made obvious that the institution will not face bankruptcy by assisting the Federal, State, or local government in bearing a disproportionately large part of unremunerated costs.

The bill itself suggests with reference to the hospital that there shall be paid for hospitalization not less than \$3 and not more than \$7 for each day of hospitalization if the period of hospitalization is not in excess of 30 days; and not less than \$1.50 and not more than \$4.50 for each day of hospitalization in excess of 30 days. It is true that the bill entrusts to the Surgeon General responsibility for entering into contract with participating hospitals for the payment of the reasonable costs of hospital service, but it should be noted that such negotiations are to be within the maxima and minima established in the bill itself. What is even more astonishing is that the bill itself specifies that such payment made by the Surgeon General to the hospital must be considered—

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.

It has been a problem to me right along to really see why that provision was introduced in that bill. I think it is one of the most difficult phrases in the whole bill, and I cannot understand why it has been introduced there.

I fear that on the basis of experience, such provisions as these will almost of necessity lead not only to dissatisfaction on the part of the cooperating hospitals but may even lead to progressive disregard of the patient. It is becoming a serious question whether the voluntary hospital system can maintain itself if it accumulates more and more of a percentage of patients for whose care, for one reason or another, the hospital is not receiving full costs. A continuance and an enlargement of such responsibilities under conditions here referred to will undoubtedly imperil the stability of the voluntary hospital.

I would to inject another thought. I am here as a representative of a university hospital, which has a per diem cost of \$4.10 chargeable against the hospital because the university carries the remainder of the expense. That expense is not chargeable against the hospital. Therefore, I am not making a plea here for any sums of money that I, personally, am interested in, but I would hesitate to underwrite a statement that I am accepting \$7 fees in full reimbursement for the cost of essential hospital services.

HEALTH SERVICES AS BENEFITS

There is a surprising, astonishing, and unique feature in S. 1606, the full import of which I have thus far failed to fathom. In the old-age and survivors program as well as in the unemployment program, I find that the benefits all take the form of a direct cash payment to the beneficiary. In this way, the dignity of the beneficiary is safeguarded. The Government indicates to him or to her that the beneficiary is trusted to use his ingenuity or his initiative or his honesty

to provide for himself through the medium of purchase with these cash benefits, such commodities as the beneficiary chooses to purchase. For some reason or another that I cannot understand, the situation is quite different in this health insurance. The benefits take the form of services to the beneficiary. The strange thing is that the services are not furnished by Government officials, at least according to S. 1606, but by those doctors, dentists, nurses, hospital administrators, laboratory technicians who have signified their intention of obeying certain regulations laid down by the Surgeon General in pursuance of which they will furnish their respective service to, not the Government but the patient.

In the old age and survivors program and in the unemployment program, there is a relatively simple contract, a contract between the employee who in cooperation with his employer pays a certain amount of money into the Federal Treasury and the Federal Treasury in turn, on the occasion of a predefined contingency, makes a corresponding payment to the individual citizen. In the health care program, however, there is a tripartite and probably a multipartite contract. The least complicated situation is a contract between the governmental agency, the physician or hospital or nurse or dentist and the patient. To make matters worse, this tripartite agreement is superimposed upon a basic and fundamental mutual contract, the contract existing between the patient and the nurse. There are complexities developing from this pyramiding of responsibilities which are most difficult to understand. Let us take the patient-physician relationship, as an example, particularly apt since in the bill itself, one of the purposes is defined to be the fostering of the patient-physician relationship. In its simplest form, that relationship demands a man-to-man contract with the patient having a certain priority of rights because he is in need and the doctor have a priority of privilege and obligation because of his professional standing and his ability to give to the patient what the patient needs.

Over and above this relationship, the patient who is a wage earner and is employed has entered into another contract with his Government by virtue of which the Government will supply funds to an as yet indetermined individual under certain contingencies. That is contract No. 2. Now the patient chooses a physician, let us assume within the panel. That contract is something quite different from the ordinary contract of the patient-physician relationship and hence, it is contract No. 3. The reason why this contract is different from the ordinary contract implied in the patient-physician relationship is that an extrinsic agency, now the Government, makes itself responsible for what is definitely called pay in the bill and because another extrinsic agency, the Public Health Service under the Surgeon General, makes itself responsible for regulating in a number of very specific ways, the relationship between the patient and the physician. There may ensue a contract No. 4, if a patient is sent to a hospital, and the hospital is chosen under the provisions of the bill, and contract No. 5 if the patient requires a nurse, and contract No. 6 if the patient requires the need of a consultant or specialist and probably contract No. 7, because the bill makes special provision for laboratory benefits. And all of these different contracts are modified and influenced by the other provisions of the Social Security Act, particularly eventual compensation for the wage losses due to illness.

Why all of this is necessary is very hard to see and I still feel that if there is to be any compulsion with reference to the elimination of a choice as to the method by which I secure my health protection, I should prefer a straightforward cash indemnity basis. I do not see why the freedom of the professions must be endangered in order to safeguard the health of the Nation; nor do I see why we have to endanger one of the most splendid relationships in our democracy, the relationship between the private agency and a governmental agency; nor do I see why we have to inaugurate this complicated system of appeals in order to get justice for the patient or the doctor or the nurse or the hospital; nor do I see why we have to create the complicated snarls in our responsibilities which arise from an unnecessary multiplication of contracts.

There are other benefits that will come from a cash indemnity, the elimination of complicated administrative machinery, the conservation of the freedom of choice of the individual, the justifiable and reasonable compliment paid to the citizen when we treat him like a matured adult capable of self-determination and capable of managing his own affairs rather than treating him as a helpless ward of the Government.

I might add, gentlemen, that giving up freedom might be too great a price.

Finally, the question must be raised, is it really the function of government to make itself the guardian of its citizens to the extent that would be implied in such a vast health program? There is so much to be done by government, so much stimulation to be given to all kinds of projects and interests that one wonders whether government should invade the intimacies of one's home and family life to the extent that would be necessary. I know there have been countries in which all of this is said to have worked successfully, but the transplantation into this freedom-loving country of ours of foreign and exotic patterns of social behavior has been tried recently enough and surely not one of us has had his love for this democracy of our weakened or diminished by the experiment. We respectfully recognize the successes of other countries and sympathetically try to understand their social procedures, but that sympathy will not blind us to our own needs and wishes nor to our own character as a nation, any more than the contemplation of the alleged success of other lands would stimulate our greed or our envy.

DESIRABLE FEATURES OF A NATIONAL HEALTH PROGRAM

In place of subjecting S. 1606 to further analysis, I should like to make bold to suggest that we can all probably agree upon a set of criteria by which we would measure a national health program and convince ourselves and others of its feasibility, or its desirability, or even its complete effectiveness.

I would say, first of all, that a national health program must take into account the moral and the social obligation of each individual to provide for his own health insofar as his financial resources, the circumstances of his life, his physical strength, might permit him to do.

Secondly, I would insist that the method by which he carried out this obligation should be a matter that is to be left to his own prudence and initiative, and, let me add, responsibility.

Thirdly, I should wish to insist that it is the duty of Government to facilitate my observance of my obligations when and if the fulfillment of my obligation becomes too onerous. This means at least two things: First, that the Government will really grant me a subsidy of some sort when I am really in need; and, secondly, that in periods when I am not in need, I shall recognize and carry out my own obligation to provide in advance for a moment of emergency. Only when I cannot carry out that obligation will the Government really grant a subsidy?

Fourthly, facilitation, however, in the observance of an obligation should not and must not mean an exemption from a responsibility; it must not facilitate the individual's shirking of his responsibility but rather must it assist the individual to the fuller realization of his own obligations.

Fifthly, I should like to insist that the obligation to safeguard one's own health and that of one's dependents is not an absolute, but a conditional and a contingent one. A national health program must take this into consideration and demand not too great a price for health security.

Sixthly, I should like to insist that since the personal relationship between patient and physician is basic and fundamental in the ethics of medical practice, the administration of a national health program must be simple, uncomplicated, direct, so that as few as possible extrinsic influences might be injected between the patient and the physician.

Seventhly, it would seem to me that a national health program should not be a substitute for the procedures and the methods which have resulted in the present high standard of health care of the American people, but should be a supplement to the presently existing procedures and methods. This implies the preservation of many tangibles and intangibles in our culture and civilization; the concepts of professional life; the freedom of professional action for the physician and the dentist and the nurse; the maintenance of intimate relationships confidential in character, in the patient-physician relationship; the freedom of the patient's choice of a doctor and of the doctor's choice of patients; the concepts of professional competence as implying ever so much more than merely formal schooling and success in skills; the place of the hospital in the community and its relationship to the individual patient whom it receives. These and ever so many other similar features of our present exalted heritage in health care deserves the utmost caution in their evaluation and in their possible modifications, for fear that by precipitate and imprudent changes we may not so much change but rather destroy them.

Eighthly, the highly desirable social purpose of universal coverage must be secured by a program which will embrace the individual who can fulfill his obligation through his payment for his health security, as well as the individual who by reason of his circumstances cannot pay and for whom society has made itself responsible.

Ninthly and finally, it is assumed in all of this that Government will aid in the creation of health facilities and that the development of health-caring personnel will, under the demands of the moment, be looked upon as the joint responsibility of the voluntary and the governmental agencies, in a program of mutual respect and cooperation.

Thank you very much. This has been a long presentation and I apologize to you. I tried to read it as fast as I possibly could.

The CHAIRMAN. You need not apologize. We are very grateful to you for your very able statement, Father. I am sure it will give us an opportunity to make very serious study of this problem.

I know that what you have said here, has been said earnestly and is your sincere conviction. I have great confidence in anything you say, and I want you to know that I will give great respect to the statement you have given here today.

Are there any questions?

Senator PEPPER. I have no questions, but I do thank the Father for his statement and I agree with you, Mr. Chairman, but I do not agree with his conclusions. I agree with you in the compliment that you paid to his earnestness in presenting his views.

Senator DONNELL. I would very much like to join in an expression of appreciation to the doctor for the great contribution he has made to our work.

I would like to ask a few pertinent questions. I appreciate the lateness of the hour, but I will try to be as brief as possible.

Doctor, you expressed willingness to indicate the basis on which you tell us that you appear on behalf of 1,100 institutional members and allied and hospital agencies.

Reverend SCHWITALLA. I would like to explain that to you because it has a bearing on the representative power of any one of your witnesses.

Senator DONNELL. Would you, please?

Reverend SCHWITALLA. The Catholic Hospital Association is an association having institutional members. The institutional member is the active member of the Catholic Hospital Association. Each one of the Sisters working in the Catholic Hospitals are Sisters in the organization. There are a few dioceses in the United States with about seven hospitals conducted by Brothers who are comparable in the background of their learning as these Sisters. Each one of those Sisters working in these hospitals, or the Brother, is an associate member of the Catholic Hospital Association. Any person, Sister or Brother, working in the institutional member, is an associate member.

The institutional members each year meet in convention and in its meeting there is a nominating committee, which committee suggests an executive board. The executive board is diversely representative of the very extensive areas in the country. There are many Sisters there. There is one from Chicago, one from St. Louis, one from Oklahoma City, one from Hays, Kansas, one from Saskatchewan, and one from Quebec. These Sisters elect their own officers and the association as a whole elects a president and three vice presidents. They have done me the great and highly valued privilege and honor of re-electing me president ever since the year 1927, and I say with terrible humility, in the presence of these good nuns listening to me here that I am aware of my responsibility. At the same time there is also connected with the Catholic Hospital Association a group which is the diocese's representatives. There are dioceses in St. Louis, one in Kansas City, another one in St. Joseph. There is no coterminus between dioceses of States. I am the diocesan representative for St. Louis. That executive committee of the Bishop's representative, and

the executive board of the Catholic Hospital Association together join several times a year as occasion demands in a common meeting. That group is called the administrative board of the Catholic Hospital Association. So that we have their official representatives and the workers of the hospital joining together in the establishment of—especially the public relations of the hospital so that, for example, this question that pertains to the matter we are discussing here has been discussed by that joint group and had resolutions passed year after year on this question of the duty and responsibility for the health care of the Nation. There have been some very vigorous expressions of opinion from that joint group. The Sisters, for the most part, make themselves responsible for the technical administration of the hospitals, the financial administration, the religious administration, of their own religious life, and of the religious life of the patients, and of the schools of nursing and of the religion in the schools of nursing. These bishop's representatives make themselves responsible for the safeguarding of the public relations of the Catholic Hospital Association.

I think it is a rare and rather responsible form of organization which makes it possible to secure very quickly the general opinion, and it gives us a cross-section of the opinion of the country because we are dealing with people who are in constant touch with the inner workings of the hospital. They are also in constant touch with the officials who govern the hospitals; that is the bishops and the diocese.

Senator DONNELL. I understood from your statement that the institutional members which are in the association are the representatives of approximately 90 percent of the Catholic institutions of this kind in the continental and the Territorial United States, and also that in appearing here, you are appearing in behalf of approximately 20,000 of the Catholic Sisters and Brothers, their friends, well-wishers, and sympathizers together with quite a number of other Sisters and Brothers.

Reverend SCHWITALLA. You represent the majority of the opinion in Missouri. That does not mean that everybody agrees with you or that everything you say would necessarily be endorsed by every person in Missouri that voted for you. This is the corporate opinion of the Catholic Hospital Association.

Senator DONNELL. We appreciate that. I would like to mention your very high conception that the medical profession has of their professional remuneration which is not, as I understand from your statement, to be considered as wages or salary or anything like that, but it is considered as an honorarium in the medical profession. That is a very high conception in the medical profession.

Reverend SCHWITALLA. If I want to give a token of affection to my girl, I don't want the Government to bring the bouquet. I don't want to be standing there while you kneel down before the girl I have respect for and offer her a bouquet. I want freedom of action.

Senator DONNELL. I think the doctor has given us a very fine explanation of it and we all appreciate that.

Doctor, you referred to the difficulty that you had of understanding why it is that the benefits under this bill take the form of services to the beneficiary.

Reverend SCHWITALLA. That surpasses all my belief. I have yet to find anyone that can satisfy me as to why that change was made in the

Social Security Act, except that it be an imitation of what some other lands have done, and that is what I meant by introducing exotic and foreign forms of social behavior into this country.

Senator DONNELL. I am wondering, Doctor, and I don't know what reason all this has because I have not talked with those who framed the bill, if that is done because of the thought that if you gave dash payments to the individuals who might become entitled to it, there would be no control over the compensation to be paid to the doctors, whereas under this plan in the bill, there apparently is, as I see it, an effort to hold down the cost of it because it would not be popular with, nor adopted by, the people of this country if the cost ran higher, perhaps, than is now contemplated.

Reverend SCHWITALLA. That thought came back three times today. Why this sudden concern for the doctor's income? This is the first time in the history of the United States that people are beginning to worry about the poor doctor. Up to now, it has always been the thought that the doctor will get the last benefit off the dead person's eyes, and he won't give you a death certificate until your bill is paid. That is what I heard said today right here three times around this table, that somebody is concerned, all of a sudden, about the poor doctor collecting his bill.

A Catholic makes the sign of a cross when he is around the Devil. That tells him to get out.

Senator DONNELL. It occurs to me that it might be well for us to have a notation in the record that possibly the reason why this plan of having services given as benefits rather than cash would be in the effort to hold down the expense, which otherwise would be so tremendous that it would not be possible to pass the bill. I do not know if that is the reason behind the bill or not.

Reverend SCHWITALLA. Perhaps it is.

Senator DONNELL. It is not original with me. It was a suggestion made by Dr. Shearon who had been here sitting to my left.

The CHAIRMAN. We cannot say that we got the idea from the operations of the Office of Price Administration because it was not actually operating at the time when this legislation was beginning to be proposed.

Reverend SCHWITALLA. Do you know where it came from? I really do not know.

The CHAIRMAN. We have had a great many doctors corresponding with us and we have had a great many cases called to our attention where doctors were compelled to give up their practice because they could not earn enough income to sustain their own families.

Reverend SCHWITALLA. Mr. Senator, I am sure that you are not taking that too seriously, are you?

The CHAIRMAN. I heard of some cases myself.

Reverend SCHWITALLA. I know I have. I am a school administrator. I have talked to medical students whose mothers or sisters or grandmothers had to mortgage their home in order to keep their boy in medical school. We have in our institution at least 52 fellowships at the present time in the clinical branches, and those boys get their check every month religiously.

Senator PEPPER. Under the Blue Cross plan, are the insured people given some money by Blue Cross and then they give it to the hospital and to the doctor?

Reverend SCHWITALLA. That is one of the main difficulties in the Blue Cross to be worked out. I have been in contact with the secretary of the Blue Cross for St. Louis and to this moment I have not been able to clarify that story. St. Louis wants it paid from the Blue Cross, but they did not want the person to pay it.

Senator PEPPER. At the present time, it still is the practice of the Blue Cross plan to pay some money to the doctors and the hospitals and the nurses rather than give the benefits to the insured?

The CHAIRMAN. The honorarium method that you spoke of at one time existed also in the legal profession, did it not?

Reverend SCHWITALLA. Yes; and in education it was originally—you are not interested in the history of these things, but as a little hint, in the Middle Ages, in the sixteenth and seventeenth centuries, these Sisters would never have taken a tuition payment from their pupils. It was forbidden for Jesuits to take tuition. It took 175 years to break that down.

The CHAIRMAN. I am sure that you have given a great deal of study to these matters, Father. Can you tell us why it was that in the legal profession that abandoned that honorarium system and came to exact fees, and some times very, very large fees?

Reverend SCHWITALLA. I cannot answer that question.

The CHAIRMAN. It would be interesting to know.

Reverend SCHWITALLA. If you visualize your own child dying through an accident, how much are you going to pay the doctor to keep that child alive? Are you not going to pay the limit?

The CHAIRMAN. Yes.

Reverend SCHWITALLA. That is the reason why if you have a tooth-ache at 3 o'clock in the morning, you are perfectly willing to pay a pile of money for relief. Of course, after the pain leaves, you are sorry that you have to pay that much money. Most people complain about the doctor bill, but they forget their suffering and when they get relief, they hate to pay the doctor. Then, all of a sudden, the doctor charges too much money.

I have seen doctors charge for the same operation \$5,000, \$50, and zero dollars. That was for the same operation. Is there any relationship between the medical services? Why is it that you can do that? Why is that fair?

This morning, Senator Pepper said that the rich man pays for the poor man. He does not. The rich man pays into a pool, and out of that pool there is drawn for this patient, that patient, and that patient, but the important thing is to know how much a man pays into that pool. It must be enough to constitute a price for what you are getting. You are getting a bargain at \$50,000 to have a leg set. That is a gratuity.

The CHAIRMAN. I have frequently come across situations under the fee system as distinguished from the insurance system which has created great havoc with families.

I know of a case in my experience as a young lawyer in the West where an operation was performed on a man where he was about ready to die and where the family was left with a very small insurance allowance for a few thousand dollars. The fees exacted made a very serious hole in that little insurance policy which was to care for the children, three or four of them. I have always, all my life, hoped

that some way could be found to protect those kinds of families where they have children and where medical costs bear so hard on them.

Reverend SCHWITALLA. It is true that there are about 5 or 6 doctors out of about 130 whom I would not put up on an altar and pray to as a saint. There are a few like that living. That does not mean to say that they all do it. There are a lot of priests like that; you are looking at one. I don't claim to be a decent priest, so don't judge a lot of the other priests by me, please. There are much better people than I am.

The CHAIRMAN. I am not going to take your advice on that because I know you too well.

Reverend SCHWITALLA. There are people who make mistakes. There may be a doctor who although he has no hope for a man who he thinks is going to die, he may be able to keep him alive for a little while, and the longer he keeps him alive, he wants to keep him alive longer. A man in our hospital was given up for dead and he is now walking around 5 weeks after. What are you going to do about a person like that? Perhaps he was not paid for his effort before a patient died. Then if he hears about the insurance, he figures that his bill ought to be paid so he submits a bill. There are some who will try to get as much as they can out of it.

The CHAIRMAN. We all appreciate the great care and study that you have given this problem, and we are very grateful to you.

Senator DONNELL. I would like to inquire of the doctor if, in his opinion, the theory behind this bill, in giving services in place of cash rests on the thought that by so doing, it will be possible to make mass contractors of doctors and hold down the fees and thereby make it possible to make this service cheap and therefore make it possible to pass this bill through Congress. If that is not the theory, is there not a danger that doctors will be put on a basis where they are going to mass produce their services on a fee basis and lose sight of the noble idea of the honorarium and are going to perform a service for \$2 or \$4.25 under statute. In other words, is there not really a substantial danger of a deterioration in the service itself because of the falling of the ideal of the doctor and of his conception of the nobility of his profession?

Reverend SCHWITALLA. I think you have expressed that very wonderfully. I fully agree with you and I am in complete sympathy with you, only I would go further.

There has to be a human side to it which is uppermost and you cannot pay for that. There is no relationship at all; one is not divisible by the other or into the other or anything else. There is no common denominator.

I can determine to the utmost fraction of a millimeter the distance between here and any spot in New York City. But, are you going to be able to find the distance between here and the end of the rainbow? There are certain things that cannot be quantitativized or whatever it is. That is what we have done with this, pardon me, damnable fee schedule.

Senator DONNELL. May I ask the doctor whether or not he delivered an address at a meeting of the National Physicians' Committee for the Extension of Medical Service at the Waldorf-Astoria Hotel on the evening of April 22 of this year?

Reverend SCHWITALLA. I had that privilege. I have no objection

to your asking that, Senator, in season or out of season. I will take every opportunity that I can to talk to two groups of people. I always talk to the sisters and it is a grand joy to do it and I always talk to doctors.

Senator DONNELL. Did you express somewhat the same views at the Waldorf-Astoria as you are expressing here today?

Reverend SCHWITALLA. Yes; I always say the same thing on a particular subject. It is a matter of ethics.

Senator DONNELL. The doctor spoke about the question as to where this plan of dealing out services under an insurance plan originated. I don't know, from personnel knowledge, where it originated, but I quote two sentences from the preface of the International Labor Office book, entitled, "Economic Determination of Life Insurance Benefits," published in Geneva in 1938:

It is therefore by no means surprising to find that in Germany, where compulsory sickness insurance was introduced in 1883, one of the first works dealing with economical prescribing dates from 1898. It is interesting to note that this work, *The Prescription of Drugs for Sickness Insurance Funds and for Private Practice*, was prepared at the suggestion of the Munich Medical Association, which entrusted the task to one of its members, Dr. Ludwig Dresdner.

They may have some bearing on the question.

The CHAIRMAN. You have no objections to a national health insurance program, as such?

Reverend SCHWITALLA. I have no objection to a national health program. But, if you come along and ask me about a national health insurance program, that is dangerous. The moment you get into that insurance question, you are trying to intermingle—unless it is insurance on a cash indemnity basis, and the moment you get into the benefits as to services to the hospital, patient and the doctor, I cannot go with you.

Senator DONNELL. In regard to this book from which I read, and I am not undertaking to vouch for it nor detract from it, this is a book, however, that was issued by the International Labor Office and distributed in the United States by the International Labor Office, whether or not the conclusions I drew from it are correct, I don't know.

I was greatly impressed by your comment at page 19 of your statement about the danger from a financial standpoint. I refer to the voluntary hospital which results from this effort to hold down these expenses and require them to consider as full reimbursement for the cost of essential hospital service.

I think you have given us food for thought, which I confess never occurred to me. I can see \$7 not being enough, but I did not have enough of a farsighted eye to see the matter you point out as the danger to the hospital service.

Reverend SCHWITALLA. When Blue Cross began, we had 10 percent of our patients from Blue Cross, and the rest of them, let us say, 80 percent, were paying patients and 10 percent were entirely free patients. It did not make much difference whether we took them from Blue Cross at a little less than hospital costs, but now, when Blue Cross is getting to be a larger and larger factor, and when you are running up to 60 percent and 70 percent and 80 percent or even 90 percent on Blue Cross patients, unless Blue Cross gives you the cost of the hospital, who is going to give you the rest of it?

Senator PEPPER. About how much a day do you think would be a proper figure if we were to adopt this bill?

Reverend SCHWITALLA. We have figures on different localities. Our costs in some areas in different hospitals run quite definitely, as low as \$6 per day. There are areas in the United States like that, if you can make the areas small enough. There are also other areas and other hospitals where the cost runs to about \$20 a day. Take the un-earned value of real estate. If you have a hospital located in one of the most costly places in New York, it is uneconomical to tear it down and put it some other place. That is one of the problems that varies.

In our hospital we need an encephalogram but I have not had enough money to buy one. It costs \$1,400, but there are other things that I need more.

Senator DONNELL. May I put into the record one item from the International Labor Office studies and reports, issued in Montreal in 1942?

Compulsory social insurance began nearly 60 years ago in Germany, and the legislation of 1883-89 associated with Bismarck, has, more than any other, influenced the development of social insurance.

Reverend SCHWITALLA. I think that is true.

The CHAIRMAN. I wish to offer in the record at this point a statement by Kenneth C. Crain, vice president and eastern editor of Hospital Management, a magazine of general circulation among hospitals, on Senate bill 1606.

I am sorry I cannot vouch for the citizenship of this gentleman in Missouri, but I believe it is not necessary.

(The matter referred to is as follows:)

STATEMENT BY KENNETH C. CRAIN, VICE PRESIDENT AND EASTERN EDITOR OF HOSPITAL MANAGEMENT, A MAGAZINE OF GENERAL CIRCULATION AMONG HOSPITALS, ON SENATE 1606 BEFORE THE COMMITTEE ON EDUCATION AND LABOR, UNITED STATES SENATE, MAY 6, 1946

Mr. Chairman and gentlemen of the committee, since numerous points of view and much factual evidence on S. 1606 have already been placed before you, I shall attempt to avoid repetition by confining myself to the discussion of three important aspects of the bill to which I believe adequate attention has not yet been given. I am also attaching, for the record, as a part of this statement, a copy of our analysis of the bill which appeared in the December 1945 issue of Hospital Management, in order to place before the committee in detail the various fundamental objections of hospital people to the measure. The three points which I desire now to discuss are as follows:

- I. The scheme and intention of the bill as framed.
- II. What the bill proposes.
- III. The principles involved.

Our views on these points, which are also the views of the vast majority of hospital people, follow in some detail.

I. THE SCHEME AND INTENTION OF THE BILL AS FRAMED

The chief object of S. 1606 is to secure the adoption of the system of Federal health insurance provided for in title II. The provisions included in the first part of the measure for aid to the States in various health matters are not in any sense necessarily allied to a plan for compulsory insurance for all who work, regardless of their wishes and of the availability of the needed facilities. On the contrary, these provisions for grants-in-aid can and should stand entirely alone. They are so stated as to demand active State interest and support, with the indicated provision of funds from the general resources of the Federal Treasury so arranged as to give a greater degree of aid to those States whose

economic status suggests the greater need. This is in marked and significant contrast to the health-insurance of title II, which we must assume is to be supported by a special income tax to be enacted later, indicated as being (at first) 3 percent on all incomes up to an initial limit of \$3,600. To attach these proposals as a bribe, or as bait, to a compulsory Federal insurance plan which is open to numerous and justifiable objections is a trick as transparent as it is offensive.

But the most striking feature of the bill is the deliberate and complete omission of all provisions for raising the enormous revenue which will necessarily be required for the operation of the plan proposed. This plan cannot possibly be adequately discussed without reference to its cost; but all provisions for meeting the cost are left out. The most persuasive argument, at a glance, in favor of Federal compulsory health insurance on a universal payroll-deduction basis is that it offers an acceptable means of meeting the cost of medical and hospital care for those who either cannot or will not meet these costs by voluntary individual action. But this argument is actually rendered meaningless and worthless by the failure of the bill to present to Congress frankly and openly the plan for financing these costs, so that it may be scrutinized and discussed.

This dubious device was of course adopted for the purpose, on the one hand, of keeping the bill and its identical twin in the House out of the hands of the committees charged with the grave responsibility of handling all measures connected with the raising of revenue, and, on the other, of placing it in committees friendly to its major purposes. The device was successful in both of these respects. It must be emphasized, however, that when and if the measure, thus carefully incomplete, and thus curiously routed, reaches the floor of the Senate, it will have to meet there the undeniable charge that its sponsors and supporters have chosen the extraordinary course of presenting a plan which will cost the Nation an enormous sum, four billions a year or more, without offering, save by implication, any means of meeting this vast obligation. If any member of either House is willing to vote for such a bill without simultaneously voting for a corresponding and adequate program of taxation whereby to meet its cost, he will in so doing offer a notable exhibition of legislative irresponsibility and of reckless disregard for the public credit, already seriously imperilled by 15 years of deficit financing.

No such bill should be sent to the floor of the Senate by this Committee without detailed, adequate, and carefully considered provisions for meeting the costs which it involves. Without such provisions, it should be rejected in toto, regardless of any other consideration. Any other attitude by this Committee, and by the Senate would be unworthy of the high responsibility resting upon Senators and of the intelligence with which they are assumed to approach their duties.

II. WHAT THE BILL PROPOSES

The failure of the bill to offer acceptable means of covering its cost demands its rejection, just as do the basic principles which it violates, which will be discussed hereafter, in part III. For the record, however, the major defects of the so-called health-insurance plan contained in title II of the measure will be here reviewed.

Proceeding upon the assumption which has been explicitly stated by many sponsors and supporters of the bill, that the American people are and have been suffering from inadequate medical, dental, nursing, and hospital care, the bill proposes to destroy the existing system by the means and for the purpose of setting up a new one, to be operated by the Social Security Board, under the immediate direction of the Surgeon General of the Public Health Service. Aside from the mountain of evidence proving the falsity of the assumption referred to, there is another vital point which has not received sufficient consideration, and which is unavoidably involved in this plan for a sweeping and revolutionary destruction and reconstruction.

This is the fact that the great majority of the professional groups which render health service in this country vigorously oppose the proposal for a Federal plan; and yet it is these same groups upon which the Federal Government must, and intends to, rely for the services which are so freely promised to the 100,000,000 people who are supposedly to be covered.

Consider this fact for a moment, with its more obvious implications. The care of the health of the individual, as distinguished from public health, involves a variety of highly specialized services, rendered by trained profes-

sional people, who indisputably are better informed about these services than anybody else could possibly be. But the views of these people are not only ignored, but are challenged, disputed, and trampled upon, frequently by the ignorant, in the effort to force the enactment of a measure which by necessity looks to them for the uninterrupted and devoted performance under it of their professional duties. So violent a contradiction in terms would be ridiculous if it were not, actually, appalling.

Instead of being disputed, denied, and rejected on absurdly inadequate grounds, the advice of the professional groups engaged in health services should be eagerly sought and carefully followed by anybody actually interested in improving conditions. It is a deadly and inescapable reflection upon the proponents of this measure that they prefer to flout the great majority of the honorable, informed, experienced, and competent people in the various professions in the health field, and to follow instead the ill-considered, half-baked, and radical views of rump organizations and of leftist pressure groups of complexions ranging from pink to red. Is this sound judgment?

The charge has been falsely made that the advice of the professional groups was sought in connection with this proposed legislation, and was refused. On the contrary, all of these groups have from time to time offered and they continue to offer constructive criticism of the pending proposals and suggestions for meeting the actual, as distinguished from the pretended, needs of the American people, in a manner consistent with American principles; for the medical profession, the American Medical Association; for the dental profession, the American Dental Association; for the hospitals, the American Hospital Association, the Catholic Hospital Association, and the American Protestant Hospital Association. These criticisms and suggestions are or will be in the hands of this committee or its predecessors, or are otherwise available for its guidance. They should be heeded, unless the committee chooses to risk presenting a so-called health plan which is unworkable, impracticable, and unnecessary, and which is moreover violently objectionable to the very individuals and institutions which alone are available to render the services so freely promised by the bill.

In brief, the Federal Government is committed by this bill to the promise, on its sole authority, of comprehensive health care to virtually the entire population, through the existing professional and institutional groups now giving the American people the best health care in the world. The Government is thus made to promise something which it does not possess, but which in order to deliver it must secure through satisfactory arrangements with the professional people concerned. Whether such a plan is feasible, and if so, what arrangements would in fact be satisfactory and workable, should as a matter of common sense be determined in advance, and not left to the dangerous process of trial and error after the fact. If the professional groups directly concerned declare on the basis of their considered judgment that the plan is not feasible, necessary or proper, as they have certainly done, then in what court, and by what process of reasoning, if any, may this evidence be disregarded?

It may be appropriate at this point also to refer to the remarkable escape clause found on page 57 of the bill, identified as section 219 (a), and more fully discussed in the attached analysis of the bill, under which "every individual" may be required "for any calendar year or part thereof" to pay a fee for any medical, dental, or nursing care notwithstanding being "entitled to general medical, general dental, or home-nursing benefit." While this clause is intended, as the section further recites, "to prevent abuses," thus according beyond any doubt support to the general knowledge that a promise of blanket medical-care coverage always produces excessive utilization and impossibly high costs, it does not indicate that complete confidence either in the individual citizen or in the system itself which might be expected. To collect a universal pay-roll tax for promised medical care under a system where the authorities have seen fit to provide themselves with such an escape clause would suggest a planned intention, in case of need, to swindle the public. The clause speaks for itself, eloquently and shamelessly.

III. THE PRINCIPLES INVOLVED

The enactment of S. 1606 is intended to and would produce Federal compulsion upon the individual in matters connected with the care of his health, a purely personal affair, instead of leaving such arrangements to voluntary action. It would mean Federal control of the entire population as individuals, in an entirely new and direct sense, as well as control of the professional and institutional

groups rendering health service. Such an extension of the powers and activities of the Federal Government would by way of precedent go far toward the destruction not only of the traditional American system of hospital and medical care, but of the entire American governmental and economic system as well. This is said with the most careful consideration of the language used.

Since the bill has the active support of many groups well known to be dominated by or sympathetic with communistic purposes, it may reasonably be suggested that perhaps this destructive result is one of its designs. Objection has been made to the application to the plan for compulsory Federal health insurance of such terms as communistic or socialistic. But these terms are strictly accurate. They convey correctly the idea that what is proposed is the imposition on the American people of a revolutionary system of controlling individual health care, ostensibly benevolent, but actually and inevitably an introduction to the slavery of statism. Compared to the dangers which this involves, and the threat to all of the traditions of a country "conceived in liberty," the pretended benefits to be conferred are negligible.

This committee therefore has the tremendous responsibility of deciding whether it will by endorsing this measure, in spite of its grave defects in principle and in detail, elect to give aid and comfort in this country to the wave of totalitarianism now threatening the world. William Henry Chamberlin, a well-known liberal in the best sense of that abused word, recently expressed this danger in the following language:

"One of the most significant features of the twentieth century has been the world-wide revolt against human liberty. This suggestion may come as a shock to minds which are conditioned to thinking of the course of history as one of unbroken progress. But it is an unmistakable fact." And he added, "It is high time to recognize that many 'waves of the future' are essentially the backwash of a dark and barbarous past and that to be 'behind the times' in resisting the trend toward dictatorship and collectivism is to be fare ahead of the times in terms of both moral and cultural values and of material well-being."

Human liberty is directly threatened by every phase of the plan proposed by this bill. The absolute right of the individual, heretofore unquestioned, to make his own arrangements for the care of his health and that of his family, is involved. Under the American system, if he cannot meet the responsibility inseparably connected with this right and duty, his community should and will step in, with or without State or perhaps Federal aid. The rights of the professional groups who have given us the best health service in the world to their freedom in their chosen work are involved. They are licensed exclusively by the States. By what process of reasoning shall their whole future be turned over to the remote control of a Washington bureau? The rights of the voluntary nonprofit hospitals, which render most of the general hospital care of the country, are involved. These hospitals, for which especially I believe I may venture to speak, compose a system unique in the world. It is characteristically American, furnishing the practical training of the doctors and nurses of the country, is created by community initiative and supported by community action. It is only by ignoring the very recent history of what happens sooner or later to most hospital care when the Federal Government assumes control that the future of these voluntary hospitals under that control may be viewed without the most serious misgivings.

No less a legal authority than the American Bar Association has suggested that the proposal to extend to control of individual health care the authority of the Federal Government is beyond the constitutional powers of that Government. This view is correct. The assertion that the authority to legislate "for the general welfare" necessarily includes the power to regulate in every detail the life of the individual ignores the common as well as the established legal meaning of the words. The legislation may be enacted, and it may even be approved by the court of last resort. But the soundest opinion will still remain that the just powers of the Federal Government, under the Constitution, do not extend to such control over the individual, and that Congress in that event, as in certain other instances, will have made into law that which is in fact grossly unlawful.

It is pertinent here to remind the committee that to a very considerable extent, aside from radical purposes, the support of this bill by organized labor may reasonably be attributed to the universal human desire to get something for nothing, to the extent of the payment which, it is assumed, will be exacted from the employer. The device of forcing employers to pay any part of the cost of health care for employees, without reference to any connection of illness with the em-

ployment, is subject to challenge on the ground of its obvious unfairness, aside from its actual effect as a tax on employment; and the plea of necessity comes strangely at a time when low-cost voluntary prepayment plans for hospital and medical care are spreading more rapidly than ever before, and when wage levels are at the highest point in history.

The parallel alleged between compulsory payments for health insurance and compulsory school attendance does not in fact exist. School attendance is required of children, not of adults; and it exists only under State law, not under Federal law. When every citizen is compelled not merely to submit to deductions from his pay for Federal health insurance, but to call upon his doctor and his dentist on such dates as may be fixed by the Federal bureau, the parallel will be accurate, and the compulsory system will have developed to its logical conclusion. Such compulsion as to calls for medical and dental examinations is in fact the only way in which the result promised for the Federal plan can be achieved. Under the existing free American system, education of the individual to the desirability of proper professional advice on health matters, so that he may himself voluntarily take advantage of the available facilities, is the only permissible method.

Like other aspects of the evolution of a free society, this may be slow in achieving full success. Americans duly licensed to drive automobiles slaughter each other to the extent of 40,000 a year, in the legitimate pursuit of business and pleasure, injuring hundreds of thousands more, and causing damage running into millions of dollars. But it is not yet proposed that they should for that reason be deprived of the right to drive on the public highways they have built. It is hoped, rather, that a continual educational process will eventually teach them to drive more carefully, to use their brakes, their judgment, and their several senses. That is a fair parallel to the matter of health care. Liberty always implies responsibility; and the exercise of responsibility develops ability to meet it, in every aspect of existence, including the care of one's health. The alternative of destroying liberty is the alternative of the dictator. It is unacceptable to a free people. It should not be imposed for the purpose of attempting to improve the care of individual health or for any other purpose.

[Hospital Management, December 1945]

(Analysis of S. 1606)

BUT WHO'S GOING TO PAY FOR THIS NEW WAGNER-MURRAY-DINGELL WARDROBE?

THIRD EDITION OF COMPULSORY HEALTH INSURANCE ATTRACTIVELY EMBROIDERED,
COYLY AVOIDS ISSUE

(By Kenneth C. Crain)

November 19, 1945, witnessed a series of well-coordinated steps in Washington intended to lead to Federal action imposing on the entire citizenship of the country a system of compulsory health insurance. On that date President Truman's message on the subject was delivered to Congress; and on that date identical bills, S. 1606 and H. R. 4730, were introduced into the two Houses of Congress, sponsored as heretofore by Senators Wagner and Murray in the Senate and by Representative Dingell in the House. But whereas the first two in the growing series of Wagner-Murray-Dingell bills were referred to the committees in the respective Houses having to do with revenue, a highly significant difference was immediately indicated in the handling of the new measure.

In the Senate the bill was referred to the Committee on Education and Labor, of which Senator Murray himself is chairman. In the House it was referred to the Committee on Interstate and Foreign Commerce. It is strictly accurate to state that this painstaking effort, the result of the utmost care and caution in the framing of the bill, is one of the several calculated devices which have been adopted for the purpose, first, of getting the bill to the floor with the favorable reports of two friendly committees, and second, of postponing until after the hoped-for passage of the bill the introduction of other measures, emphatically including broad revision of the social-security system, with a sharp rise in payroll taxes, which will be essential if the proposal for compulsory health insurance is to become operative.

ATTEMPTED OLIGARCHY

Analysis of the bill and of the proposals in the President's message will show quite clearly the amount of thought which the Social Security Board has given to the whole matter, and will by the same token show with equal obviousness the graver defects of the newest attempt to ease into being the indefensible and un-American plan of placing the whole population under the permanent domination of a small group of men, who will thus become the most powerful oligarchy in this country if not in the world. Those who are opposed to any such plan will by such an analysis be in a position to express themselves with appropriate vigor to their representatives in both Houses of Congress on the subject.

Moreover, it is highly appropriate here to point out that the new bill and the circumstances surrounding its introduction show with remarkable force the effect of the just and devastating attacks made on its predecessors, particularly Wagner-Murray-Dingell bill No. 2, which was introduced only last May. Opponents of this sort of legislation have cause to congratulate themselves and the cause for which they are fighting, the independence of the individual, of the voluntary hospitals and of the medical profession, in the studied care with which the Social Security Board has endeavored both to meet their criticisms and to leave fewer vulnerable points in the new measure. By the same token, the powerful propaganda machine already in motion to force the bill through will unquestionably claim that now there is no reasonable objection to it, and that on the other hand it will achieve all of the generally admirable objectives named by Mr. Truman. Neither of these claims is true, as will be shown.

SHOULD BE DEFEATED

The outstanding difference between the new bill and its immediate predecessor in the procession is that the attempt to steal S. 191, the measure sponsored by the American Hospital Association providing for Federal aid in hospital construction, has been abandoned. It was exclusively pointed out in this magazine (June 1945, p. 31) that not only was it futile for the Social Security Board to hope for hospital support, on the basis of this attempted appropriation of a sound idea, but that the amazing effrontery of the requirement that the States surrender their unemployment insurance reserves of about \$6,500,000,000 in return for any assistance would arouse general opposition. This suggestion obviously struck the seekers of power as so sound that a new approach has been adopted, which should be met promptly and, with understanding of its aim and course, should be defeated with ease.

The plan now emerging is one of the oldest in American or indeed in any legislative bodies, however new it may be as a means of securing support for proposals to which many conscientious legislators are known to be opposed. It is known as logrolling—"you support my bill and I'll support yours." The Hill-Burton bill (S. 191), providing the answer of the hospital field as well as of the medical profession to the challenge of those who ask for a program of Federal assistance, has been carefully worked out and is not opposed by anybody.

But the Wagner-Murray-Dingell series, including the current offering, is widely and strongly opposed by the vast majority of those who are against increased Federal power over the lives and actions of individuals. The plan will therefore be to trade support for the Hill-Burton bill for support for the other measure and its highly objectionable scheme for compulsory health insurance. Senator Hill himself has already indicated his strong support of the compulsory scheme.

PASSED BY SENATE

Passage by the Senate on December 11 of the Hill-Burton bill, efforts of Senators Wagner and Murray to secure amendments limiting functions of the proposed advisory committee in order to leave Federal control complete, is an interesting commentary on the general situation. This is rendered noteworthy by the fact that debate on the Wagner and Murray amendments found Senators Taft and Hill united in opposition to them. It remains to be seen what will happen when the measure reaches the House as it shortly will. The prediction stands that logrolling will be attempted on behalf of the Wagner-Murray-Dingell bill, with the Hill-Burton bill as a lever, now or later.

The logrollers can then support the Hill-Burton bill—which, however, majorities in both Houses will do anyway—and later claim as a reasonable quid pro quo more general support than would otherwise be extended to the Wagner-Murray-

Dingell bill. It is what a prominent American once described as a clever little scheme; but it should fail, and fail completely, since the Hill-Burton bill is a commendable effort to do a necessary thing, whereas the whole Wagner-Murray-Dingell drive is a dangerously motivated attempt to do a wholly unnecessary thing. Every member of both Houses of Congress should be given all possible aid in keeping clear the essential difference between these two measures and the groups who respectively support them.

SAME OBJECTIONS

The same fundamental objections to governmental control of medical and hospital care apply to this bill as to its predecessors. Despite all assurances that no control is intended, and that the independence of the citizen, the hospital and the professional man or woman will be preserved, control is inevitable where, as President Truman's message promises and as the intent certainly is, every person who works will be covered and will thus be a Government patient. The record is clear, moreover, that Government control, especially in this area, means the lowering of standards, the waste of funds, and the degradation of both patient and physician by reason of indifference to everything but political considerations.

On the other hand, the implication that Government action is necessary because the existing system has failed is so false that even the ordinary citizen can testify eloquently to the contrary. The only really substantial way of securing the correction of many minor ailments, such as caused the rejection of so many men by selective service, is to compel everybody to make regular visits to the Government doctor. This is undoubtedly to be attempted if the first and biggest part of the compulsory scheme is enacted; but it is certainly not to be advertised, as yet.

WHO WILL PAY?

With these considerations in mind, it will readily be understood why the most remarkable feature of the new bill is its scrupulous and successful effort to avoid providing for any of the necessary taxes to meet the admittedly enormous cost of medical, hospital, dental, laboratory, and nursing care for the entire working population. The former measures, honest after their lights, specifically provided for these costs by allocating 3 percent of income up to \$3,000 or \$3,600 for the payment of these expenses, as a part of the social-security set-up, so-called.

President Truman in his message of November 19 suggested that perhaps 4 percent of income up to \$3,600 might be a proper tax for the health-insurance purposes which he referred to. But the Social Security Board and the clever legislative experts in charge of its proposals realized, at last, that open dealing might have to give place to guile.

A proposal such as that contained in the previous measures for specific taxes would have placed the bills in the two Houses in the hands, respectively, of the Senate Finance Committee and of the Committee on Ways and Means. The gentlemen on these committees, with the great responsibility of the National Budget on their hands and in their minds, have been and would, it was justly feared, remain cold to the unnecessary addition to the tax burden of the enormous amounts needed for these purposes. Hence the clever little scheme of omitting entirely from the new bill any tax plan for meeting the financial requirements necessarily involved. The bad news will come later, after the sweetness and light.

UP-THE-ALLEY

The Social Security Act is referred to, as it was necessary to the plan of providing "personal health service benefits" to indicate that only persons "currently insured" under that legislation are covered; but the bill itself is an amendment not of the Social Security Act—that would have brought it under the vigilant scrutiny of the committees charged with revenue legislation—but of the Public Health Service Act. Its title is "The National Health Act of 1945." And the around-the-corner and up-the-alley method of financing its far-reaching grant of power over the American people is outlined thus coyly, on pages 61 et seq. of the bill:

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

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

GALL AND NAÏVETÉ

It is from this "Account," then, that payment is to be made for the services to be provided, including all who work, on their gross income up to \$3,600, as another part of the bill indicates. But note the amazing combination of, to use a good American colloquialism, gall, and naivete, in this proposal; as amazing as the hastily abandoned effort to club the 48 sovereign States into support of the previous measure.

It is obviously the considered view of the proponents of this extraordinary proposal that the mature men who legislate for the United States in Congress are going to be stupid enough (*a*) to enact this measure without providing for ways and means of financing it, and that they will then, surprised and helpless in the face of what they have done (*b*) feel compelled to enact the detailed measure which will in due course be presented to them, covering the unpleasant process of paying the fiddler.

This sort of scheme has been successful at times in the past, it is said—to slip through on one pretext or another a bill whose payment then had to be provided for later on; but it is safe to say that never before has a legislative proposal so deeply affecting American life been placed before Congress with so transparent a reason for waiting until later to present the bill. It is almost touching in its childishness. A not-so-clever little scheme.

PIG IN A POKE

The fact is, of course, that nobody has any idea what the scheme will cost, especially with the characteristic spendthrift methods of the Federal Government in control. Estimates range from three or four billions to double those enormous amounts; and while there is to be an initial pay-roll tax of, apparently, 3 percent, presumably to be paid on equal terms by employer and employee, there is in the nature of the thing no limit to the amount of this tax when the social security system, as a whole, and this part of it, in particular, if authorized, begins to show the enormous deficits which may be confidently predicted.

The temper of Congress in the matter of increasing these gross income taxes has been shown by its refusal to permit the scheduled annual rises; in consequence of which Chairman Arthur J. Altmeyer, himself, points out that the old-age and survivorship program alone faces bankruptcy in a relatively few years unless the taxes designed to support it are substantially increased.

This situation and the new proposals must stand comparison with the sound idea of permitting the self-supporting and self-respecting citizen to look after his own health insurance, as he is doing to increasing millions, while the States look after those who are not able to carry the burden for themselves. The destruction of such voluntary plans as the great Blue Cross network, and the increasing subserviency of the States, are among the most serious and obvious of the vicious results of Federal action.

WHO WILL RUN IT?

Having now followed through their, in some respects, intricate windings, the efforts of the seekers for power to avoid certain of the more vulnerable weaknesses of the former bill, and having noted that in these efforts they have blundered into other self-betrayals, the analysis of the bill may proceed to the provisions directly affecting hospitals and those rendering health services.

The chief administrator of the act is, as heretofore, to be the Surgeon General of the Public Health Service, "under the supervision and direction of the Federal Security Administrator, and after consultations with the Advisory Council." The Surgeon General will not always be Dr. Thomas Parran, a fine and able individual; but the Federal Security Administrator will always be a virtually independent bureaucrat, in whose hands under this measure will lie the greatest power ever dreamed of over the lives of Americans.

The Advisory Board is described exactly as before, from which it may reasonably be inferred that its make-up and limited authority are more than a little dear to the hearts and purposes of the seekers for power. It is still provided that the 16 members of this Council "shall be selected from panels of names submitted

by the professional and other agencies and organizations concerned with medical, dental and nursing service and education and with the operation of hospitals and laboratories and from among other persons informed on the need for or provision of medical, dental nursing, hospital, laboratory, or related services and benefits."

In a word, these "other persons" will be hand-picked stooges satisfactory to the Social Security Board. They will in a safe majority be the obedient tools of the organization. The same comment applies to the provisions for appeal and review. The whole system would be under control which cannot be successfully fought. The machinery for review is made to sound impressive, but on analysis it proves to be virtually meaningless.

HOSPITAL CONTRACTS

The provisions concerning the extent of hospital services and the amounts to be paid for them, as well as the permission to the Surgeon General to make contract arrangements at rates which will be in full payment of services, are similar to those in the preceding bills. A maximum of 60 days of hospitalization is provided for, except where it is found that additional funds are sufficient to pay for more, a contingency not likely to arise; and "hospitalization benefit" is defined to be an amount (not a service) "not less than \$3 and not more than \$7 for each day of hospitalization, not in excess of 30 days, which an individual has had in a period of hospitalization; and not less than \$1.50 and not more than \$4.50 for each day of hospitalization in excess of 30 in a period of hospitalization: and not less than \$1.50 and not more than \$3.50 for each day of care in an institution for the care of the chronic sick."

The danger involved in the provision that "the Surgeon General may enter into contracts" in lieu of such compensation has been emphasized before, but should be stressed again. Only a limited degree of familiarity with the facts of life in a political atmosphere is needed to give rise to the suspicion that this power might be unworthily used for the purpose of giving over the inhabitants of many areas to the mercies of enterprising individuals with influence—and contracts.

No perceptible recourse against this is noted in the bill. It is hardly necessary to note that the maximum payment provided for is less than the patient-day cost of many hospitals. If the voluntary hospital system which has served the country so supremely well is to be subjected to such control that its utter degradation to political purposes is certain, a little preliminary starvation is a relatively unimportant detail which will merely speed the process somewhat. Since essential principles are involved, it is the larger question which must first be debated, thoroughly, searchingly, vigorously, and boldly.

It is for this reason that little space will here be devoted to the provisions of the bill for grants to the State for public health services, for maternal and child health services, and for the medical care of needy persons.

Of these it is only to be said, as of the provision of Federal funds for needed hospital construction, that if it is considered wise for the National Government to assume responsibilities heretofore resting exclusively on the States, this is the way to do it; and these reasonably commendable proposals for Federal aid should not be tied in, after the fashion of unscrupulous merchants in the late and present days of scarcity, with stuff as objectionable, as violently controversial and unacceptable, as the provision for a compulsory health-insurance scheme.

They are not in any sense inseparable from such a scheme. On the contrary, every item of these provisions for grants-in-aid can stand alone, and should do so, without the slick attempt to make them drag with them, as if inevitably, the ugly threat of permanent and costly bureaucratic domination of the individual citizen, the voluntary hospital, and the professional man and woman in the health field.

DANGER CITED

Of more than passing interest, however, as a significant recognition of the certain danger of overwhelmingly impossible demands on the professions whose services are thus to be drafted, is the provision in section 210 (a) to the following effect:

"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 fur-

nishing such benefit to pay a fee with respect to the first service or with respect to each service in a period of sickness or course of treatment.

Such determination shall be made only after good and sufficient evidence indicates that such determination is necessary and desirable to prevent or reduce abuses of entitlement to any such benefit, and shall fix the maximum size of such fee at an amount estimated to be sufficient to prevent or reduce abuses and not such as to interpose a substantial financial restraint against proper and needed receipt of medical, dental, or home-nursing benefit. Such determination may also limit the application of such fees to home calls, to office visits, or to both, and may fix the maximum total amount of such fee payments in a period of sickness or course of treatment."

THINK ON THESE THINGS!

As the great Apostle said, "think on these things!" They carry their own comment. They indicate that the seekers for power are by no means unaware of the facts of life, not that anybody thought they were; but these specific provisions for refusing to pay for "the first service" or "each service in a period of sickness," and for compelling "every individual," however "fully insured," to pay his own bills, in order to prevent abuses (suspicion of the individual written into the bill, that is) simply show on their face the existence of the insuperable difficulties which march side by side with the broad promises of the President and of the proponents of the measure.

"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," said Mr. Truman in his message. Aside from the generally recognized fact that widespread education of the public on health matters is needed, that sounded reasonable.

But under this bill, which pretends to meet once and for all every health problem of every individual, "every individual" may be required to pay his own bill in spite of being apparently covered. What is the value of these broad and generous assurances when they may be completely contradicted, in the emergency, by the arbitrary action, on "good and sufficient evidence," of the powers that be?

A COLLOQUY

In the Congressional Record of that memorable date, November 19, 1945, after Senator Wagner had delivered, or secured permission for the inclusion in the Record of, his remarks on the bill, including the famous set of questions and answers in which he himself presented all of the objections and answered them, with surpassing ease, the following cheery colloquy is reported:

"Mr. HILL. Mr. President, will the Senator from New York yield?

"Mr. WAGNER. I yield.

"Mr. HILL. I have been very much interested in the statement of the Senator from New York about the bill which he on behalf of himself and the distinguished Senator from Montana (Mr. Murray) has just introduced. Does the Senator's bill take care of all the people, particularly I have in mind the large group engaged in agriculture and those living in the rural districts?

"Mr. WAGNER. It does.

"Mr. HILL. In other words, it is all-inclusive.

"Mr. WAGNER. Yes, it is all-inclusive.

"Mr. HILL. The provision for the prepayment of medical costs under the insurance plan would take in everybody.

"Mr. WAGNER. Yes.

"Mr. HILL. I think the Senator."

But despite the importance attached to this point by Senator Hill, and the emphasis with which it was asserted by Senator Wagner, nothing can be more clear to the anxious investigator of the bill's provision than that it actually does not "take in everybody." Certainly it is the intention of the scheme eventually to take in everybody; about that there can be little doubt. But the Wagner-Murray-Dingell bill as it stands is only a part of the scheme.

It will not be until that other measure, the bad news, surely already drawn and awaiting its call to the stage as it lies in some desk in the offices of the Social Security Board, is presented, debated, and passed that the scheme will "take in everybody": all who work, for wages or for themselves; in all factories, mines and mills, on the farms and in the little one-man stores and shops all over the

country; irrevocably and without their consent, save as they are made to understand this matter and thereby enabled to talk turkey to their Representatives in Congress. Now is the time to do this, before action is taken which Congress may feel binds the hands of Congress.

That is the task of those who still believe in the essence of the American system, individual liberty; as some do not, despite their ardent professions. The debate with the seekers for power, before the public and Congress, is on. The right of the individual self-supporting citizen to handle his own affairs, the independence of the great voluntary nonprofit hospital system, and the freedom of the medical and related professions from the stultifying hand of Government control, are involved in this matter, aside from the grave danger to the American system of government and economics threatened by this proposal for further encroachment on the duties and responsibilities of the States. Let all this be clearly understood, in and out of Congress, and the result should be the defeat of the plan.

The CHAIRMAN. I think that will conclude today's session. We will resume tomorrow at 10:00 o'clock in the morning.

I want to thank you again for your statement.

(Thereupon, at 5:40 o'clock, the Committee recessed until 10 a. m. on May 7, 1946.)

NATIONAL HEALTH PROGRAM

TUESDAY, MAY 7, 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 hearing will come to order.

We are very pleased to have the Right Reverend Monsignor John O'Grady, Secretary of the National Conference of Catholic Charities, here this morning as a witness.

Monsignor, we are very glad to have you.

STATEMENT OF RT. REV. MSGR. JOHN O'GRADY, SECRETARY, NATIONAL CONFERENCE OF CATHOLIC CHARITIES

Reverend O'GRADY. Mr. Chairman and members of the committee: I am testifying this morning on the part of the Catholic Social Welfare Agencies in the United States.

THE RELATION OF HEALTH INSURANCE TO SOCIAL SECURITY

It is inevitable that there should be a greater extension of social security to protect American wage earners and the self-employed against the major hazards of life. The progress that has already been made in old-age and survivors insurance and unemployment compensation encourages us to hope for better things in the future. We need larger coverage under old-age and survivors insurance; we need improvements in the benefit structure; we need to face realities in regard to the amount of pay-roll taxes required to support adequate benefits.

In regard to unemployment compensation, we must give more thought to a simplified system, adequate and uniform benefits and the elimination of the increasing disqualifications under the various State laws. In a word, we need more national standards, both in the actual content of State legislation and in its administration.

Ever since the Social Security Act went into effect, there has been much discussion in regard to ways and means of providing adequate protection against the hazards of ill health. That was discussed fully in 1935. Everybody recognizes the great advances that have been made through voluntary effort in extending the benefits of medical and hospital care to larger and larger numbers of people, and those advances are going ahead day by day.

It is now quite clear that voluntary effort in this field will grow by leaps and bounds. If the discussions of the past 10 years had no other result than to provide an incentive to the development of voluntary effort in the field of health security, they would be entirely worthwhile. However, discussion has done more than this. It has clarified thinking in regard to the character of the hazard of ill health.

Until very recently, social economists were inclined to place ill health in the same category as old age, premature death and unemployment. Insofar as illness merely cuts off the workers' income, it may be placed in the same category as old age and unemployment. And you will note in this connection that there is very little question about the desirability of extending protection against the wage losses due to ill health. Most everybody seems to be in favor of extending unemployment compensation to cover that part of ill health. But ill health involves many other ramifications. It involves the medical profession with all its traditions and its practices. Any program that is set up whether by voluntary effort or by government reckon with these traditions and practices.

In providing for ill health, we also have to reckon with the hospitals and with their programs and their policies.

In the past, government's dealings with the medical profession and with the hospitals has been confined largely to the care of the indigent sick. Until very recently doctors gave their services to the indigent sick free of charge. In the past few years, government, especially local government, has been endeavoring to work out methods of compensation for medical care on a local basis. This has been done for the most part by process of negotiation between local medical societies and local governments. Some progress has also been made in regard to hospital rates for the indigent sick. Usually these rates have been, and for the most part still are, very inadequate. That is a field in which, while progress has been made, a great deal remains to be done.

In a few States, progress has been made under workmen's compensation in the setting up of more systematic methods of hospital rate-making for the victims of industrial accidents. For the most part, however, the rates paid under workmen's compensation are most inadequate. They are not at all equal to the cost.

In dealing with voluntary hospitals and physicians in regard to medical and hospital care, and I think you can understand the attitude of hospitals. When you take the whole, States pay \$2.50 a day for workmen's compensation cases, hospitals do not pay very much attention when it is confined to a limited group of people, but when you propose a system that is going to cover everybody and you propose \$3 a day, which is less than half cost, then of course the hospitals begin to be concerned about it. You can readily understand that.

Government under a national health security program would be entering on a new and comparatively unexplored field.

That does not mean it should not be explored.

It is well for us to keep these considerations in mind in comparing a health security program with a program designed to meet the hazards of old age and unemployment.

INADEQUATE COVERAGE OF VOLUNTARY PLANS

It is generally recognized today that in spite of the great advances that have been made by organized voluntary efforts and by local welfare agencies in providing medical and hospital care for the American people, we still have a large number of people who are not adequately protected. Our problem is to extend coverage without interfering with the gains that have already been made as well as with the further gains that are bound to be made in the future by voluntary efforts of all kinds.

Before entering into a discussion of the question of universal coverage against the hazard of ill health, it would be well for us to keep in mind a few fundamental principles of social philosophy. In our society—in fact in any society that is based on a clear understanding of the infinite worth of human personality—it must be assumed that our first objective must be to encourage the individual to provide health protection for his family through his own effort. It follows that we must also encourage the individual to enter into associations and organizations of his own choosing for the purpose of providing health protection for himself and his family. Government should encourage and promote such voluntary efforts on the part of the individual. It should not seek to supplant the efforts of these organizations, for in doing so it would be striking at the very foundations of a democratic society. Government, therefore, has to proceed very carefully in the implementing of voluntary effort in the field of health protection.

THE NEEDS TEST WILL NOT WORK

In providing more adequate health protection for the American people, we are confronted with certain fundamental ideological concepts. We have the concept of those who believe that a national health security program should be confined to the so-called medically indigent; that those who need medical and hospital care might go to the local welfare agencies and submit to a needs test in order to secure it. This would place medical and hospital care in the same category as relief or public assistance.

Those who would confine any public provision for medical and hospital care to the indigent sick believe that if local governments are unable to provide this care their efforts might well be implemented by assistance from the Federal Government.

It is very doubtful whether American wage earners or the self-employed will be willing to submit to a needs test in order to secure medical and hospital care. The ordinary American wage earner does not want to submit to a needs test except as a last resort. Those who have had experience in administering a needs test know very well how people feel about it. They regard it as a confession of complete failure in life.

Now, if you were to move around among the farmer folks, you would find very quickly the attitude they have toward submitting to a needs test for health care.

I remember a few years ago, I was on the Detroit Forum, and some of my friends suggested I explore this topic. I drifted around the county seats in Iowa and talked to every farmer I could, to find out how the ordinary farmer secured hospital and medical care.

The answer was very simple. He called up the county supervisor and said, "My wife wants to go to the State hospital. We do not have cash on the barrel-head," which was the picture at that time.

He said, "We will get it in order."

The county supervisor sends a note to the State university hospital and indicates to them that his wife wants to be given medical and hospital care.

I found that quite uniform. They did not go around and submit to a needs test.

And I canvassed the same situation in Nebraska several years ago and found the same attitude. In Nebraska, they had the attitude that they should get the farmers to pay as soon as they were able to, but I do not think they succeeded in very many instances.

I doubt, therefore, if over a long period of time this needs test is going to work. That is, that they will gradually break down, just as in many States it is breaking down on old-age assistance.

I mean, you are getting to the point more and more where the legislatures are writing the needs test of old-age assistance.

That is not true in all the States, because in some States old-age assistance is like any other form of relief.

So, I think that is one of the things to be kept in mind in discussing the attitude, and those are quite large representative groups, the attitude of men who feel that this program, this need for health care of the ordinary middle-class American can be met by public assistance and a needs test.

I think that needs to be explored very fully from the standpoint of what happens. It looks very nice on a national level. You have a flexible program and flexible grants to the States, and that looks nice in theory, but how does that work in the ordinary county level? That is what has to be judged.

The Federal Government, through the Social Security Act, is now providing grants-in-aid to the States to enable them to provide assistance for the needy aged and for dependent children in their own homes and the homes of relatives. If the Federal Government is willing to aid the States in providing food, clothing and shelter for the aged and for dependent children, it should also be willing to aid them in providing medical and hospital care for these two groups.

It should be remembered, however, that the grants to the States for the needy aged and for dependent children are transitional grants. Under the basic philosophy of the Social Security Act, as I understand it, most if not all the aged and the dependent children eventually will be taken care of by old-age and survivors insurance. That is what we are working for. We do not expect that this public assistance approach is a permanent approach, at least, as a means of taking care of these ordinary hazards of our social and industrial life.

Any aid extended by the Federal Government to the States for the health and hospital care of the aged and dependent children would also be regarded as transitional.

Any large extension of grants-in-aid to the States at the present time for medical and hospital care of the indigent might seriously jeopardize the long-range objectives of a national health security program.

In other words, people come along and say, "Here you have got it. Now, this is our solution." But, as I pointed out, the question is, in the long run, whether that solution would stand up under severe tests, whether the needs test would stand up.

Those who feel that medical and hospital care can be administered on the basis of a needs test should study what is happening in many of our Middle Western States. For instance, in Iowa and Nebraska when a farmer does not have the funds necessary to pay for medical and hospital care for himself or for his family, he goes to the county commissioners and through them makes arrangements for the necessary care. But there is really no needs test. Suppose this pattern were extended over the country. What would it mean in the long run? It is clear that it would mean straight public medicine. I have referred to that already.

There is a second concept with which we have to deal in planning a national health security program. It is the concept of those who believe in a general program of public medicine for all the people of the United States. We find such a concept in the Maternal and Child Welfare Act of 1945 (S. 1318). This proposed legislation would provide a complete program of medical and hospital care for all mothers and for all persons under 21 years of age. This would mean a complete program of medical and hospital care for 50,000,000 people in the United States.

This objective would be attained by certain fundamental changes in title V of the Social Security Act. Title V was originally designed to provide educational services for maternal and child welfare in rural areas and areas of severe economic distress. S. 1318 would extend these services to every section of every State. It would provide not only services, but actual programs of care.

Senator AIKEN. Is that the maternal and child welfare bill?

CHILDREN'S BUREAU SHOULD INTENSIFY, NOT EXPAND

Reverend O'GRADY. That is the maternal and child welfare bill. I wanted to emphasize that is another concept, another philosophy that we are going to provide medical and hospital care for all the people. If you provide it for 50,000,000 people, why not for all the people? That was discussed very fully in 1935 when this act was passed. There was a question then of areas of special need. And, of course, areas of special need ought to be taken care of. I do not think anybody seriously questions that, but you have a tendency in these Federal programs to spread out over the entire State instead of thinking of the areas for which they were first established.

S. 1318 would not only provide fundamental changes in the maternal and child health services and services for crippled children, but it would also bring about fundamental changes in the program of child welfare services.

The various provisions of title V of the Security Act were originally designated to meet special situations in rural areas and areas of special need. When these sections were being written it was pointed out that the rural areas and areas of severe economic distress presented especially acute problems and that it was necessary to make special provision for them. Entirely sound thinking, because there is a tendency on the part of rural communities to lag.

It was felt that such provision could be made without entering into the complete programs of the States. It was thought that the United States Children's Bureau would be given an opportunity of doing a fine demonstration job. The changes now proposed would extend the provisions of title V to the entire area of the United States. It would extend them to every community in every State. It is feared that under such a plan, the money might be spread out thinly over entire areas and that the rural areas and areas of special need would still be neglected, and that it would provide for the larger communities means of economizing on the expenditure of local funds.

If additional funds are needed to take care of the problems of rural communities and the areas of special need, there is no reason why these funds should not be made available, but it is a far cry from the original program of the Children's Bureau to a complete program of public medicine. After all, if we have a complete program of public medicine for 50,000,000 people, there is no reason why we should not have it for 35,000,000 people.

What is true of medical and hospital care is equally true of child welfare. If the Children's Bureau needs additional funds to take care of areas that have not been reached by existing programs there is no reason why it should not have the necessary funds. But when it wants to reach out to every community in every State, one may question the validity of its program. It might be much more desirable for them to intensify their efforts in needy areas rather than to look to new fields.

Maternal and child health services and services for crippled children under title V of the Security Act, should be intensified in the areas for which they were originally designed. If, however, these programs are to be truly effective, it would be necessary for the United States Children's Bureau to adopt a different type of relationship toward voluntary efforts not only in the field of health, but also in the field of child welfare. Any further intensification of its program should go hand in hand with specific provision for joint planning with voluntary organizations in the fields of health and child welfare.

HEALTH INSURANCE REQUIRES ADEQUATE PAY-ROLL TAXES

A national program for health security should be based on the joint efforts of the individual, of industry, and of government. I am assuming here it should be built up on the principle of earned benefits. The benefits paid under such a program should as far as possible be earned benefits. They should be based on contributions made by the worker, by industry, and by government.

In order that the benefits may retain the character of earned benefits, the largest part of the cost should be borne by the individual and by industry with government playing a supplementary role. That, as I understand it, is a fundamental principle of social insurance.

In a health security program, we are liable to face the same experience that we faced in old-age and survivors insurance. Industry has been unwilling to meet the cost of an adequate system of old-age and survivors insurance, and in this connection I am not indulging in any utopian thinking. I think we ought to have grants that are reasonable. It keeps on resisting increased taxes, with the hope that the largest part of the cost may be borne by the government. Under such

conditions we are very liable to drift into a system that does not meet fundamental standards of adequacy.

In building a program of health security, we should be sure from the very beginning that pay-roll taxes are sufficient to support an adequate system. An adequate health security program will be of very little benefit to the American people. Many of the problems that we are now facing in the consideration of this program center around the assumption of inadequate funds. Why do we have to have so much centralized control over administration? Why do we have so many rules in regard to hospitals and in regard to medical fees? Is it not due to a desire to spread an inadequate fund thinly over a very large number of people? I believe, therefore, that it is most important that we should begin our national security program with adequate benefits based on an adequate pay-roll tax.

And I think the people studying the technical end of it should be required to explore the thing fully. Our experience is limited. That is an excuse we have, although we are gradually building up experience through the private funds, but I think from the very beginning, we are to face that question of the consideration, just like we have to sometime, like we should have in old age and have failed to do so far.

From the very beginning, a national health security program must have universal coverage. That is, a program that does not have universal coverage is not going to meet our needs.

This does not mean that everybody will be included in one governmental system. It does mean, however, that everybody must be covered. Coverage must be compulsory in fact, but voluntary in form. And what does this mean? It means that all those who are now covered by voluntary programs can continue in their present status. It means an opportunity and an incentive to provide new voluntary programs. Those programs should be continued and some sort of definite relations ought to be worked out between those programs and the governmental set-up, and it seems to me that that is a thing that can be done with openmindedness on the part of everybody concerned.

I believe there is fairly general agreement now that a national health security program should include universal coverage against the hazard of ill health. There is general agreement moreover—and I think the people in the Social Security Board agree to this, as far as I can find out from my discussion with them—that voluntary organizations engaged in rendering health and hospital services should be made part of the national program. There is, however, much difference of opinion in regard to the actual role of voluntary agencies in the national program.

THE ROLE OF VOLUNTARY PLANS UNDER NATIONAL HEALTH INSURANCE

I think most of the people are agreed, and I think most of those who take the objective attitude feel that it can be worked out to the satisfaction of everybody concerned. At least, I feel that way about it, and I know that there are many others who feel likewise.

What position are they going to occupy in it? Simply using them in a secondary role under the control of the Surgeon General of the United States, does not meet the basic objectives of a sound program. I believe, however, that with open-mindedness on both sides, it should

be possible to reconcile conflicting views in regard to those who want a prepayment plan as the basis of a national health security program.

That, as I see it, is our fundamental objective, to build up a system of earned benefits and use all these other programs as transitional.

It is a matter of difference of opinion on the one hand between those who want to give the voluntary agencies a major place in the program and those who want to give them a relatively minor one; between those who want an adequate plan and those who want a purely minimum plan; between those who want highly centralized administration and those who want decentralized organization on a local basis, with the major problems and policies decided on the local basis, but with the right of appeal on the part of each local group, each local professional group of each local agency, to the national authorities.

In projecting a health security program for the American people, the weight of the arguments, in my judgment, is in favor of a national group administered directly by the National Government, but with the large degree of autonomy on the part of local communities in administration and policies. The national administration would be patterned in some measure on old-age and survivors insurance but there would be some important differences due to the local character of medical and hospital organizations. There would have to be a local committee which would be fully representative of different local groups having an interest in the program. There would be also the professional groups which would determine policies in their field, subject to certain national policies.

In the field of health security, the Federal Government is entering into a new field and yet those who are thinking of it in terms of administration are people who have been patterned by a public health background, and at times I have been critical of the Public Health Service, and I am still critical of it in lots of respects. It does, at times, tend to become very bureaucratic even in its own hospitals. They think in terms of a program administered entirely by Government. They think of a Government official rendering decisions without much respect for democratic processes, and here again, I think you have to think more and more about democratic discussion with the various groups concerned. Of course, it will be quite clear that if a Government official tries to impose his views without respect to democratic processes, the people and their representatives will not accept them, so one gets political pulling and hauling as a substitute for democratic processes on a factual basis with the groups that are immediately concerned.

In this program, therefore, we may very well think of a new approach in the making of Government policies. We already have this approach in the relations of Government to labor, and other groups.

More and more Government is willing to reckon with labor even in regard to the conditions of employment of Government workers. The relationships of Government to voluntary agencies may very well be based on democratic discussion and the reaching of an agreement by process of negotiation rather than by the use of Government authority.

Those who have been planning a national health security program seem to attach great importance to advisory committees both on a

national and on a local basis. In evaluating the place of advisory committees, we might well think of the position that advisory committees occupy in present Government programs. Usually they are selected by the Government executive in charge of the program. He usually selects people who agree with him and usually, moreover, he is the presiding officer at all the meetings. The members of the advisory committees have very little access to the facts. Those charged with the administration place at their disposal such facts as they may desire.

Clearly, advisory committees operating under such conditions cannot be very effective. If advisory committees are to be truly effective, they must be more fully representative of different interests in the field. They must have more independence. They must be able to give more time to the work; they must pay their own personnel so that they may be in a position to make their own studies. They should have their own officers. They should elect their own chairman. And they should be in a position to call their own meetings when it becomes necessary to do so.

The CHAIRMAN. Now, Monsignor, you have traveled very extensively in the United States during the last 10 or 20 years, and have come in contact quite directly with the people of this country.

Reverend O'GRADY. Yes; I have traveled some.

The CHAIRMAN. Have you found in your travels, and in your experiences that there is a lack of adequate medical care for the masses of our people?

Reverend O'GRADY. I think, for the great middle class, as I pointed out in referring to Iowa and Nebraska farmers, I find there is. There is a very severe hazard.

The CHAIRMAN. You find that condition exists also in some of our great industrial areas?

Reverend O'GRADY. Yes. I found in some of my earlier studies of old age, for instance, and I make many studies and I gave a good deal of time to the study of old age in 1919 and 1920, certain industrial communities, and I found that that was one of the basic reasons why more than one-third of our people were unable to save for old age, this hazard of ill health is a serious hazard, not only for the individual, but for the members of his family.

You find many times a family, in a short period of time, uses up the savings of a lifetime.

I found that in the study of individual cases, because, again, my attitude toward this group, I think, in dealing with this problem, as in dealing with other problems, too; you have to consider that great middle class. You do not consider just the poor people, because, somehow or other they manage to get hospital care. The physicians are very generous. The medical profession is. The hospitals are very generous.

But the ordinary wage earner, no more than he has ever been reached by the housing program, he has not been reached by these programs, except that, of course, now, hospital care is spreading.

I think more are protected now, especially in the cities.

Now, in the country, that is not to the same degree. You have got this question of the farmers in the country, too. You see, the farmer does not have the cash all the time, and there is a question of special adjustments for him.

He cannot pay cash on the barrel head, you know, and I have followed this program in the country, in the counties I have visited.

I suppose of the 3,000 counties in the United States, the chances are I have been in certainly more than 1,000 and maybe half of them, and I have been around among the people in those counties. I have not satisfied myself with visiting the county officials. I have been in the market place, and I have been in the cities, too. I have been in the lines. I have seen and talked to lots of people about this problem, and what it means to them, the actual problem of care.

You begin to sum up and you find two or three in a family ill in the course of a year, and you begin to figure up what it costs, the hospital charges, the doctor's fees, the extras. It is a very serious problem.

The CHAIRMAN. Monsignor, while you point out that the people in the very low income brackets are able to get by in some way, do you find that the medical care that they get is not sufficient to really provide for them and for their families?

Reverend O'GRADY. Well, in the lowest group, I will have to say this: In the big cities, I think that with all these hospitals and clinics, I think it is fairly good. Of course, it is unevenly distributed throughout the country districts. So you have a spread of hospitals, the hospitals are run pretty well on the whole, because the doctors insist on that, you know. The doctors do.

But I think in the lowest group, as far as I have been able to see, in the country you have the question of coverage.

I realize that is very important, and in many of the agricultural regions, I am thinking now about this group of workers in which I have been interested especially. That is the migratory agricultural workers. I have followed them around every year in certain areas.

The program of care for them has been quite inadequate up to date.

The CHAIRMAN. Monsignor, it has been pointed out to us during these hearings, that a man has a duty or a moral obligation, based on the natural law, to provide protection and health care for himself and his family.

Reverend O'GRADY. Yes.

The CHAIRMAN. What have you to say under modern conditions as to the ability of the average person to carry out that moral obligation or duty?

Reverend O'GRADY. Well, I think, again, it depends on how much income he has got.

That is a matter of cold figures, I think, as to how far the ordinary man can furnish that. I suppose you can easily figure it out in terms of budgets. I have not done it recently for health.

I have done a good deal on the housing recently, how much a man can pay.

You can tell what it will cost to buy that. I should say that the ordinary man, who earns about \$1,500 a year, could not pay the cost.

Of course, the cost of hospital care is not so great. That is the cost of the ordinary protection of 30 days, let us say. That cost could be carried.

What strikes one, I think what is especially difficult about this problem is the serious, the more serious impact of illness. That is, you take a person who has an illness. If a head of a family has been ill for 50 days, and he had just 20 days' coverage under his hospital plan, now he would have to pay for 30 days.

Now, that man was earning about \$2,000 a year. Now, you take his loss of income over that period, his medical bills. He paid about \$6 a day, for about 30 days. Now, then, I do not know exactly what his doctor's bills were, they certainly were very high. He had a lot of other hospital fees. Now, I would imagine that that illness alone certainly did not cost him much less than \$600.

Now, out of his income he certainly could not afford to pay \$600. If that man had a series of illnesses in his family, illnesses among the children, and you count those up year by year. Here is one. Here he has \$600. His wife has a new baby that costs \$200 or \$300. Then the children are ill.

It is the uncertainty of the hazard. Measure the character of it, and you find that most of your systems provide a limited protection.

Now, that is a very serious question. I think the man who is ill for a longer period of time needs the protection more than a person who is ill only a short period of time.

You have got all these problems arising in this particular field.

Of course, people should be encouraged to carry their own obligations. There is no question about it. The families ought to be encouraged.

The CHAIRMAN. But that obligation, you feel, Monsignor, is limited?

Reverend O'GRADY. Limited by his resources. I think that is the only measurable method we have got now. What he would have to pay an insurance company to carry that risk.

The CHAIRMAN. And every man with a family has to go through the experience of having various illnesses among his children.

Reverend O'GRADY. That is right.

The CHAIRMAN. You go through all these children's diseases.

Reverend O'GRADY. When you take a person between the ages of 30 and 45, then, of course, his own morbidity incidence increases in his forties. I find many people who have had savings used up because of their illnesses, the increased amount of illnesses they have to face in their forties.

The CHAIRMAN. Your experience has led you to the conclusion, then, Monsignor, that it is impossible for a man with a limited income to meet these obligations, however desirous he may be to carry out his obligation to protect his health and the health of his children?

Reverend O'GRADY. That is right. I think he ought to be encouraged to do it, and he ought to be encouraged to form associations of his own to do it.

The CHAIRMAN. Do you not think, though, that the breadwinner avoids the cost of medical care for himself in order to provide full protection for his family?

Reverend O'GRADY. That is, he wants to build up. He wants to do what people naturally do in a democratic system. He wants to build organizations for certain purposes which he joins to promote certain purposes which he cannot promote as an individual. And he wants to spread the cost.

It is a natural desire.

That desire of association goes back very far in human history. The desire to get together to form associations, to form guilds, to form groups of different kinds, which will spread this risk over a wider area.

That is a very natural human instinct, and certainly ought to be encouraged in a democratic system. We do not want to jump immediately from the individual and from the family to Government. We have to think of certain other groups in a society, that one of the reasons why the Danes were able to resist Mr. Hitler so well was because they had these democratic groups, and you could not get at them. You could arrest an individual and throw him into jail, but the power of these cooperative groups remained.

I think they were a very important element. I am a firm believer in cooperatives of all kinds, and they ought to be encouraged to cover as much as they can of these hazards. I think that is a good American philosophy.

The CHAIRMAN. Monsignor, do you think that these cooperative plans or voluntary methods of meeting this need are adequate for the great majority of the working class of the country and the small farmers?

Reverend O'GRADY. They are inadequate in coverage. They do not cover sufficient.

VOLUNTARY PLANS SHOULD BE ENCOURAGED

I pointed out the importance of having universal coverage, but insofar as they are able to go, they ought to be encouraged.

In other words, because they do not cover the whole field, we should not start out to discourage them and to throw cold water on what they have done any more than we can on private effort in any other field.

In other words, I think that in a democracy that is a mistake, to simply discourage them and say, "You have not done it and we will cast you out of doors."

They have made progress, and are making more. It is as clear as daylight to me that they cannot do it all, that you need a governmental system, and a large area will have to be covered by Government, but Government ought to work with the existing facilities.

My feeling is we ought to have a universal prepayment plan. Everybody ought to be protected against these hazards.

As I pointed out, there is a large question here about the relationship of Government to these existing voluntary systems. That is a problem that has to be faced, and ought to be met on a democratic basis. We ought to use the best that we have in our traditional methods and implement that and support that and extend it so that we get universal protection for everybody. I think that goes without saying.

I am in favor of a system that will provide universal protection against this hazard for all those who need it.

Of course, what income group you are going to include, that is another story. That is a matter of figuring what income group you want. How far you are going to go in the scale of income. You have had that in regard to forms of social security, old age and survivors; you went up to \$3,000.

In other words, this Congress has virtually said that in old age, those over \$3,000 can take care of themselves.

I am not saying whether that is high enough or whether it is low enough. It has been set.

There have been suggestions recently by a special committee that that should be extended to \$3,600. That is a question. I think that is a question of detail, a question of experience, and budgeting studies and what actual experience has shown.

Either you make a good guess or you build it up on the basis of experience. I suppose we have sufficient experience, to some extent, in that particular field, on the basis of the health studies, as to the income groups that can take care of themselves. In other words, what income groups, maybe, can provide insurance themselves.

The CHAIRMAN. Well, Monsignor, you have found in your studies of this problem that the American people have sought to foster and encourage those voluntary systems to the fullest extent?

Reverend O'GRADY. That is right.

The CHAIRMAN. They have developed voluntarily among the people, and the Government itself has sought to encourage them even to the extent of bringing suit in the country to prevent interference with them.

Reverend O'GRADY. That is right.

The CHAIRMAN. So that every effort has been made on the part of the American people and on the part of the American Government to foster and encourage those voluntary systems; is that not true?

Reverend O'GRADY. Yes. I think that, on the whole, the Government has encouraged this.

I think that there is a question as to whether or not some more methods of encouraging them should not have been developed. There is a little bit of tendency, in my experience, on the part of certain governmental agencies, to do their own planning, sort of independently of what has been done in the field.

I have kept on pointing that out around this town for years and years, and I am still keeping on pointing it out. I pointed it out to the advisory committees. They appoint people to agree with them. Most of these executives in this town want people on the advisory committee that agree with them, and if you do not agree with them, you get off pretty quickly.

I think we are going to need, in a democracy, strong militant voluntary organizations. I think they are necessary for good standards. I think all people who exercise great power in Government, and I mean these men, need these checks and balances.

You know what power does to people. The check of a strong voluntary system, I think, has great value. It has a great value in keeping up good standards. A Government program alone is likely to become pretty tough, you see.

The CHAIRMAN. If voluntary systems could be developed to the degree of taking care of the needs of the American people, it would be a desirable system.

Reverend O'GRADY. No. They cannot. I agree, there is no question about that. There is no question in my mind about the fact that you have to have an over-all governmental program. There is not any question about that. You have to face that fact. It has to be based on the principles I have pointed out, in my judgment.

The CHAIRMAN. The voluntary systems are of varying kinds.

Reverend O'GRADY. That is right.

The CHAIRMAN. Some of them will supply one phase of the needs and others will cover some other phase, but none of them seem to give the average workingman an opportunity to provide full coverage for all of the illnesses that may occur in his family.

Reverend O'GRADY. That is right. I think that is right. I think they need to be implemented, and we need to have universal coverage.

Of course, if you have State systems, you must remember you are going to have what really amounts to one system in one State, another system in another State, and a third in another. And, like old-age assistance, we have 48 systems.

The CHAIRMAN. Then, we have in this country, too, the situation where working people move from one area to another, and under those systems, it is sometimes difficult for them to provide for medical care under voluntary systems.

Reverend O'GRADY. That is right. That is right. It has difficulties.

The CHAIRMAN. Even though the voluntary system were complete and adequate for the purposes, it still would not work effectively where they move around from one place to another.

Reverend O'GRADY. That is right.

The CHAIRMAN. Do you think that it would be possible to ever completely develop a voluntary system in the United States that would take care of the needs of a great majority of the American people?

Reverend O'GRADY. I think it is hard to tell how far it will go, but I do not think so. I do not think that there is enough. I do not think we can ever get the type of coverage needed through a voluntary effort alone.

The CHAIRMAN. You believe, then, that a compulsory system of some kind is needed in this country to meet this problem for the American people?

Reverend O'GRADY. I think I explained clearly the point of view at which we have arrived. This is not merely my own point of view. I am speaking for some others who are interested in this discussion.

My individual point of view might be one thing. The point of view of a group is another thing. I think we are convinced that there ought to be something compulsory in fact. Everybody should be included.

If he is equally well protected, I do not think you ought to force him into a governmental plan. You ought to dissolve these existing plans. You ought to provide for their survival and for their development. The individual man may not be able to do it now, but he may want to go ahead and select an organization of his own choosing. I know there are some technical difficulties that the experts will bring up against that. They will say, "You are going to be left with the poor risks."

I think you have got to measure democratic values on the others, and the values on the standpoint of the active interrelationship between Government and voluntary systems.

And I know in the States, one of the most discouraging things in the States, in these new public-welfare systems, nobody seems to care. "Turn it over to the Government and they will take care of it." You begin to wonder why you can stand the type of institution they have got in certain States. The answer is, nobody cares. They turn it over to the Government and forget about it. You cannot have a good standard under that sort of system. You cannot preserve the spirit of humanism, interest of a man in his brother man. If you do not get

that, you can have all the superstructures you want, but they are likely to defend to the level of bureaucratic mechanical devices, and I would say even cruel systems. I would use that term, because I have seen that in many types of service in the United States. I could point my finger to certain things I have seen. I know them.

I have crusaded against them.

I think you need that. That is the reason why we need to preserve the spirit of voluntary enterprise, for the purpose of keeping alive the Government programs, keeping Government programs up to good standards. That is one of my reasons.

The CHAIRMAN. Your experience is that it is only through a broad general coverage that that can be done?

Reverend O'GRADY. That is right.

The CHAIRMAN. In a system that would make it possible to spread the cost and make the modern medical care more accessible?

Reverend O'GRADY. That is right. I agree with that.

The CHAIRMAN. Bring it within the means of the American people.

Reverend O'GRADY. That is right.

The CHAIRMAN. Medical costs have mounted tremendously in this country during the last quarter of a century.

Reverend O'GRADY. That is right.

The CHAIRMAN. And the costs are so high that the ordinary family, ordinary man with a family of children, is unable to get that care within his financial means.

Reverend O'GRADY. That is right. I think we agree.

The CHAIRMAN. You believe, then, that a universal system in the interests of the welfare of the whole people should be adopted?

Reverend O'GRADY. That is right.

The CHAIRMAN. Thank you.

Senator DONNELL. Mr. Chairman, I would like to ask the Monsignor some questions, please.

The CHAIRMAN. Yes.

Senator DONNELL. Monsignor, I have been greatly interested in the discussion of the importance of the preservation of the spirit of private enterprise to which you have addressed yourself so clearly.

As I understand it from your statement, and I quote from it, where you say:

From the very beginning, a national health security program must have universal coverage. This does not mean that everybody will be included in one governmental system. It does mean, however, that everybody must be covered. Coverage must be compulsory in fact, but voluntary in form. And what does this mean? It means that all those who are now covered by voluntary programs can continue in their present status.

And then a little further on,

There is general agreement, moreover, that voluntary organizations engaged in rendering health and hospital services should be made part of the national program.

That is your view?

Reverend O'GRADY. That is right. That is my view.

Senator DONNELL. There was one sentence you used a little while ago that I am not sure whether, in the context, it appears that your meaning was quite clear.

You used the word "dissolved." Did you mean to say, Monsignor, that these voluntary programs should be dissolved or not be dissolved?

Reverend O'GRADY. I meant they should not be dissolved. On the contrary, they should be encouraged to grow and develop. I think that it would be a tragedy to the maintenance of a spirit of brotherhood in our legislation.

Senator DONNELL. Yes.

Reverend O'GRADY. That is my basic philosophy which I have applied in other areas of legislation as well.

I am not just thinking of it in this particular area. I am thinking particularly of this area in which it is so essential to maintain the basic principle. If a man does not care about his brother man and does not have his interest, you do not have a spirit of humanism and brotherly feeling, and then you can establish all the programs you want, but they will just be mechanics.

Senator DONNELL. That is what I understood the general tenor of your view to be.

Reverend O'GRADY. That is right.

Senator DONNELL. And I wanted it perfectly clear that you are not advocating the dissolution of these voluntary agencies. I think possibly the word "not" was omitted inadvertently, but at any rate, this makes it perfectly clear.

The CHAIRMAN. Yes.

Senator DONNELL. You do not favor the dissolution of the voluntary agencies. That is correct?

The CHAIRMAN. You believe, on the contrary, that it was very fortunate that we had these voluntary organizations during the time that they have been in existence, and that they should have been more encouraged than they were, because they at least made a contribution to the problem of medical care for the people in this country.

Reverend O'GRADY. I hope they will make a continuing contribution, too, because I think they will be needed, and the more you get Government into the field, the more they will be needed. They will be needed to criticize, to constructively criticize, I mean. They will be needed to keep the situation before the public all the time.

The CHAIRMAN. You believe that these voluntary organizations can be adopted into and brought into a national program?

Reverend O'GRADY. I do. I think that there are a lot of details to be worked out, and I think this is a conservative program.

I am advocating a conservative program. I am not advocating a radical program, because I think the program I advocate is more conservative than that that is advocated by public medicine, than what the Children's Bureau is advocating.

I think the public assistance approach is going to lead you into the same thing, because I do not think for a moment the needs test is going to stand up over a long period of time.

I think it is going to break down and lead you into the same kind of public medicine.

That is what I say, if you are going around among the farmers in this country, do they stand the needs test? The farmers? The farmers in Missouri or Iowa or Kansas are not going to stand the needs test. When they need medical care, the farmer is going to get it through the county, whether they get the public assistance or not. He is going to get it without a needs test, and the needs test is going to break down.

I think the people advocating the public assistance approach are

advocating a much more radical approach than I. I am advocating an approach in harmony with the spirit of American philosophy and thinking.

I think the people who are advocating a public program are out in the open. They are advocating straight public medicine.

The CHAIRMAN. You think in our country we should have a system where everybody pays his way?

Reverend O'GRADY. Yes. Everybody pays his way who can who is able to pay anything. I think they feel "This belongs to me." I get that in unemployment compensation all the time. A fellow says, "Pay me what you owe me and get me out of here." You get a different spirit from what you get in a public assistance office. You get the spirit of supplience, people coming in asking something, begging something from the Government.

Many times I have been along the lines in the unemployment offices, and people are there applying for unemployment compensation, and I noticed their attitude. I get in a discussion with them, as to what they are doing, and how much the Government owes them, and all that kind of stuff.

There is a different mentality. This fellow feels this is a part of his wages, and it is his, and it is a right, and he does not come with bowed head, or two or three statements about how many people he has to feed, how much bread he has got left in his cupboard, or how much he has got left in his pantry, or anything like that.

In other words, he does not feel that he is a bankrupt individual. He does not come because he is bankrupt, because all his resources are exhausted.

That is, of course, the spirit of the poor law. Of course, some people tell you they make sure, as one public official told me a short time ago, and this was not just in the old days, he said, "You know, before we give them anything in this district"—he says, "we pauperize them." In other words, he meant we let them spend every cent they have got before we give any assistance.

The CHAIRMAN. Monsignor, you are opposed to that philosophy, then?

Reverend O'GRADY. I am opposed to that philosophy.

The CHAIRMAN. You think we should not establish two classes of people in this country. One class who cannot afford to pay for medical care, who have to be set aside as a pauper class?

Reverend O'GRADY. No.

The CHAIRMAN. And then the class that can afford to pay should not be a different system.

Reverend O'GRADY. I believe that we ought to have one system in the United States for all the people.

The CHAIRMAN. And we should have a system, then, whereby the people in the lower-income ranks can have their medical care at such a cost that they are able to pay for it?

Reverend O'GRADY. Well, yes. Of course, you will have to get in all these instances some support from Government.

I think that they ought to be minimized. I would like to see this come largely from this man's industry, from his own wages, so that he feels and has a feeling that he has done something for himself.

I would like to conserve that spirit in the United States as far as that can be done.

The CHAIRMAN. That is right. Thank you.

Senator DONNELL. Mr. Chairman, may I continue with my examination now, please?

The CHAIRMAN. Yes.

Senator DONNELL. Monsignor, I understand that not merely do you regard these voluntary methods and programs of insurance as of historical value, as the chairman put the question to you in substance a few minutes ago, but you responded you hope that they will be of continuing value in the future; is that right?

Reverend O'GRADY. That is right.

Senator DONNELL. And you do not favor the dissolution of these voluntary programs. That is correct?

Reverend O'GRADY. That is right.

Senator DONNELL. And then your judgment is that they can be organized in as a part of the governmental program?

Reverend O'GRADY. That is right.

Senator DONNELL. Yes.

Now, Monsignor, one question was asked by the chairman of you a little while ago as to whether the Government has not in every way encouraged these voluntary organizations.

Now, I am not saying that the Government may not have done so in some instances. I do not know about that. But there is one instance, is there not, Monsignor, in which the Government might very well have had additional encouragement, namely, by providing for pay-roll deductions for the voluntary agencies from the compensation paid the governmental employees?

That would be quite a considerable encouragement to them, would it not?

Reverend O'GRADY. That is right. I think that is one important step. They ought to be encouraged to keep the chance of surviving. They will have to provide for some sort of reimbursement.

I did not go into all the details, because I think there are some questions that need to be negotiated. I did not want to close the door entirely. I think we need something. I think the Government folks have come some distance. I noticed that in their thinking on that.

They have not gone far yet. The exports have not gone as far as I would like to see them go. I think they are going to have to come a little bit further, if we are going to get a system that is more agreeable, that is going to operate. I think they will have to yield a little bit more on that, on the more general acceptance of these voluntary systems, and providing for them.

You should not just have a double system of taxation. You should not compel all these folks to pay into this fund and then for the support of all the systems on the side.

I know what the theory is here. I do not think it is a sound theory. The theory is that the Government plan will be a minimum. I think that is unsound thinking to begin with, because I think we can get just a most inadequate system under those conditions, a plan that does not reach even the standards of decency. We will get something like we got in old-age and survivors insurance, about \$22 a month for each individual, and \$35 a month for each couple, and that certainly is not adequate.

I would not use them as supplementary. I am opposed to that thinking of certain Government people, and certain people in Public Health, who want that sort of a system. I would not go along with that. I do not think that this program or thinking of social security as just a minimum is adequate.

Now, for instance, that group will think of railroad retirement. They say, "Well, that is too high. We ought to include all these railroad people under this program."

Now; of course, I think if we have made an adequate system there, I think it ought to be encouraged by Government.

Senator DONNELL. Pardon me, Monsignor. For instance, in this bill, S. 1606, at page 68, and I do not know whether you are familiar with the details of the bill——

Reverend O'GRADY. I have been over it.

Senator DONNELL. Page 68, lines 9 and following, that has reference to the power of the Surgeon General to enter into contracts with participating hospitals.

I observe there that there is a provision that in lieu of such compensation, which, by the way, according to the testimony that has been given here, is very much less in figures than it really costs the hospitals to furnish the services.

Reverend O'GRADY. That is right.

Senator DONNELL. It says:

In lieu of such compensation, the Surgeon General may enter into contracts with participating hospitals for the payment of the reasonable cost of hospital service at rates for each day of hospitalization neither less than the minimum nor more than the maximum applicable rates specified in this subsection, such payment to be full reimbursement for the cost of essential hospital services, including the use of ward or other least-expensive facilities compatible with the proper care of the patient.

Do you see in that, Monsignor, the danger to the hospitals of the country such as was envisaged yesterday by Dr. Schwitalla that if the hospitals are to be limited down to a very low amount on a widespread national basis, that they may be confronted with real and substantial financial cost as to how they are going to support themselves if they are going to get a very small amount under the terms of this bill.

Do you see a danger along those lines?

Reverend O'GRADY. I see that same danger to which I have already averred, the danger of a wholly inadequate system, or a so-called minimum.

Senator DONNELL. Yes.

Reverend O'GRADY. So many people talk about that. I see a danger in that. I think we ought to start off with the idea that this is fairly adequate. I think the trouble with this thinking is this: That I think that all these details, which I think belong in administration instead of writing them into a bill, what you are going to pay, set up the per capita cost, of course, everybody knows this cannot get hospital care for even \$4.50 a day.

Senator DONNELL. I think it runs down to \$1.50 at one point in the bill.

Reverend O'GRADY. Now, we are getting, and we have negotiated recently with some public-assistance people for the chronically ill, for more than that.

Now, I think this rule-making, you see, irritates a lot of people. I think if we begin with an adequate system, I would not oppose the principle because of certain details in this bill. Undoubtedly, a lot of these things need to be changed.

Senator DONNELL. Monsignor, may I ask you this question: I understood you to say something to the effect a few minutes ago, that you would not favor the idea of compelling a man to pay twice. That is, if he is in a voluntary system and adequately insured, I understand you would not favor requiring him to pay again for insurance he would not need?

Reverend O'GRADY. That is right. There should be some plan for reimbursing that man, or encouraging him to continue his association with his present group. I think that this is the whole question of rates, that this should not be written into a bill. I think we ought to work that out. We will have to work it out, an adequate system of compensating hospitals. Otherwise, if we are going to have a sort of system that simply pays the hospital for all their patients, let us say, \$4 a day, you are going to put the hospitals out of business. There is no question about that.

Senator DONNELL. Yes.

Reverend O'GRADY. Now, as it stands at the present time, a lot of the hospitals go along with that, because most of their care is not in that field. They find they go along with an inadequate system of compensation under workmen's compensation in the States. It simply means that the hospitals are subsidizing private industry, because, after all, that affects the industrial-accident rates in the States.

Senator DONNELL. Monsignor, have you worked out in your own mind the machinery of working into this governmental plan these voluntary organizations?

Have you gone into that?

Reverend O'GRADY. I have in some detail. I have been discussing it a good deal with a number of the people concerned.

Senator DONNELL. Yes.

Reverend O'GRADY. Now, I think that there are some details. When I showed this testimony of mine 2 weeks ago to a well-known expert in the field, one of the best known, he said:

I think you have something there.

And he said:

I think you need to spell out the details of your organization a little bit more. You need to spell out the details of the local organization a little bit more.

You notice I believe in a national-local system instead of a national-State system. I think if you get into dealing with States, it becomes sufficiently complex, and I think on the whole the general principles of my underlying point of view are that I think that is rather clear.

Senator DONNELL. Yes.

Reverend O'GRADY. I think there is some place here for negotiation. That is what I am pointing to.

Senator DONNELL. Yes.

Reverend O'GRADY. That I am in the position of a negotiator right now. In other words, if I were in the matter, if I had the responsibility for working out the details of a system, I would want to enter into a chance of negotiating with certain people who have given this thing a good deal of thought.

I would not want to commit myself at the present time to all the details of a set-up, because I think I need to give it more thinking.

I know what is going to happen if I commit myself to all the details.

Then, of course, I know the bureaucrats will jump all over me and say that the thing will not work for this reason, and that other thing will not work for that other reason.

Senator DONNELL. May I interrupt at this point, if you will pardon the question.

You mentioned earlier in your testimony that the Government officials have a tendency to plan for themselves. You observed that and mentioned it.

Reverend O'GRADY. Right.

Senator DONNELL. Is there any reason to think that that same tendency would fail to exist after this Government insurance plan was put into effect? Would it not continue to exist?

Reverend O'GRADY. I think we have had some improvements. I think it is our fault that the Government is that way. I think if we keep on insisting long enough and hard enough, and the voluntary systems work on it, I think we can benefit. I am not a pessimist dealing with Government. I am an optimist in regard to this Government of ours.

I think we can change the point of view of Government officials. I think there is a better chance of changing the point of view of the Federal Government than there is of changing the Federal Government of 48 State bureaucracies.

That is my honest-to-goodness conviction.

STATES' RIGHTS

I know that sounds like I were talking about States' rights. I take a pretty realistic view of States' rights. I think that in dealing with this Federal Government, and with the Congress here, which is close enough to the people, if we keep close enough and get our facts and keep on building up the facts and keep in close contact with it, I think that we can compel the Federal bureaus to reckon with the point of view.

They do tend to become bureaucratic; there is not any question.

Every man tends to become bureaucratic when he gets a good deal of power in his hands, especially when he can build up around it the kind of machine they build up by some of these Federal-State systems.

I could mention Federal-State systems that work that way. They have State blocs. You will notice when you have something before a State committee, the Federal bloc marches up in line, and they are supported by Federal funds, and if they were Federal officials they could be brought up under the violation of the Hatch Act, but because they are State officials, you cannot touch them, and they come

here and they make what I feel constitutes some of the toughest bureaucracies in the United States right now.

The CHAIRMAN. Monsignor, right there, do you not think that is the reason why there is this great struggle to protect what they call States' rights?

In this country there is talk in a great many States of the Union that the States are under the domination of certain industrial and financial interests who control the operation of the State government.

In my State of Montana, for instance, they say that the State government is not over in the capital of the State, but it is on the sixth floor of the Hennessy Building, where the corporations hold forth, and that situation exists in many States of the Union. They completely dominate and control the lower governments.

In my State of Montana all the press, for instance, is owned and controlled by the corporations, and that, of course, is making a great fight for States' rights.

That situation prevails in many places, does it not?

Reverend O'GRADY. I think there is this question. I have been concerned more, I think, with its immediate impact in here. I know that a Federal official who is administering grants to the States can get a powerful bloc in here any time he wants to support any measure that they want, and it is very, very difficult to discuss them—very difficult to get them out in the open so you can discuss them in a democratic way.

You bring up the question of States' rights. You bring it up in a situation in which they are talking about a matter of States' rights.

It is a matter of, sometimes, decent standards—objective standards—and bringing the thing out in the open and discussing it.

That is what I am interested in. I am interested in good government—good administration—administration that keeps in mind the welfare of all the people of the United States.

That is my basic concern, and I think that is hard to maintain under this system of grants-in-aid to the States.

Senator DONNELL. Monsignor, I would like to ask just a very few more questions.

In the first place, I get your thought that you do not favor having persons who are insured under voluntary plans to have to pay twice?

Reverend O'GRADY. No.

Senator DONNELL. In other words, if they get complete protection—and we will assume that they have complete protection under some plan of voluntary organization worked out—you would not advocate that they be compulsorily required to pay the Government a second time?

Reverend O'GRADY. Except if there were a provision for reimbursement.

Senator DONNELL. For reimbursement.

Reverend O'GRADY. If that were done, I am satisfied. It has to be worked out by exempting them or reimbursing them, or having the fund reimbursed, or possibly have the fund pay over to the organization the amount that they would have paid into it.

I think that is a matter that has to be worked out.

I think that if you have closed minds, of course, you are not going to work out very much, but if you get open-mindedness in regard to it I think it can be worked out in a satisfactory way to all.

The CHAIRMAN. Do you know of any voluntary system, Monsignor, that provides this full coverage?

Reverend O'GRADY. Surely.

The CHAIRMAN. Which would give the complete coverage?

Reverend O'GRADY. Absolutely. You have lots of voluntary systems. Take the Edison plan in New York City. There are quite a number of plans all over the country that provide adequate medical care and clinical care also.

The CHAIRMAN. In certain industrial organizations, like the Kaiser people on the Pacific coast?

Reverend O'GRADY. Yes. They have very complete care.

The CHAIRMAN. You understand that this bill makes it possible for all those systems to be brought into this universal plan under this bill?

Reverend O'GRADY. I think an awful lot depends on how they are brought in. That is, you can bring them in in a way that will stymie them, or you can bring them in in a way that will encourage them. I think that should be worked out.

The CHAIRMAN. You think that should be worked out in the legislation?

Reverend O'GRADY. In the legislation.

The CHAIRMAN. The legislation can be so formulated as to make it possible to bring them in and utilize them in this general plan?

Reverend O'GRADY. And encourage them.

Senator DONNELL. At any rate, Monsignor, in S. 1606, you do not have in mind that that has been worked out in S. 1606?

Reverend O'GRADY. I did not want to come here and say that I was opposed to everything. I wanted to come here with constructive ideas.

Senator DONNELL. This plan of working the voluntary system in as a part of the Federal compulsory health insurance, you do not find that set-up in S. 1606?

Reverend O'GRADY. It needs to be revised and improved.

Senator DONNELL. Yes.

The CHAIRMAN. That is the purpose of this hearing, is it not, Monsignor, to determine what is the proper language that would make it possible to accomplish this.

Senator DONNELL. One other thing with respect to the veterans.

We had General Bradley here the other day, who was very anxious, I think, to effect the same point, as I understand it, which you have in mind on this duplication of expense.

For instance, if a veteran should have under the veterans' law, the right to complete the coverage, we will say—

Reverend O'GRADY. That is right.

Senator DONNELL. Suppose he did that. I am not arguing whether he does or not, but suppose he did. You would not favor that he would have to, in the ultimate effect, pay twice. You would not favor him having complete care once under the law, and then have to pay for it again?

Reverend O'GRADY. That is sound. If the Federal Government is going to provide a certain program for him, there is no reason why it should be duplicated.

Senator DONNELL. Just one other thing. There are a number of things here, but I am mindful of the fact that time is flying on, and we must go on.

Reverend O'GRADY. I must go before another committee, too.

Senator DONNELL. I will only keep you a few minutes, Monsignor.

THE ADVISORY COUNCIL

On this matter of advisory committees, I noted your comment, which I think is well taken, that there is a tendency on the part of appointive power to appoint advisory committees, to appoint persons he thinks will agree with his views.

He is not apt to appoint antagonists.

Reverend O'GRADY. And he presides in the meetings.

Senator DONNELL. He presides in the meetings.

Reverend O'GRADY. He is chairman.

Senator DONNELL. Your comment is very apropos to section 204 (a), which says:

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 it has even got it down here in so many words—

and 16 members to be appointed without regard to the civil-service laws by the Surgeon General and with the approval of the Federal Security Administrator.

Of course, you are familiar, Monsignor, with the fact that under this bill it is not required that this Council consist of any special number of doctors, any special number of laymen, any special number of different classes.

That membership is left to the appointive power under the direction that the Council shall include medical and other professional representatives and public representatives, in such proportions as are likely to provide fair representation, et cetera.

I want to call your attention also to the fact—

The CHAIRMAN. Before you leave that, I would like to ask the Monsignor if he has any recommendation to offer the committee in this regard.

Reverend O'GRADY. You mean in regard to the Council?

The CHAIRMAN. Yes.

Reverend O'GRADY. I think I would suggest that the committee be organized to appoint its own chairman, and that is one suggestion I did make in there.

And the second suggestion I made was whether or not the committee should not be able to make its own independent research.

How are they going to get the facts? Take the question of rates. There is a question that needs to be explored a great deal. Any of the figures I have seen, I do not think they are adequate.

I think that needs a great deal of study, to see what rates are necessary to support medical assistance.

There are a lot of things to be discussed in regard to which I think an advisory committee should be independent. They should be able

to make a study if they want to, themselves, and not to have to depend on such facts as the Surgeon General may place before them.

These are two specific recommendations that I would have to make about advisory committees.

I think that would strengthen the position of the advisory committees very greatly.

Now, an advisory committee, of course, so far as I have been able to see them in this city, they have not been very successful. They think they are possibly a method of meeting this new demand for participation on the part of voluntary groups, but I do not think they are yet an effective method, and we have to do a great deal more experimenting with advisory committees than we have done up to this date, so far as I have been able to see, and I have served on some of them, as you know.

I know we are called together occasionally, and somebody presents a lot of material to us, and you are supposed to just O. K. it. If you reply to many questions, well it is too bad.

The CHAIRMAN. Well, Monsignor, one of the witnesses appearing here yesterday, Rev. Father McGowan, of the National Catholic Welfare organization, suggested that instead of having the Surgeon General at the head of this system, that there should be a board of three to handle it instead of the one individual.

What do you think of that?

Reverend O'GRADY. I really have not given that thought.

I did not have a chance to discuss that in detail with Father McGowan.

I made the suggestion here that the committee elect its own chairman. I think that would be an improvement. I think we have got to gradually spread the idea around, "This committee has some status." And that it should participate more fully in the formulating of the policies, and that the Attorney General could not override it.

I think that there is a field there to be explored.

I know, of course, we have certain people who are authorities in Government in the United States. Some of them are friends of mine, and they think that that is very bad, to give their advisory committees too much power, because they are free, and it makes government impossible, but if the advisory committee had a chance of making its own studies, making its own reports independently to the Congress, that is a matter which would strengthen the advisory committee.

If the committee had an opportunity of making a report directly to the Congress instead of to the Attorney General—

Senator DONNELL. You mean instead of to the Surgeon General, do you not?

Reverend O'GRADY. Instead of through the Surgeon General, if they had their own authority, I think we have to think out various ways and means of giving these committees an independent status.

I think now they have for all practical purposes that I know of, and I cannot speak for those I do not know, the advisory committees I know of around this town, I think they are not very effective.

Senator DONNELL. Yes, sir.

Reverend O'GRADY. And I think that many of the Government officials recognize that, that you have got to find some other methods of participation of voluntary agencies in government besides these advisory committees.

As they are presently constituted, I do not think anybody is satisfied with them, except those that want everybody to agree with them.

Senator DONNELL. And you think this bill, S. 1606, should have careful thought with a view to improving the conditions along the lines of the Advisory Council?

Reverend O'GRADY. Yes; with a view of strengthening their position.

Senator DONNELL. I think that is all, Mr. Chairman.

The CHAIRMAN. I wanted to call your attention to some provisions in the bill which undertake to make it possible for these various voluntary groups to be brought into the system which is being provided.

I cannot seem to find the particular section at this moment.

Reverend O'GRADY. I think I know pretty much what the provisions are:

The CHAIRMAN. Here it is. It is subsection (c) of section 203 (a), and it provides as follows:

In carrying out the duties imposed upon him by this title, the Surgeon General is hereby authorized and directed, after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, to negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any State or political subdivision thereof, and with other appropriate public agencies, and with private agencies or institutions, and with private persons or groups of persons, and with combinations thereof, to utilize their services and facilities and to pay fair, reasonable, and equitable compensation for such services or facilities,

and so forth.

Reverend O'GRADY. I think that I know pretty much what you mean. I have discussed that with the people, in thinking about it, and I think it is a step. I think they have made some progress in the thinking, but that same thing was in the Wagner-Murray-Dingell bill, quoted almost exactly from the similar provision in the Wagner-Murray-Dingell bill.

It is a step. I think they are moving in this direction, but I think there are still a number of things to be worked out in regard to the position of the voluntary agencies in the whole set-up.

I think these questions that the Senator from Missouri raised in here, I think, get to the core of it. The relationship in the structure. The position they are going to occupy in the structure.

Now, I think this is a step. I think you have gone a step in this bill.

I do not want just to be taking a destructively critical attitude.

The CHAIRMAN. No.

Reverend O'GRADY. That is not the point.

I still believe there are a number of things to be ironed out.

If you want to give them a real position, that is. In other words, if you want to reduce them to purely inferior positions, if you want to gradually move them out of the system, that is one thing.

If you want to adopt a purely tolerant attitude, that is one thing. You are tolerant.

But if you want to reckon with them as something that is good, and that is going to be a continuing influence in the field, I think it is important.

The CHAIRMAN. I understand you are in a hurry to get away, Monsignor, and I will not ask any more questions.

Reverend O'GRADY. Fine.

The CHAIRMAN. You have another engagement, I understand.

Reverend O'GRADY. Yes. I am going to have. I was supposed to have.

The CHAIRMAN. I am sorry if we kept you here too long.

Reverend O'GRADY. Thank you very much.

The CHAIRMAN. We thank you very much for your appearance here this morning, Monsignor.

You always add to the study that we are pursuing, and I greatly appreciate your contribution.

The next witness will be the Honorable Arthur Lewis Miller, Congressman from Nebraska.

STATEMENT OF HON. ARTHUR LEWIS MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. MILLER. I have a prepared statement. I did not have it mimeographed as I was instructed to do. I might talk a little off the cuff, and if you see fit to put some of it in the record we will do so.

The CHAIRMAN. Your entire statement will go in the record. I am sure it will be a contribution to our studies and we will be glad to have it. If you wish you may summarize it and make any comments you wish, but the entire statement will appear in the record.

Mr. MILLER. I appreciate the opportunity of appearing before you and giving you any thoughts I have. I might qualify myself in stating that I am a physician. For the past 6 years, I have been in Congress and have been the State health director. I was president of the State Medical Association in Nebraska and the Fellowship of the American College of Surgeons, and I think I know more about being a physician than I do about Congress.

With that preliminary I might say that the bill, S 1606, entitled the National Health Act of 1945, should be considered in the light of how it will affect the American people. Will it improve the quality of medical care and bring a higher standard of healthy living? What would be the cost? Does the means justify the end?

I am sure, Mr. Chairman, that your committee is giving serious consideration to all of the pros and cons now being presented to you, by both the advocates and the opponents of this legislation.

DRAW-BACKS OF THE BILL

I have read the bill very carefully, and wish to address my remarks on title III, of the bill, which is the prepaid personal health service benefits. It is my humble opinion that if this section of the bill was adopted, that the family physician of every citizen would be a memory of the past. There would be a new character on the scene—Uncle Sam, M. D. I believe that this section of the bill would not only regiment the citizen and all health activities, but it would provide a political and socialized medical-care program. It would provide for a form of regimentation of medical service administered from the national level. It would be expensive, wasteful, and time-consuming. It would be ill-suited to the care of the sick in general, and medical emergencies, in particular. Such a program could not be adminis-

tered in a democratic manner, pleasing either to the patient or the physician.

The quality of medical service to the patient would be strained and inferior in the beginning and would rapidly deteriorate. Medical research would be curtailed. Medical education would be static, and medical progress in general would be set back many years. I say this, Mr. Chairman, because that has been the experience in those countries where regimentation of medical services has been tried.

DETERIORATION OF MEDICAL SERVICE IN EUROPE

Speaking of experiences with socialized medicine, I have had the privilege of making three trips to Europe. First in 1927, where I studied, in some detail, the working of various forms of panel medicine in England and in Germany. I had the opportunity again in 1935, to look, rather closely, into the type of medical service being rendered in Hungary, Austria, and Germany. Perhaps I can illustrate, to the committee, what I mean when I say that the quality of medical service is very poor under the system practiced in Europe, by giving you two illustrations. At one clinic in Budapest, I was amazed to find four or five major operations proceeding at one time in one small room. The technique used by the surgeons would not be permitted in the lowest grade hospital in the United States. Professor Slutznig, an outstanding surgeon, told me, after I had watched him doing a gall bladder operation, that he was very discouraged. I pointed out that he was not careful in covering up the raw surfaces of the liver after the gall bladder was removed. He merely placed several yards of stained gauze in the patient's belly. The gauze had been used and reused many times. He told me that he had no interest in his work; that he was getting about \$75 a month in our money, and if it were not for the American physicians, like myself, who paid him a small fee for attending his clinics, that he and his family could not live in the manner to which they had been accustomed before socialized medicine came into being. He said that the patient was only a number to him. He knew nothing about them and had no personal interest in them.

Another experience I had, was in a hospital in Heidelberg. I spent some time attending clinics and visited various operating rooms. On several occasions, I found interns or house physicians operating without caps, masks, or gloves, and chattering like a couple of magpies over the open belly. I went, several days later, to the rooms where the patients that were operated on, under these conditions, were taken, and the stench and odor coming from those rooms was almost unbearable. Infections of all kinds prevailed. I had many visits with a young Hungarian, who had taken a postgraduate course at Johns Hopkins. A fine, outstanding, well-qualified doctor. He wanted to come to this country. He saw nothing in the future of medicine in Germany. He had little or no interest in his patients. He said he was unable to practice good medicine under regimentation.

Mr. Chairman, when one is ill they want personal contact and service from their physician. The practice of medicine does involve a personal contact between physician and patient. There comes a time in the life of all of us when cold hard facts of science do not prevail.

The people want a personal service, with sympathy, particularly cheerfulness and confidence in the doctor. No amount of scientific service can take its place in the dark hours of sorrow and trouble so common in the experience of all of us. These are intangible things, and I have found, as a physician, that through the troubles and situations of life, fame often dies; honor may perish; but loving kindness is immortal.

I am certain, Mr. Chairman, that this national health bill does not spring from our traditions, nor from the public spirit. It is an offspring of foreign ideology, first brought to perfection by that German statesman, Bismarck. In every country where facism, nazism, and socialism prevail, there is socialized medicine.

I would remind the committee that the United States gained its leadership in medical education and care by methods that have been tested in the crucibles of time and economic hardship. This national-health bill would abolish the voluntary control and inspiration that have brought medical education, hospital management, drug purity, research, and medical service to their present high level. The best medicine in the world is practiced in the United States. We have the finest hospitals, medical equipment, and techniques in all the world. This bill would completely revolutionize medical practice, medical schools, hospitals, and technical research. Should we not consider carefully the progress made in the United States, under our free-medical enterprise, before we adopt a system controlled by salaried political bureaucrats? Certainly this bill would put the life of every citizen in the hands of a medical czar, not necessarily run by doctors, but controlled by politicians who hang around the courthouses of the country.

Free medicine, unshackled, and with little Government interference in this country, is the envy of the world. In 40 years, the death rate has been reduced by 60 percent in the United States. This-national-health bill is designed to centralize all social welfare and public-health activities in the hands of a few persons. You should ask yourself the question, "Shall medicine be continued to be practiced by men and women who are scientifically trained, and who have devoted themselves to the relief of the suffering humanity, or shall the practice of medicine be made over by a group of medically untrained bureaucrats who would use the medical profession as a tool, and the sick as clay in molding a huge political machine?"

The arguments for socialized medicine are often tied up with the number of men who were rejected by the Army. There were a great many men rejected because they were physically unfit. But the Army, in the beginning, had very high standards of physical requirements. The proponents of national health never point out that many of those rejected were rejected because of illiteracy and that this country has had compulsory education for many years. Some were rejected because of mental illness, and the care of the mentally ill has been under the direction of the Government for many years. The results are not very satisfactory. Some of the rejects had physical defects and deformities which could not have been prevented or cured.

It seems to me, Mr. Chairman, that if we were to create a federally controlled system of compulsory sickness insurance, which would include an estimated 110,000,000 people, that you would also create a tremendous Federal bureaucracy to handle all the details of such a

plan. I am wondering if the doctor's finger might not be stained with ink instead of iodine. The system would certainly destroy the American way of practicing medicine, which has developed in a healthful manner over the entire period of the history of medicine in the United States. The section in the bill involving medical education would remove the incentive that stimulates the student to require the best medical education obtainable, by offering that student a regimented practice, federally supervised, and controlled.

PROS AND CONS ON S. 1606

I have read the statement of the sponsors and authors of the national health bill.

1. They state: There is complete freedom of choice of doctor by patient.

This is incorrect. If either the patient or the doctor named on the panel by the Surgeon General declines to accept the other, the patient is assigned to some other doctor.

2. They state: There is complete freedom of choice of hospital by patient.

This statement is incorrect. There is no provision for freedom of choice of hospital. The entire system is under regulation by the Surgeon General.

3. They state: There is freedom of medical practice for the doctor.

This is misleading. The plan is so extensive that in time there will be no private practice.

4. They state: There is freedom of types of remuneration for the doctor.

This is misleading. The doctor is forced on a salary or on a fee basis or on a combination of the two, as determined by the Surgeon General who approves the fee tables.

5. They state: There is freedom of types of remuneration for the hospital.

This is incorrect. Hospital rates are determined by the Surgeon General with the approval of the Social Security Board.

6. They state: No doctor is forced into the insurance system.

This is misleading. He must go into the insurance system or be forced economically to cease the practice of medicine.

7. They state: No doctor is forced on a salary basis.

This is misleading. The doctor is forced on a salary or on a fee basis, or on a combination of the two, as determined by the Surgeon General.

8. They state: Arrangements for obtaining medical, laboratory, or hospital care would be essentially as they are now in this country, except as to payment out of insurance fund.

This is entirely incorrect. The whole medical system is supervised, regulated, and controlled by Government.

9. They state: Voluntary hospitals are eligible to participate in the plan.

This is misleading. They may participate if selected by the Surgeon General.

The question must be asked, "Is this in the interest of the patient?" I am of the opinion that the bill creates a panel and service would be

limited as to the number of patients he might have on that panel. You might want that physician, but his panel would be full. Under such a system, the physician would naturally work certain hours of the day. He would not be on call 24 hours a day as is the case now. Your little Jane had better arrange to have her gangrenous appendix removed only when her favorite surgeon is on the job. Your wife might want a special doctor to care for her during the birth of her child. That might not be possible under this bill.

The entire care of the individual is placed under the Surgeon General, and the Federal Security Administrator, and they prescribe the rules and regulations under which the practice of medicine and the care of the sick shall be carried out. It is true that there is an Advisory Council, but the Council is merely advisory. It seems to me that the local area committees set up on page 39 of the bill would be subject entirely to the superstructure of rules and regulations prescribed by the Surgeon General and the Federal Security Administrator in Washington.

As the State health director in Nebraska for 2 years I know that we have advisory committees. We were called in occasionally to Washington, but merely to O. K. some plans that had already been drawn up. We had no force in objecting. I would object to a number of things, but the plan was drawn up and here it is. You must take it.

In the State health directory in Nebraska, we had a maternal, child-health department in the labor department and the United States Public Health Service. We had to keep two sets of books. They were competing with each other as to how much money they would offer the State, overlapping and duplicating efforts of each other. We had immunization and vaccination, and so forth. The United States Public Health Service has been doing it for years. The Children's Bureau comes in and offers you a little more money. "Accept this and we will give you a little bit more."

We had two sets of nurses and inspectors, who would come around and inspect the work that you were doing under the Children's Bureau and the United States Public Health Service. Both of these agencies had their advisory councils, which was merely a figurehead to O. K. that which was already set up in Washington.

The Surgeon General is chairman of the Advisory Council. It can hardly be said that there will be any effectual local control. The Advisory Council, which meet not less than twice a year, and need not be made up of physicians.

On page 46 I note that the services of a specialist or consultant shall also be available to individuals entitled to a specialist, and only when approved by a medical administrative officer appointed by the Surgeon General.

When you need a specialist to look at your gall bladder or your ruptured gut, you do not want to wait a lot of hours because fatality rises every hour that you wait for a specialist to treat your acute illness.

In other words, if you felt that you were well enough, and wanted a specialist, you must first get the approval of an administrative officer.

I am certain, Mr. Chairman, that the type and quality of medicine practiced under this bill would not be the same that people wanted, and have been used to in this country. It would soon deteriorate as it has done in countries which has had socialized medicine.

If a physician does not care to practice under this measure, he may decline, but all of his patients, under this compulsory medical bill, must pay him, outside of their insurance, if he is to be employed. The patient would have no other choice.

The physician could not charge for any extra or special services which he might want to render to his patient.

Now I realize, Mr. Chairman, that some of the statements which I have made are opinions; inflammatory perhaps. Maybe they will be stimulative of thinking. It does appear to me that in the United States we have developed a system of medical care that, while it is true there may be a large group of people that feel they are not getting sufficient medical care, I submit why keep or confine the work of the committee to just medical care? There are people in the country who are not getting sufficient housing or food, which is just as essential as medical care. I would ask the committee that before you report out any bill to your body that the present bill be carefully redrawn.

I think the monsignor who preceded me here has a proper thought, that there is a large number of volunteer organizations which are only 4 or 5 years old but making steady progress in the line of voluntary insurance.

I think that any plan that might deduct payments from the pay envelope of the worker, if that worker is now in some voluntary system, industrial or otherwise, that he should be permitted to continue in that system.

Perhaps the answers are to enlarge, if you must have compulsory medical care, if payments be made to voluntary systems to carry on.

OTHER SOCIAL PROBLEMS ARE MORE IMPORTANT

I introduced a bill in the House to care for the old-age recipients of assistance. I am convinced that many of those men and women are ill because they are constantly worried about how they are going to take care of themselves and they do become ill.

The annual payments of States to old-age recipients amount to about \$60 a year now for presumably medical care, after much red tape and filling out the blanks they are permitted to get their two, four, six, or eight dollars a month for medicine. Their needs for food and clothing may be so great that they spend that money for food and clothing.

I suggested to Mr. Altmeyer, and I have a letter agreeing that the program might be worked out whereby insurance companies would take over a limited-insurance program for the recipients of old-age assistance under the payment that is now being made to them so that when they become ill they can be assured of medical care, hospital, dental, and nursing care.

It occurs to me that the problem of housing and food is just as important as medicine. I was in England a year ago last October when they were talking about the Beveridge plan. I sat in on one of the early conferences of the health program in England, where they were drawing up the blueprints to provide, what some people say is the "cradle-to-the-grave security."

Certainly the shepherd and the banker would be buried in the same casket, and a complete regimentation.

It occurs to me that this bill is a step forward toward the regimentation of the American people, the further regimentation of the people.

If we are going to adopt collectivism or stateism or socialism or regimentation in the country, then we should adopt, not only compulsory insurance, but compulsory housing programs and other care for the American people.

I am convinced that the majority of people, certainly in my district, are not in favor of further regimenting the American people.

The CHAIRMAN. We are very pleased to have your contribution to our studies. We are particularly anxious to get all of the criticisms on this bill so that it may be given a very complete study and we appreciate your appearance here this morning.

Senator DONNELL. Mr. Chairman, I want to concur in that statement to the Congressman too. Dr. Miller, I think instead of your utterances being subjected to any apology, that they have been extremely helpful to the committee. You made the suggestion that this bill should be very carefully considered and redrawn. I want to ask you, Doctor, do you mean at all to leave the inference from that statement that you favor compulsory health insurance?

Mr. MILLER. No; I am very much opposed to it.

Senator DONNELL. I was interested in your description of your personal experiences in foreign countries, and the observations that you have made. I would like to ask you, the State of Wisconsin is generally considered quite progressive along the medical lines, is it not?

Mr. MILLER. Yes; it is.

Senator DONNELL. I wanted to read a couple of paragraphs here from a statement by J. G. Crownhart, who was secretary of the State Medical Society of Wisconsin, located at Madison. This was published in 1938 and I want to ask you whether or not this concurs at all with your view as you personally saw conditions in Europe.

He says:

Again and again the observer is impressed that the standards of medical and hospital service in Europe are not generally those of America. The director of one of the large public-health institutes in Denmark pointed out this fact and referred to a lessening in the quality of teaching service in their medical school as one of the byproducts.

"Sickness insurance is a leveling disease," said this professor, who had visited this country on occasions. "It assures the mediocre physician just about the same reward as he would give an outstanding service if he were to have time. The incomes tend to be leveled but that's not all—the tendency over the years is to level the services to something that is neither bad nor good. But the incentive is gone and we develop fewer brilliant minds in our teaching centers and America catches the lead in health and methods to regain."

Generally speaking, does that accord with your observations, Doctor?

Mr. MILLER. Senator, I was shocked when I saw some of the treatment being given to the patients in Europe, treatment that would not be followed in this country, even in our poorest hospitals. The term "disability" and "neurotic" came out of Germany when they adopted compulsory health insurance. Patients were paid when they were unable to work, supposedly, and many of those folks developed a disabling illness. Neuroses of various types developed. This was in order to get the physicians to issue a certificate that they were unable to work. Europe lost their position of importance in postgraduate work in about 1920. Before that time many American physicians

went to Europe. I went because I thought it would give me a little prestige in saying that I had attended a clinic in Budapest, Heidelberg, and Hamburg, which I did, but I found that in 1927 and again in 1935 that we could get far better training in America than we could in European countries.

Senator DONNELL. I take it your observation would generally concur with this as I read it from Mr. Crownhart's statement?

Mr. MILLER. The quality of medical service in Europe greatly depreciated beginning in the early 1920s.

THE BILL WOULD CREATE A BUREAUCRACY

Senator DONNELL. You referred also in your statement to the number of bureaucratic administrative officers and so forth who were necessarily to be involved in the plan of this kind. I am going to read you just one more paragraph, if I may, from this same article by Mr. Crownhart, appearing on page 15.

He says, "It is also to be noted that in the experience of Europe there will be an employee in the system outside of the delivery of actual medical service for at least every 100 persons insured. While the nature of the work of such employees is held for later discussion, our concept of the legislation in its basic proportions is that it must include the Government as both the agent for the collection and the disbursement of the premiums, and, furthermore, as a vast employer for its necessary administration.

I assume, Doctor, that your observations and views are that there would be a great number of employees necessary in the administration of the system which undertakes to require a compulsory payment on the one hand from 107 to 112 million persons, and on the other hand the rendition of service to the equivalent number and perhaps even more. Do I correctly state your views?

Mr. MILLER. There must be necessarily many many Federal employees to handle such a system.

Senator DONNELL. I observe likewise along those lines in a book entitled "Compulsory Health Insurance in the United States," issued in 1943, the author of which is Herbert D. Simpson, emeritus professor of public finance at Northwestern University. The following statement appears therein:

One such consideration is the fact that if we assign this problem to the sphere of governmental responsibility it will mean probably the greatest expansion of the Federal bureaucracy that we have ever witnessed in peacetimes. The number of employees would be required to administer such a system it would be difficult to estimate. There are between 45 and 55 million gainfully employed persons in the United States at the present time; this, with members of families and dependents, would swell the number of potential beneficiaries to over 100,000,000, depending of course upon the type of coverage embraced in the system. The number of illnesses per 100 members in Germany ranged over the period 1925 to 1934 from 0.6 to 52.4, which would suggest something approaching 50,000,000 cases per year in the United States.

All of these cases would have to go through the process of certification, filing, inspection, payment, complaints, and adjustments. If an adequate field and inspection staff were not provided, it would mean wholesale profiteering at public expense. If an adequate staff and organization were provided, it would mean an army of Government employees.

Doctor, does your general opinion coincide with the statements made in the book I have just read from?

Mr. MILLER. Yes; they must necessarily be a large number of Federal employees to supervise this system.

Senator DONNELL. Now you referred, Doctor, to the fact that there is a tendency, as you very graphically put it in your opinion, for the doctor to become the wielder of ink rather than iodine, which I thought was very excellent. It is a simile or metaphor, I am not sure which it is, but at any rate in that connection I call to your attention without asking you to lift it, this book of 1,200 and some hundred pages, containing the "Law of the National Health Insurance" with rulings, explanatory notes, reported cases, statutory rules, and orders in Great Britain published in 1939. That is a rather hefty volume and somewhat tends to indicate what a good deal of paper work would be required by the doctors.

Mr. MILLER. The physicians in England that I talked to in 1937 and 1945 were greatly concerned about the amount of paper work, of the tendency for the patients to come in and sort of look at the sun and the doctor says "Here is prescription No. 7," and that was the type of service in the clinics. It was not a personal service.

People of America have been used to and entitled to a very personal service and they want and expect it, and if the doctor does not deliver that type of service he has no business having patients.

Senator DONNELL. Did you ever hear of a doctor in this country under our plan requiring a patient to sign a paper before he starts in on the treatment, freeing the doctor from all personal liability of any kind for the treatment?

Mr. MILLER. I think there might be isolated cases where that might be done. I never practiced it.

Senator DONNELL. You have never heard of it as a widespread practice?

Mr. MILLER. No; there are always a few black sheep in any profession.

Senator DONNELL. May I read you a few sentences of the book issued by the British Medical Association, which reads as follows:

The acceptance of a fee of an insured person not on your list, who specifically asked for treatment as a private patient does not constitute a 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 a request and applies for repayment as explained above. No doubt the statement would have to be signed before giving him treatment, but even so you are not free from the possibility of the patient making trouble on some of the unbounded allegations later.

Do you regard it as a wholesome symptom to have a situation existing between the physician and the patient by which there is such an element of distrust and fear on the part of the physician against the patient that before he would start to treat him he would want a signed statement?

Mr. MILLER. Of course it isn't good policy. Any patient that goes outside of the panel in England to receive treatment, that is quite a common practice in England to have them sign a statement that liability is not incurred. That is partly due to the fact that the physician under the panel system in England, is not permitted to make any extra charge for a patient. A patient might say "I want Dr. Jones, he is a specialist and he knows about my condition," and

Dr. Jones is not permitted to treat that patient, but the patient says "Doctor, I will pay you extra. I want some care. You have been my physician and know about me." So they sign this type of legal instrument, so to speak, to relieve him of the liability.

Senator DONNELL. You spoke in your statement, to quote the one that is going in the complete record—

The people want a personal sympathy, particularly cheerfulness and confidence in the doctor. No amount of service can take its place. These are intangible things.

Doctor, would you regard a system under which signed documents to save the physician from danger of a patient telling an untruth against him—would you regard that as tending to build up conditions of confidence and cheerfulness and fine psychological surroundings between physician and patient?

Mr. MILLER. Of course not.

Senator DONNELL. I have two other questions. I have here this book by Sir William Beveridge, which is the "cradle to the grave" document. That is quite an expensive book itself, as you observed. I think it contains about 290 pages. You are familiar generally with the general underlying principles of that plan, are you not?

Mr. MILLER. Yes; I have the book.

Senator DONNELL. Now, Doctor, I have another question and I will desist, and that is with respect to the matter of hospitals over in England. Are you familiar with the fact that there has been a great amount of publicity here recently culminating the other day in England with the filing of a bill, publication of a bill, put out by the Government? It was a Government bill for England and Wales, of which this statement is made in the London Times of March 27, 1946:

The estimated cost in the early years will amount to £150,000,000 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.

Were you familiar, generally speaking, with that situation?

Mr. MILLER. Yes; I have seen that statement.

Senator DONNELL. I saw a little thing in a Washington paper the other day to the effect that the health bill passed, I think, the House of Commons the other day. As I understand it, the bill that was before the House of Commons was this very bill, a part of which involved the matter of the Government taking over voluntary municipal hospitals.

Mr. MILLER. That is my understanding. I sat in on one of those earlier conferences in 1944 when the bill was being discussed.

Senator DONNELL. So I understand, Doctor, you are decidedly and without any question opposed to compulsory health insurance as set forth in S. 1606?

Mr. MILLER. Yes; I do think it would be bad for the American people. I do feel, however, and I have not been lax in criticizing ordinary medical groups who are not taking the lead in setting up voluntary health insurance. I think there are some groups in organized medicine who have been derelict in their duty to the American people.

I think they are going forward now. The American Medical Association has adopted some very active steps, which should be the means

of bringing many more folks under a voluntary system of medical care. I think it far supplants compulsory medical care, where those people who are unable to take care of their medical needs, housing needs, food needs, and the poor are always with us. I think there is a duty of Government, national and political subdivisions, to shoulder their responsibility to these people.

Senator DONNELL. You recognize the system of grants-in-aid to enable local subdivisions, such as State or lower subdivisions, to administer their plans?

Mr. MILLER. That is right.

Senator DONNELL. Are you from a city or a small town?

Mr. MILLER. I come from a small town of 2,000 inhabitants called Kimball, Nebr.

Senator DONNELL. You are familiar with the problems of the country physician?

Mr. MILLER. I am very familiar with them. I had a very very large practice and I ran a small hospital. I never refused to take care of anyone in the community. I practiced from 1919 and let up in 1940.

Senator DONNELL. That was about 21 years you actively practiced your profession?

Mr. MILLER. Yes.

Senator DONNELL. You were elected to Congress in your district?

Mr. MILLER. Yes, I was.

Senator DONNELL. Were you reelected?

Mr. MILLER. Yes, this is my second term.

Seantor DONNELL. Were you elected initially and reelected in the same district?

Mr. MILLER. That is right. I have no competition in the primary which occurs June 11 of this year, so I might be back to bother you next year.

Senator DONNELL. I am sure we will be happy to have you do so.

The CHAIRMAN. Are you still a licensed practitioner?

Mr. MILLER. Yes, I am.

The CHAIRMAN. Are you a member of the American Medical Association?

ATTITUDE OF THE AMERICAN MEDICAL ASSOCIATION

Mr. MILLER. Yes, I am. I have scolded many times in the past, Senator, about not taking the lead in medical-care problems, shaping and molding public opinion. I think there has been a laxity upon their part and I have told them many times unless the organized medicine got into the lead they would get in the way of public opinion and when they did they would get run over and hurt.

The CHAIRMAN. Do you not think they have made some efforts to mold public opinion, but that they have made an effort to develop an adequate system of medical care in the country which would provide for the masses of our people that have been unable to get proper medical care in the past?

Mr. MILLER. A big part of that comes about, Senator, because in small towns where I practice and in other areas, doctors have never refused to take care care of anyone. I know of no one in Kimball, Nebr., or in Nebraska that does not get all the medical care that they

want, whether they are able to pay for it or not. I think in some of the larger cities, a doctor is a little more choosy and it is a little more difficult for a large group of people to get medical care like they would like to get it.

The CHAIRMAN. But you do recognize that while the medical profession has contributed a great deal toward molding public opinion, they have not offered to the American people an adequate system of medical care which would make it possible for vast numbers of our people to avail themselves of modern medical care because of their financial condition?

Mr. MILLER. Well, I am of the opinion, Senator, that many of these people who say they are not able to get medical care are spending more money for chewing gum and other things than is necessary.

The CHAIRMAN. That does not exactly answer the question, Mr. Miller. I would like to have you answer the question that I presented to you. I realize that many members of the profession are very anxious to see some improvement, and a great many of them are assisting us in trying to work out that program. But I am talking about the great organized medical profession in the United States. Is it not a fact that while they have contributed a great deal toward molding public opinion, they have not made any satisfactory contribution to this problem that we are struggling with here, the problem of bringing to the general people of this country an adequate system by which they may be given medical care?

Mr. MILLER. No; I would not agree with you. I think they have made a great contribution to voluntary plans of the American people. I think they have hid their light under the bushel basket for many, many years. The doctors are busy practicing medicine, and taking care of the sick people. They are not politicians.

The CHAIRMAN. They all have been busy.

Mr. MILLER. I realize there are large groups in the country, some groups that we do not have out in Nebraska, thank God, that are quite anxious and active in developing compulsory forms of insurance, sickness insurance, and so forth. They would also have compulsion in other things in America, which this humble Congressman is definitely opposed to.

The CHAIRMAN. But organized medicine as a group have not undertaken to promote either compulsory or voluntary systems in the past. In fact, they were the subject of indictment and prosecution and conviction for their opposition to efforts on the part of groups of people in this country to organize themselves so as to make available to their members adequate modern medical care within their reach.

Mr. MILLER. Senator, I am sure you are familiar with the action of the American Medical Association of last January when they took very definite steps to approve a voluntary health program throughout the United States, and those programs are in operation now, I think, in every State in the Union. They are rapidly growing over a short period of time. There are not enough people in them, but more are coming in all the time and they are growing. The Blue Cross and other voluntary systems are being approved by the American Medical Association. That will be a great contribution to society.

The CHAIRMAN. I am directing my questions to prior to last January, during the period that this struggle has been going in this

country. Prior to last January we did have this situation where organized medicine, that is, the American Medical Association and the national physicians committee, which is a branch of that organization, has been fighting this effort to bring better medical care within the reach of the masses of our people.

Mr. MILLER. That might be true as far as the national American Medical Association is concerned, but back in 1939, when I was president of the Nebraska State Medical Association, we started a voluntary plan and many States started before that and had some very fine plans operating during the past 5 or 6 years. Beyond that time little was done.

The CHAIRMAN. But witnesses appearing here have told us that the American Medical Association represents and speaks for the American medical profession in this country, and they, as a group, according to some of the critics, have not made this contribution which they think should be made to the American people.

They were in a position to know how to do it and they took no action and it became necessary because of the serious condition of the health of the American people, as illustrated by the reports of the Selective Service Administration, that something should be done to relieve the situation.

Mr. MILLER. Well, Senator, just because somebody has a tooth missing and does not get into the Army, that does not say that he is ill and a physical wreck. You and I know that the selective-service figures indicate the standard for the Army which was very high. I mean men were rejected from selective service because teeth were lacking. Many were rejected for other reasons.

The CHAIRMAN. On the contrary, Doctor, my recollection of the report is that they took into the Army almost hundreds of thousands of men whom they subsequently had to reject because of their physical defects and insufficient health, to enable them to serve in the Army.

Mr. MILLER. Some of the men were not properly screened as to their mental illnesses and mental illnesses have been under the care of the State, 85 percent of them, for many, many years. Most of them were mental illnesses.

The CHAIRMAN. Many may have been, but sometimes those of mental illnesses come from families who have been deprived of proper medical care in their families and conditions of that sort.

Mr. MILLER. Senator, you would not change the shape of your nose or the color of your hair because you happen to be born of a certain group. You cannot change that in medical illnesses. You are born with a crack in the convolutions of your brain or you are not. When they get out of a groove and get into something else, they crack up and go to pieces.

The CHAIRMAN. But a lot of people crack up in this country because of the system that we have to live under whereby two or three hundred corporations rule the country and great masses of our people are denied adequate income upon which to live and maintain their families and educate and care for their children and give them proper medical care. People crack up under that kind of a system too.

Mr. MILLER. Oh, yes; indeed they do. But the thing I am getting at in this compulsory medical program; why confine it to medical care? Why not go the whole gantlet and give it to housing and food and

completely regimentize and sovietize the American people. If that is what the majority wants, that is what we will do.

The CHAIRMAN. The majority want a democratic system. They do not want a system whereby two or three hundred corporations rule the country or whereby monopolies are expanded to such a degree that the great masses of the people are unable to live with any degree of prosperity and good health. I think the trend toward collectivism in this country has been brought on by industry.

The great growth in power and wealth of corporations and monopolies has brought these conditions to prevail in this country. The people are seeking to avoid it. They want to live under democracy.

Senator DONNELL. Mr. Chairman, pardon me a second. I would like to have the record show that my silence here is not any agreement to the proposition that this country is ruled by 300 corporations.

The CHAIRMAN. I do not think that is necessary because the record is pretty well filled with evidences of your desire to oppose, and I have given you full liberty to oppose and I welcome all of your cross-examinations and your efforts to thoroughly examine the problem.

Mr. MILLER. It is not very often, Mr. Chairman, that a Member of the House gets to have such a personal contact with Senators at the upper body.

The CHAIRMAN. I am one Senator who is willing to condescend to the Congressman.

Mr. MILLER. We like to discuss these problems with you.

The CHAIRMAN. I recognize the right of a Congressman to come here and express his views, but I think at the same time we have a right to let you know what we individually think about it, and call your attention to what the American people are thinking about it as they have testified here for our committee to their representatives.

Mr. MILLER. I think any spirited and honest discussion of the problem is healthy for this committee and for the American people. As to large corporations, I think monopolies need to be controlled, and we have machinery of Government, through our Justice Department, to control monopolies.

The CHAIRMAN. They are controlled by Congress and limited in their funds through which they are able to stop this growth of monopoly and collectivism. It occurs in the House especially.

Mr. MILLER. The individual, whether Henry Ford or Mr. Kaiser, that comes up from the bottom and develops a large industry, employs thousands of people, is a great benefit to this country, and whether it is medicine or not, I think that medicine has made a tremendous contribution to society. The death rate in this country has been reduced remarkably in the last 20 years, and I am hopeful that any bill that this committee will report out will not stymie medical research and not discourage the scientists from going along and developing these new ideas which have been developing all along in this country, which in turn in countries which have socialized medicine have gradually gone down, and down, and down until they are completely discouraged and regimented to a point where there is no individual initiative or ability to proceed.

The CHAIRMAN. On the contrary, this bill is designed to bring about a spread of scientific investigation and development of new ideas in medicine.

Mr. MILLER. I wish I could think so.

The CHAIRMAN. If you study the bill, you will come to that conclusion, because that is the very purpose of the bill.

Mr. MILLER. If that is the purpose of the bill it certainly is not very well expressed in the bill and it needs considerable working over by a group who knows something about it, and not Isadore Falk and Mr. Cohen in the Security Division, because I think they had some other ideas in mind when they prepared the bill.

The CHAIRMAN. I am not speaking for Isadore Falk or anybody else. I am speaking from my own experience. I live in a far Western State, and we have the problems out there, so I think that I have a right to have an opinion on that subject, just as well as any Member of the House.

Mr. MILLER. You certainly have and you do have them. I will say that.

The CHAIRMAN. We do, and we intend to present them and study them and we are not going to be stymied by any group in this country or any American Medical Society or national positions committee, who oppose it. We are getting to the bottom of it and we are holding the hearings for that reason, and everyone who has appeared here has admitted that these studies have made a great contribution to the American people and have brought before them this serious problem. No matter what happens, we have made a great contribution.

Mr. MILLER. I agree with you about contributions, but I will say this, you do what you want in the Senate but I do not think the House has any interest in this kind of a bill.

The CHAIRMAN. Maybe next election we will find that they will be given ideas from their people at home.

Senator DONNELL. I am inclined to believe that, there will be a change in the complexion of both the Senate and the House.

The CHAIRMAN. The people in this country are studying just as we are, and they have a right to their opinion about it.

Mr. MILLER. That is right.

The CHAIRMAN. Thank you for your appearance here, and I do not want you to feel from anything that I have said that I do not recognize your right to come here and express yourself. You are a doctor belonging to a medical association and you have a right to your views. We are glad to have them and we will study them.

Senator DONNELL. Mr. Chairman, I observe although this clock is still 27 after 12, I think the correct time is 26 to 1 and the chairman will recall that the cloture matter is to be voted upon at 1, and I respectfully suggest that we recess until this afternoon.

The CHAIRMAN. We will recess until 2:30.

(Whereupon, at 12:35 p. m., Tuesday, May 7, 1946, the committee recessed to reconvene at 2:30 p. m., the same day.)

AFTERNOON SESSION

(The committee resumed at 2:30 p. m., pursuant to recess.)

The CHAIRMAN. Gentlemen, the hearing will come to order.

The first witness this afternoon is Leonard W. Mayo, president of the Child Welfare League.

Mr. MAYO. Senator Murray, I am glad to see you, sir.

May I introduce Dr. Helmholz, of the Mayo Clinic.
The CHAIRMAN. I am very glad to meet you, sir.
Mr. Mayo, you may proceed with your statement.

STATEMENT OF LEONARD W. MAYO, CHAIRMAN, NATIONAL COMMISSION ON CHILDREN AND YOUTH, ACCCOMPANIED BY HENRY F. HELMHOLZ, M. D., SECTION ON PEDIATRICS, MAYO CLINIC

Mr. MAYO. Mr. Chairman, I have a statement here which is in your hands and the hands of the other members of the committee here, which I would like to read for the record, with your permission.

The CHAIRMAN. Yes.

THE NATIONAL COMMISSION ON CHILDREN AND YOUTH

Mr. MAYO. My name is Leonard W. Mayo. I am dean of the School of Applied Social Sciences of Western Reserve University, Cleveland, Ohio. I appear in behalf of and with the authority of the National Commission on Children and Youth, formerly the National Commission on Children in Wartime. This commission is composed of approximately 100 men and women prominent in education, public health, medicine, social service, labor, and civic activity.

Such groups as the American Association of University Women, the Child Welfare Division of the American Legion, the National Council of the Young Men's Christian Associations, the National Committee for Mental Hygiene, the National Congress of Parents and Teachers, labor unions, and the American Farm Bureau Federation are represented on the commission, plus some of the other organizations on the commission; though, of course, they do not necessarily always speak for their organizations, but for themselves. In all instances, at least that.

The original commission was appointed in March of 1942 following a meeting called by the United States Children's Bureau of the Department of Labor to consider the critical and emergency problems of children during wartime. At the close of that session the group acting on its own initiative moved to organize the Commission on Children in Wartime.

Following the close of the war, the name of the commission was changed, and it was formally voted at the last meeting of the commission on February 7, 1946, that its work be continued under the name, "The National Commission on Children and Youth," with emphasis on the immediate and long-range problems and protection of children and youth in a democracy.

The major purposes of the commission have been and are as follows:

1. To collate and present to appropriate public and private bodies information concerning the general welfare of the children and youth of the Nation.

2. To bring together representative individuals and groups in the Nation who are concerned with the welfare of children and youth in order to discuss and recommend ways and means by which the needs of children and young people may be more adequately met through existing and new public and private welfare and health

services in cities and towns, in counties, in States, and in the Nation as a whole.

3. To act as a clearinghouse and as a center for exchange of information on the state of children and youth in the country, to analyze plans successfully promulgated for the meeting of such needs, to encourage the development of more extensive coverage and a higher quality of service for children and youth in the fields of education, health, and in other welfare services.

Acting under these mandates, the commission published in April of 1945, a pamphlet, which I have here, sir, entitled: "Building the Future for Children and Youth." This document was written under the direction of a committee selected by the chairman with the authority of the commission and was upon completion submitted to the entire membership for approval. A subcommittee under the chairmanship of Dr. Henry Helmholtz, of the Mayo Clinic, pediatrics section, Rochester, Minn., who is here today, was appointed to draw up the recommendations pertaining to health. Several members of the commission made suggestions which were incorporated in the final draft with the result that the pamphlet as it now stands, represents the point of view and has the backing of the commission as a whole.

The CHAIRMAN. The document you have referred to may be filed with the committee.

Mr. MAYO. All right.

Mr. MAYO. Among the members of the executive committee of the commission at the time when Building the Future for Children and Youth was written and published were the following:

A. W. Dent, Dillard University; Dr. Nicholson J. Eastman, Johns Hopkins University School of Medicine; Kermit Eby, Congress of Industrial Organizations; John W. Edelman, Textile Workers Union of America; Mrs. William A. Hastings, National Congress of Parents and Teachers; Mrs. Kate B. Helms, South Carolina State Department of Public Welfare; Dr. Henry F. Helmholtz, section on pediatrics, Mayo Clinic; Mrs. Harriet A. Houdlette, American Association of University Women; Dr. Oscar L. Miller, North Carolina Orthopedic Hospital; Miss Emma C. Puschner, executive secretary, national child welfare division, American Legion; Boris Shishkin, American Federation of Labor; and Dr. George S. Stevenson, executive secretary, National Committee for Mental Hygiene.

It is primarily with respect to title I, part B, of Senate bill 1606, that I wish to testify. The section which, as I understand it, really provides the community planning and facilities aspect of care for children and mothers.

In this connection, I would like to quote from the National Commission on Children and Youth a paragraph in its official statement, "Building the future for children and youth." I quote from page 11, paragraph 6, of the document already presented for the record:

To be most effective, the maternal and child-health and crippled-children's programs must ultimately fit into a total medical-care plan designed to lift the level of health and medical care for all people, but—

the report continues—

expansion of the services necessary for mothers and children must not be delayed pending decision on the total plan.

May I interpolate here that the commission has made it very clear in its statements and many of its meetings, that child-welfare services, as well as health services, are the basic necessity for proper development of children.

Also relating to the juvenile delinquency and proper care of children without homes, and it is the urgent desire of the commission that the committee consider the importance of that matter as well as the importance of the health services.

I would like to present the following data compiled by the Commission with respect to the need for increased maternal and child-health services and for services to crippled children, provisions for which are made in S. 1606 in title I, part B, section 121 through 129 inclusive:

EVIDENCE OF NEED

One in every four 18-year-old boys were rejected by the Selective Service System as unfit for general military service. Of these, hundreds of thousands were rejected for causes correctable in childhood.

Physical defects found in children during school examinations are found again year after year at repeat examinations. No major steps have been taken to correct this state of affairs. Health examinations are merely the first step in the process of building a healthy nation. Neither the provision of medical care or the education of parents on how to use available facilities has kept pace with scientific knowledge.

In 1942 for the country as a whole, out of every 1,000 babies born alive, 40 died before the end of their first year. In one State, the rate was 98; in another, only 29. The rate for Negro babies is almost twice as great as for white babies. Experience shows that infant-mortality rates could be cut in half, if we had the funds, the facilities, and the proper organizational approach.

Each year some 200,000 babies are born without medical care; and yet the first day of a child's life is the most critical.

Over 30,000 babies die each year because of premature birth. Deaths of infants on the first day of life have decreased little in the last decade, according to official vital statistics.

In the first year of life 9,000 infants die annually from gastrointestinal diseases; 17,000 from pneumonia and respiratory diseases; nearly 3,000 from measles, whooping cough, and other communicable diseases.

Maternal mortality decreased 56 percent from 1935 to 1942, and yet in the latter year in the country as a whole, 26 women died in childbirth for every 10,000 babies born alive. In one State the rate was 53; in another, 7.

In July 1944 agencies in the States dealing with crippled children had registered 373,000 such children.

Out of every 1,000 children under 16 years of age in the general population, there are eight, on the average, who are crippled.

Recently a number of State agencies reported a total of 15,000 children at one time who could not be given care because of lack of funds.

Some 17,000 children are deaf, and approximately 1,000,000 have impaired hearing.

Some 15,000 children are blind; 50,000 have only partial sight; nearly 4,000,000 have difficulties requiring glasses.

Approximately 1,250,000 children are handicapped with asthma; 35,000 with diabetes, and 200,000 with epilepsy. Such children require prolonged and expert care. With one exception, no State has made provision in its crippled-children's program for children suffering with diabetes, asthma, and epilepsy, and yet these are among the greatest and most powerful of the many enemies of robust childhood.

LACK OF FACILITIES

In the light of these and other urgent needs our facilities are still woefully inadequate.

The county is the fundamental local health unit of the country. Such units, according to the Public Health Service of the United States, should consist of at least one health officer, a sanitary engineer, and a public-health nurse. Only three-fifths of the counties in the Nation are thus equipped. Nearly 1,000 counties of the 3,000 in the Nation still have no public-health nurse.

Two out of every three rural counties have no child-health conferences where mothers can bring their children for periodic check-ups. These and other services are especially deficient in rural areas and in small towns.

One out of six small cities has no school nursing service.

Many cities, towns, and counties do not have health or medical centers with adequate space, equipment, and personnel for prenatal clinics.

PROPOSED ACTION

The National Commission on Children and Youth has proposed Federal legislative action designed to extend existing Federal-State grant-in-aid programs. Such legislation should enable the State health agencies to meet immediate needs of mothers and children and to provide progressive expansion of the broad program of maternal and child health and the crippled children's services until each State is able to assure the availability of these services to all mothers and children within the State who need them.

And by that phrase "who need them," we mean those who have medical needs that need to be met.

The members of the commission are persuaded that every child born under the American flag is entitled to the best and most skillful medical care our country can provide, regardless of the size of his father's pocketbook. The commission has estimated that for the fiscal year 1946 the maximum authorized for appropriation from Federal funds for grants should be raised by approximately \$50,000,000, \$25,000,000 of which should be allocated to maternity care and care for infants and preschool children; \$15,000,000 to preventive and corrective health services for children of school age; and \$10,000,000 for dental care.

It is further recommended that Federal funds for crippled children's services should be increased by at least \$25,000,000 broken down as follows: For orthopedically crippled children including those with cerebral palsy, \$5,000,000; for children with other physically handicapping conditions, \$5,000,000; for children with rheumatic fever and heart disease, \$15,000,000.

In this connection, Mr. Chairman, I would like to bring up another matter which is not in my written statement, but the need for which is pointed out by the commission, and that is the need for discretionary funds, part of the funds being available in a discretionary basis, making it possible for administrators of the State, and those in the Federal Government concerned with these programs, to help catch up on the backlog in States where the need is the greatest, and to make it possible to use such money wisely where the need warrants it, and where the States are in desperate need of it.

CONDITIONS FOR APPROVAL OF STATE PLANS

The commission has further recommended that Federal legislation devoted to extension of maternal and child-health services and services for crippled children should be based on the following principles:

(1) Financial participation by the States with due regard for their ability to share in the cost. The poorest States should not be penalized because of their inability to pay to the extent possible for other more prosperous States; as I understand S. 1606, that provision is included in the bill.

(2) Administration by the State health agencies. As I understand it, S. 1606 in that connection, it provides for administration by the State health agencies not on a mandatory basis which makes it possible, but as I understand the provisions, it does not include services for crippled children, and the commission recommends that that should be added.

(3) Availability of the service to all mothers and children who elect to participate without discrimination because of race, color, national origin, or residence. I understand that the bill before us does so provide.

(4) The development of a State-wide service within 10 years. I believe that is included in the bill.

(5) Administrative provisions as follows: Personnel standards on a merit basis; the right of families to select the physician; clinic, hospital, or other facility of their choice.

I think that that provision I just read last—

the right of families to select the physician, clinic, hospital, or other facility of their choice—

is not included in part B, title I, to which I am particularly addressing myself, and it would be the recommendation of the commission that it be so included.

The right of a physician to accept or reject a case; adequate remuneration of professional personnel and opportunity for training; appropriate distribution and coordination of services and facilities.

(6) Cooperation of the State health agency with medical, nursing, education, and welfare agencies and organizations and the establishment of a State advisory council.

I think that there is no provision for a State advisory council in connection with this title and part, and the commission would so recommend.

(7) An adequate method including fair hearing by which mothers and children entitled to care or services may appeal from decisions on matters affecting their interests.

And the commission has added also, although I do not have it in writing here, from which physicians and organizations furnishing care can also appeal, if they have questions about their treatment in the matter.

ENDORSEMENT OF S. 1606

The Wagner-Murray-Dingell bill, S. 1606, in title I, part B, covers virtually all of the above recommendations.

The provisions of the bill as a whole include the kind of safeguards which a free society must jealously guard. These include the appointment of personnel on a merit basis and through local machinery, the operation of the plan with the advice and guidance of appropriately appointed advisory councils, general supervision by an appropriate official of the United States Government and decentralization through the health departments of the several States, and freedom of choice for patients and physicians.

I urge upon the committee favorable consideration of this far-reaching bill so vital to the entire future of the Nation, together with the amendments submitted by Senator Pepper before this committee on April 2, 1946.

As I review these amendments, they relate to scope of the program and include the noninsured as well as insured under the program.

The amendments clarify methods of financing, and clarify also the coordination of titles I and II.

COUNTRIES WITH LOWER MORTALITY RATES THAN UNITED STATES

Seven countries had lower infant-mortality rates than the United States in the years immediately preceding World War II. Some 7 to 11 countries had lower death rates among children. It is a known fact that the burden of illness falls unevenly, unpredictably, and often on those unable to carry it. Inability to meet sickness bills means lower incomes for doctors and hospitals. Illness is deleterious to business and industry as it substantially reduces general purchasing power.

The CHAIRMAN. Would you be able to furnish us a list of those 11 countries that have lower death rates among children?

Mr. MAYO. I have the first seven I mentioned, Mr. Chairman.

Would you like those for the record, to be read into the record?

The CHAIRMAN. You may read them into the record.

Mr. MAYO. The seven countries which had lower infant mortality rates are Iceland, Norway, the Netherlands, Sweden, Switzerland, Australia, and New Zealand.

Senator DONNELL. Do you have also the 7 to 11 countries that had lower death rates among children?

Mr. MAYO. I am sorry. I did not get those. My recollection is that in those 11 are included the 7 I have just read. That is my recollection.

Senator DONNELL. Pardon me. I am not quite clear just what you mean "7 to 11." Could that be ascertained?

Mr. MAYO. Yes. I think it can.

Senator DONNELL. Do you know which it is?

Mr. MAYO. My recollection is that in some years there were more than seven, and in other years only seven.

As in many areas of national and community life, the American people must make choices. This bill presents to the Congress, and hence to the people of this country, an opportunity to choose between a vastly improved national health provided under our system of free enterprise or the continuance of a health situation of which no great and wealthy nation can be wholly proud. The children and youth of America comprise its total wealth and its entire future; the safeguarding of their health is a great and sober responsibility.

The CHAIRMAN. Doctor, might I ask you if the National Commission on Children and Youth have made any study of health insurance for the mothers?

Mr. MAYO. I am glad you asked me that.

The commission has not yet made a study of health insurance, and we asked the executive committee to so suggest at its next meeting.

The CHAIRMAN. Yes.

Mr. MAYO. I think in the light of the matters presented by this bill it would be entirely appropriate for us to do so.

The CHAIRMAN. You think some sort of a national health program which would make it possible for the mothers and children of the country to receive the best modern medical care at costs within reach would be an advisable program?

Mr. MAYO. I would say a highly essential program.

The CHAIRMAN. You said that the national commission is opposed to the application of a means test in the provision of health and medical services for children.

Do you think that a means test should be applied in connection with any system of health and medical care?

Mr. MAYO. I am not an expert, but my personal opinion is that the means test should not be applied. We should look upon health as a right as we do upon education.

The CHAIRMAN. Well, Doctor, your statement here is very important for the committee, and we would be glad to have you continue your studies, insofar as relates to the need of a general comprehensive health-insurance program.

Mr. MAYO. Thank you.

The CHAIRMAN. Thank you.

Senator DONNELL. Mr. Chairman, may I inquire of the doctor, please?

The CHAIRMAN. Yes. Very well.

Senator DONNELL. Doctor, I observe at the beginning of your statement three titles applicable to you which lead me to inquire are you appearing today on behalf solely of the National Commission on Children and Youth?

Mr. MAYO. Solely officially only in that connection.

Senator DONNELL. You are not appearing officially for the Child Welfare League of America?

Mr. MAYO. I am not.

Senator DONNELL. Nor for the Western Reserve University?

Mr. MAYO. That is correct, sir.

Senator DONNELL. Yes, sir.

Doctor, I note also you are dean of the school of applied social sciences in the university?

Mr. MAYO. Correct.

Senator DONNELL. What are the subjects that are studied in that school?

Mr. MAYO. The school of applied social sciences, Senator, is a graduate professional school preparing social workers, sometimes called welfare workers, for services in family agencies, child-welfare agencies, medical-social work, psychiatric-social work, settlement work, club work, and the like.

The whole range of activities that come under the general heading of "social work" today.

Senator DONNELL. Do you discuss semipolitical subjects, such as socialism or communism?

Are those subjects discussed?

Mr. MAYO. Our attention is very definitely and purposefully centered upon training of people to do adequate jobs in social work.

It is perfectly obvious, in a class of graduate students, questions about this and other governments come up for discussion.

Our purpose, though, is very clear, and we stick to it. We are not a political science school. We are a professional graduate school on the same level as the school of medicine.

Senator DONNELL. You do not have a course on socialism or communism or anything of that type?

Mr. MAYO. We do not.

Senator DONNELL. I see.

Now, Dr. Mayo, are you a practicing physician at this time?

Mr. MAYO. I am not a physician, sir. My degree is in the social sciences.

Senator DONNELL. In the social sciences.

What is the degree, doctor of philosophy?

Mr. MAYO. Doctor of social sciences.

Senator DONNELL. Doctor of social sciences. I see.

From what university did you receive that degree?

Mr. MAYO. My graduate work was done in the New York School of Social Work, now part of Columbia, and New York University. My degree is from Colby College, in Maine.

Senator DONNELL. Colby College, in Maine. I see. Yes, sir.

Doctor, I wanted to ask you a little about the National Commission on Children and Youth.

Mr. MAYO. Yes, sir.

RELATIONSHIP OF COMMISSION TO THE CHILDREN'S BUREAU

Senator DONNELL. I note your statement says that the original Commission was appointed in March of 1942, following a meeting called by the United States Children's Bureau of the Department of Labor.

Mr. MAYO. That is correct.

Senator DONNELL. What was the name that was given to the original commission when it was appointed in March of 1942?

Mr. MAYO. The National Commission on Children in Wartime.

Senator DONNELL. Did it not have also prefixed to its name the words "Children's Bureau"?

Mr. MAYO. That prefix was frequently used, Senator, in the early days of the commission. Whether it was ever a part of the official

name, I do not recall, but the group which later formed the Commission was called together by the Children's Bureau, and I think that prefix in the early days would be quite natural.

Senator DONNELL. I have in my hand a document entitled "Building the Future For Children and Youth."

Next steps proposed by the National Commission on Children in Wartime.

Which I understand was put out by the Children's Bureau of the United States Department of Labor, April 1945, and I call your attention to the language on the second page of that document, which in fact precedes the pages that are numbered, I believe, reading as follows:

The National Commission on Children in Wartime was originally appointed as the Children's Bureau Commission on Children in Wartime in February 1942.

That is the commission which is designated in your statement as the original commission?

Mr. MAYO. That is correct.

Senator DONNELL. You say it was appointed in March of 1942. I am wondering if it were not February instead of March, in view of your statement in this publication by the Children's Bureau.

Mr. MAYO. The publication that I have, I think, is the same as yours, and it says here "February," so I stand corrected.

Senator DONNELL. February of 1942.

Who was it that appointed the Children's Bureau Commission on Children in Wartime?

Mr. MAYO. Well, I think I can answer that very quickly.

Miss Lenroot, of the Children's Bureau, called together a group of some 100 people for the purposes I set forth in the beginning of this statement.

Following that meeting, in which we discussed the things I explained here, we formed an executive committee.

I was appointed the chairman, and we were left to decide as to whether we wished to continue as a body interested in the purposes here set forth.

It is correct to say that when the name of the commission was changed as of last February 7, that the new commission then appointed was appointed by the executive committee of the new commission. The original group was called together by Miss Lenroot of the Children's Bureau.

Senator DONNELL. So the component members of the original group so called together in February 1942, were designated and selected by Miss Katherine Lenroot?

Mr. MAYO. That is correct.

Senator DONNELL. What was her official capacity at that time?

Mr. MAYO. Chief of the Children's Bureau.

Senator DONNELL. Chief of the Children's Bureau.

Did Dr. Martha M. Eliot have anything to do with the selection of the members of that commission?

Mr. MAYO. I am not sure. I think it would be natural that she might have been consulted.

Senator DONNELL. How many persons came together at this meeting called by the Children's Bureau, of the Department of Labor, in March of 1942?

Mr. MAYO. My recollection is about 100 people, sir.

Senator DONNELL. Did the entire 100 people, or substantially the entire 100 people constitute the original commission as it was resolved into following that meeting?

Mr. MAYO. I would say virtually the same number.

Senator DONNELL. Virtually the same number.

Mr. MAYO. Virtually the same people.

Senator DONNELL. At that time, it was the Children's Bureau Commission on Children in Wartime?

Mr. MAYO. Yes, sir.

Senator DONNELL. Before following through the history of that organization, may I ask you if you are also chairman of the Children's Bureau Advisory Committee on Child Health?

Mr. MAYO. No; I am not, sir.

Senator DONNELL. Were you ever?

Mr. MAYO. No; I was never chairman.

Senator DONNELL. Were you an officer of that advisory committee?

Mr. MAYO. No.

Senator DONNELL. Did you have any connection with that advisory committee?

Mr. MAYO. I have a very tenuous one. I do not remember now of ever attending a meeting of that committee.

I have sustained, by virtue of my position as president of the Child Welfare League, of which I have been president for 5 years, I have sustained a very close relation to the Children's Bureau, as the Bureau is functioning with respect to the needs of children throughout the country, and the Child Welfare League as a private agency is doing the same kind of work—we work together closely.

Senator DONNELL. There is a committee called the Children's Bureau Advisory Committee on Child Health?

Mr. MAYO. I think that is correct, sir.

Senator DONNELL. But you have never been a member of that committee?

Mr. MAYO. No.

Senator DONNELL. Returning to the Children's Bureau Commission on Children in Wartime, formed in February 1942, how long did that organization continue under that name?

Mr. MAYO. My recollection is 2 years.

Senator DONNELL. That would bring it up until February of 1944.

Mr. MAYO. Nineteen hundred and forty-four.

Senator DONNELL. I quote this language from this document, issued, as I have indicated, April 1945 by the Children's Bureau, and ask you to state whether this is correct, immediately after the sentence which I have read; namely, the sentence reading:

The National Commission on Children in Wartime was originally appointed as the Children's Bureau Commission on Children in Wartime in February, 1942, is this sentence, and this is the one to which I direct your attention, and ask you whether it is correct:

It was reappointed by the Chief of the Children's Bureau in February 1944.

Is that correct?

Mr. MAYO. I think that is correct.

Senator DONNELL. And was the membership of this reappointed Commission in 1944 substantially the same as had been the Children's Bureau Commission on Children in Wartime from February, 1942 up to February 1944?

Mr. MAYO. This, I know, Senator, that a good many of the same people continued. As chairman of the commission, I remember appointing a committee to review membership and to invite certain new persons to join.

I was given by the commission that authority to so do.

Senator DONNELL. Doctor, this sentence that I have read to you, saying "It was reappointed by the Chief of the Children's Bureau in February 1944" causes me to inquire of you: Who was the Chief of the Children's Bureau in February 1944?

Mr. MAYO. Miss Katharine Lenroot.

Senator DONNELL. Miss Katharine Lenroot.

So, at the time of the reappointment in 1944, the reappointment was made by the same persons who had appointed the commission originally?

Mr. MAYO. That is correct.

Senator DONNELL. Was there any change in the name of this commission in February 1944, or did it continue at that time under the same name under which it had been organized 2 years previously?

Mr. MAYO. Senator, the date at which the commission by mail vote decided to use the term "National Commission on Children in Wartime" instead of "United States Children's Bureau on Children in Wartime," I do not recall.

My best recollection is it was shortly after or about 1944 that that change was made by mail vote, and it was suggested to me by a number of the members of the executive committee that that might be submitted to the membership, and it was so done.

Senator DONNELL. And the new name, you think some time in 1944, was the National Commission on Children in Wartime. Is that right?

Mr. MAYO. That is right. And the next change in name came in February of 1946.

Senator DONNELL. When the name was changed to the National Commission on Children and Youth?

Mr. MAYO. That is correct.

Senator DONNELL. Doctor, what was the reason why the name Children's Bureau was eliminated from the name of this commission in 1944, so that instead of "Children's Bureau Commission" the wording "National Commission on Children in Wartime" was thereafter used?

Mr. MAYO. As I recall the discussion preceding that change, Senator, a number of the members of the executive committee, and some of the members, felt that it would be wise for the commission, as it gained in its knowledge and experience, to assume an even greater amount of independence as an entity than it had had logically in the first instance.

We felt that the change in name might perhaps help reflect what was taking place.

Senator DONNELL. Had there been some criticism you had heard of directed against the commission on the ground that it was the organ of the Children's Bureau in lobbying affairs, lobbying matters?

Mr. MAYO. I never heard that. As a matter of fact, the commission had not lobbied, and I did not hear that criticism.

Senator DONNELL. Was its function at or about 1944 and from then until the present time largely the influencing of legislation?

Mr. MAYO. I would say not. I would say that its purposes and functions throughout have been largely to bring together information with the hope that that information would so inform and equip competent and knowledgeable persons and groups in the country that they might, on their own, take such steps as their wisdom and discretion indicated in providing more adequate services for children.

Senator DONNELL. Doctor, in 1944, at the time of the reappointment by Miss Lenroot of the members of the commission, until February 7, 1946, which was the date, according to your statement, that the formal vote occurred for the change of name to the National Commission on Children and Youth, did the membership continue substantially as it had been, and was, on the date of the reappointment in 1944, possibly with some additions?

Mr. MAYO. There were a number of additions. Some persons did not continue in membership.

My recollection does not serve me, so I cannot say exactly what the shift was; but there are always new people, quite continually.

I checked today, and I think the actual membership at the present time is 160.

Senator DONNELL. Who was it, between 1944, when Miss Lenroot reappointed the membership, who designated the added persons between then and February 7, 1946?

Mr. MAYO. The chairman has done that. I have done it.

Senator DONNELL. The chairman of the commission?

Mr. MAYO. Correct.

Senator DONNELL. Does the commission have any constitution or bylaws or formal evidence of its underlying law?

Mr. MAYO. We have no formal bylaws; no, sir.

Senator DONNELL. Did the appointments which you make meet the approval of Miss Lenroot? These additional appointments?

Mr. MAYO. I consulted with her, and I have a feeling they did meet with her approval.

Senator DONNELL. That was your best judgement, that they did?

Mr. MAYO. That is right.

Senator DONNELL. There is no constitution or bylaws which designate the maximum number of persons who may be upon the commission or the qualifications of the persons; is that right?

Mr. MAYO. In February, Senator, the Chair appointed a committee, at the request of the commission as a whole, which set forth the main purposes and methods of operation and goals of the commission, which, as I understand such organizations, really serve very effectively in lieu of a constitution or formal bylaws.

Senator DONNELL. Who was it that issued that?

Mr. MAYO. The Chair appointed a committee which drew up such a statement, and the statement was duly presented to the membership February 7, 1946, at a meeting held in Washington, and passed unanimously.

That is on our records.

Senator DONNELL. How large an attendance was there at that meeting of February 7, 1946?

Mr. MAYO. The meetings continued over 2½ days, and I think at the business meeting there were something like 80 people present.

Senator DONNELL. Was Miss Lenroot present throughout most of the sessions?

Mr. MAYO. Most of the sessions she was there.

Senator DONNELL. Yes, sir. There has never been any person placed on this committee, that you know of, who met the disapproval of Miss Lenroot; is that right?

Mr. MAYO. There has been no person placed that is on the commission that met with the disapproval of either the executive committee or the Chairman, or, to my knowledge, Miss Lenroot.

Senator DONNELL. Yes, sir.

Now, who is the secretary of the commission?

Mr. MAYO. The secretary of the commission is Miss Edith Rockwood, who is on the staff of the Children's Bureau.

Senator DONNELL. She is on the staff of the Children's Bureau which issued this pamphlet I referred to?

Mr. MAYO. I think it would be more correct to say the Children's Bureau printed that and the Commission issued it.

Senator DONNELL. It says here:

Children's Bureau, Washington 25, D. C., April 1945—

and says that at the top—

Building the future of children and youth. Next steps proposed by the National Commission on Children in Wartime, prepared by the executive committee and revised by the members of the commission.

Is that an accurate statement?

Mr. MAYO. That is correct.

Senator DONNELL. And it was issued by the Children's Bureau?

Mr. MAYO. Your copy says that. Mine does not.

Senator DONNELL. Miss Rockwood, you say, is the secretary of the commission; and what is her connection with the Children's Bureau?

Mr. MAYO. I am not fully acquainted with her duties, Senator, but at the request of the executive committee of the commission, early in its formation, Miss Rockwood was assigned to work with the commission as its secretary.

Senator DONNELL. Who made that assignment?

Mr. MAYO. Miss Lenroot made it, at the request of the commission.

Senator DONNELL. Is Miss Rockwood on the pay roll of the Government?

Mr. MAYO. She is on the pay roll of the Children's Bureau. She would be on the pay roll of the Government.

Senator DONNELL. She draws no salary from the commission?

Mr. MAYO. The commission has no salaries.

Senator DONNELL. Has no funds?

Mr. MAYO. No.

Senator DONNELL. Refreshing your memory, is not Miss Rockwood the secretary to Miss Lenroot, also?

Mr. MAYO. That is not my understanding. If she is, I am not aware of it.

Senator DONNELL. I am not certain of that. That is the inference I draw from information in my possession, but I may be in error.

Mr. MAYO. If you mean stenographer-secretary, I can state definitely she is not.

Sometimes the word "secretary" is used in other connections.

Senator DONNELL. But you do not know what her official connection with Miss Lenroot is?

Mr. MAYO. Except that she is on the staff of the Bureau.

Senator DONNELL. Except that she is on the staff of the Bureau and is paid by the Bureau and not by the commission?

Mr. MAYO. That is correct.

Senator DONNELL. Yes, sir.

Now, Doctor, you are the chairman of the National Commission on Children in Wartime, or you were?

Mr. MAYO. That is correct.

Senator DONNELL. And you are now the chairman of the National Commission on Children and Youth?

Mr. MAYO. That is correct.

Senator DONNELL. Yes, sir.

Doctor, you said that the commission has no funds, I believe. Am I right in that?

Mr. MAYO. That is right.

Senator DONNELL. Who pays the expenses of the National Commission on Children and Youth?

Mr. MAYO. The printing of such material as you see here has been done by the Children's Bureau.

Senator DONNELL. Pardon me. So that we will have it clear in the record. I know you want it clear, just as I do.

Mr. MAYO. Surely.

Senator DONNELL. Some of us, including myself, are not as familiar with your terminologies as you gentlemen are. You mean the Children's Bureau of the United States Department of Labor?

Mr. MAYO. That is correct.

Senator DONNELL. And that is the organization which pays the expenses of the printing of the document such as you have presented here today?

Mr. MAYO. Correct.

Senator DONNELL. How about the mimeographing of the testimony, such as you are giving? Who pays for that?

Mr. MAYO. The mimeographing of this material you have before you was done in my office in Cleveland by my own office staff.

Senator DONNELL. Yes.

Mr. MAYO. And the statement was written by me unaided.

Senator DONNELL. Yes, sir.

Mr. MAYO. I would also add that my expenses to attend this meeting and other trips that I have made in connection with charity meetings, or attending committee meetings, or subcommittee meetings of the commission, have been borne by action of the executive committee of the Child Welfare League of America, in terms of the Child Welfare League's interest in child welfare development in the country as represented by both the commission and the Children's Bureau of the Department of Labor.

Senator DONNELL. Yes, sir.

Now, the National Commission on Children and Youth does not have any assessment or dues?

Mr. MAYO. No.

Senator DONNELL. It has no income of any kind; is that right?

Mr. MAYO. That is correct.

Senator DONNELL. Yes.

Do you know approximately what the expenditures of the Children's Bureau of the United States Department of Labor has been in the aggregate during the last 12 months for the expenditures of the National Commission on Children and Youth?

Mr. MAYO. I do not have the exact figures, but I know that it is very small.

Senator DONNELL. Approximately how much would you say?

Mr. MAYO. This booklet was published in April of 1945, and I do not know what the cost of the publication of such a booklet is. But I would say if the Children's Bureau spent \$50 a month, it would be a pretty high estimate.

Senator DONNELL. The booklet that you have—do you know how many copies there were printed of that?

Mr. MAYO. I do not. I suppose in the neighborhood of 2,500 to 3,000.

Senator DONNELL. How large a booklet is that? How many pages are there, Doctor?

Mr. MAYO. There is about 60 pages; 58.

Senator DONNELL. And was that circulated throughout the country, do you know?

Mr. MAYO. That was given pretty wide circulation.

Senator DONNELL. Do you know who paid the expenses of the circulation of it?

Mr. MAYO. I take it that the Children's Bureau did. I do not know to the contrary.

Senator DONNELL. With the exception of the traveling expenses to which you referred, and the expenses of mimeographing your own testimony here today, is it a fact, Doctor, that all the expense of the National Commission on Children and Youth within the last year has been paid for by the Children's Bureau of the United States Department of Labor?

Mr. MAYO. I would add there are other office expenses borne by the Child Welfare League carried on in my office, such as mailing out letters.

I take care of the postage, and we share it in that way.

Senator DONNELL. But the Children's Bureau of the United States Department of Labor has paid the expenses along the lines of what you have indicated?

Mr. MAYO. That is right.

Senator DONNELL. And the commission itself has no resources whatsoever; is that right?

Mr. MAYO. Has no resources of its own.

Senator DONNELL. Now, I wanted to ask you, in respect to the executive committee of the commission, is the booklet you have there entitled "Building the Future for Children and Youth"?

Mr. MAYO. That is correct.

Senator DONNELL. You state that was published by the commission in April 1945?

Mr. MAYO. That is right.

Senator DONNELL. Is that the thing that I have here?

Mr. MAYO. I think it is essentially the same. The printed copy following that, after some changes were made.

Senator DONNELL. This that I have here.

Mr. MAYO. That was the original form.

Senator DONNELL. This is a mimeographed or multigraphed copy, with a picture on the outside?

Mr. MAYO. That is correct.

Senator DONNELL. Yes, sir.

Doctor, who was it that composed the actual contents of that book? The actual person or persons who composed it.

Mr. MAYO. The content of that book was collated and brought together by a committee appointed by the chairman of the Commission on Children and Youth.

The health material was brought together by a subcommittee on health, of which Dr. Helmholtz, who is here today, was the chairman.

Senator DONNELL. Pardon me. Is Dr. Helmholtz one of the gentlemen appointed by Miss Lenroot in February 1942?

Mr. MAYO. My recollection is he was one of the first members of the commission; yes.

Senator DONNELL. He was appointed by her at that time, in other words?

Mr. MAYO. I think so.

Senator DONNELL. Very well.

And this committee to which you referred prepared this document; is that right?

Mr. MAYO. Correct.

Senator DONNELL. Entitled "Building the Future for Children and Youth"?

Mr. MAYO. Correct.

Senator DONNELL. I want to ask you just a little bit about the executive committee of the commission.

Who determines who constitutes the executive committee?

Mr. MAYO. This February, the chairman, at the request of the commission, appointed a committee on nominations, which presented nominations for both the executive committee and the officers.

The chairman and the vice chairman.

Senator DONNELL. And the commission itself elects the executive committee and the officers; is that right?

Mr. MAYO. Yes, sir.

Senator DONNELL. Was the personnel of the executive committee and the proposed officers submitted to Miss Lenroot before it was sent to the commission?

Mr. MAYO. I do not know, sir. I was not present at that meeting. I was not in Washington at the time. I do not know.

Senator DONNELL. I note that Mr. Kermit Eby is one of the members of the executive committee. He is denominated in your statement as of the Congress of Industrial Organizations. That is the CIO?

Mr. MAYO. That is correct. My understanding is his official position is research director.

Senator DONNELL. Mr. John W. Edelman, of the Textile Workers Union of America.

I do not know whether that is affiliated with either of the larger unions or not, the CIO or the A. F. of L.

Do you know?

Mr. MAYO. I know Mr. Edelman, but I do not know that.

Senator DONNELL. Mr. Shishkin, of the American Federation of Labor, is a member?

Mr. MAYO. He is also research director of that organization.

Senator DONNELL. Yes.

Doctor, I understood that your testimony is today primarily, and, in fact, almost entirely, with respect to title I, part B, S. 1606?

Mr. MAYO. That is correct.

Senator DONNELL. You have not made a study, I assume, of the compulsory health insurance features of that bill to any great degree, am I right?

Mr. MAYO. That is correct. I have read it, and have read summaries, but I have not made a careful study.

Senator DONNELL. Then you are not undertaking to give testimony today on that, but your testimony is with respect to title I, part B, of the bill?

Mr. MAYO. That is correct.

Senator DONNELL. You are not discussing with respect to the compulsory health insurance phases of the bill?

Mr. MAYO. Precisely. The commission took no action on that.

Senator DONNELL. That is all.

Thank you, Doctor.

Mr. MAYO. May I add one point here, Mr. Chairman?

The CHAIRMAN. Yes.

Mr. MAYO. I want to say for the record, in my capacity as president of the Child Welfare League of America, that while the Child Welfare League has not taken any official action on this bill or any portion of it, the record of the Child Welfare League with respect to the need for extension of grants for maternal and child health services is very clear, and the former executive director of the league, C. C. Carstens, was one of the most active people in the country in the development of the child welfare services and maternal and child welfare services of the Social Security Act.

I would like also to say that it is my clear understanding that it is the proper function of the Children's Bureau, under the act of Congress, to bring together, collate, and distribute to the Nation, pertinent information with respect to the general welfare and health of children, and as president of the Child Welfare League and as chairman of the Commission on Children and Youth, I turn as naturally to the Children's Bureau for cooperative endeavor, as more naturally to it than to any other organization in the country, because of its function as established by Congress and because of its outstanding record in the development of child-welfare and child-health services in the country.

Senator DONNELL. Mr. Chairman, could I ask one question along that line?

Doctor, do you not think it would be somewhat more fair to the general public to reveal in the name of the commission the fact of its very close connection financially and otherwise with the Children's Bureau, so that the country might understand clearly that this commission is actually extremely closely related to a governmental organ-

ization, the Children's Bureau of the Department of Labor, which understanding, of course, is not obvious at all from the name which the commission now bears?

Mr. MAYO. From the reports from the paragraph you read in this booklet, which, as I stated, has been distributed all over the country, it is pretty clear, of course.

Senator DONNELL. Well, I do not think, Doctor, with all due respect, that the name of the organization, namely, the National Commission on Children and Youth, is at all descriptive of the fact that this organization is very closely affiliated with the Department of Labor, and I do not mean this critically.

Mr. MAYO. That is all right.

Senator DONNELL. Indeed, I do not discover that fact from your testimony.

I observe the statement about the original appointment of the commission.

Mr. MAYO. That is right.

Senator DONNELL. Following a meeting, but I do not observe any statement here as to who it was appointed the commission, nor any of the facts that have been developed this afternoon as to the financing of the commission.

I simply present to your consideration the query for your own judgment or response, such as you may deem proper, as to whether you do not think it would be somewhat more fair to the public in the name given to your organization preserved, as it did at the outset, the name "Children's Bureau" as a part of the name so that everybody could know that this was closely affiliated with a governmental department, that would be a policy of utmost frankness, would it not, to the public?

Mr. MAYO. Mr. Chairman, I think there are a good number of rather distinguished precedent in the country by which organizations that have been promoting the same general purposes and goals of other organizations have continued without a name which indicated originally affiliation of some kind.

I think that both ways are perfectly honorable and aboveboard, and I really have no apology for the name of the commission as it now stands.

Senator DONNELL. May I ask the doctor if one of those other organizations to which you refer, as a precedent, or an illustration, is the American Academy of Pediatrics?

Mr. MAYO. No. I think that pretty clearly carries—

Senator DONNELL. Carries what?

Mr. MAYO. I think the American Academy of Pediatrics, to my knowledge, is not affiliated with any other group. It may be.

Senator DONNELL. I note Dr. Helmholtz is listed on the national committee of that organization, and I observe that the headquarters for the study which I understand is being carried on by the American Academy of Pediatrics is 7950 Rockville Pike, Washington 14, D. C., Bethesda Station, which I understand is the headquarters of the National Institute of Health of the United States Public Health Service.

Mr. MAYO. I know nothing of that.

Senator DONNELL. You know nothing of that?

Mr. MAYO. I know nothing of that.

Senator DONNELL. And I also note that Dr. Allan Butler, who has previously testified to our committee, is also a member of the national committee of the American Academy of Pediatrics along with Dr. Helmholz.

That is all at this time.

The CHAIRMAN. Doctor, all these men whose names have been mentioned by the Senator examining you are men of high standing and reputation in the United States are they not?

Mr. MAYO. The highest, sir.

The CHAIRMAN. I noticed that in your statement here you say that the original commission was brought together for the purpose of considering the critical and emergency problems of children during wartime?

Mr. MAYO. Yes, sir.

The CHAIRMAN. Was there any other, and sinister, motive in bringing those people together at that time?

Mr. MAYO. There was no motive, sir, other than the one you have stated: to get an objective view from persons throughout the country who had some knowledge of the situation, of what this Nation was doing by way of furnishing adequate protection for its children during wartime. That was its stated, open purpose.

The CHAIRMAN. That was not unusual in the Government during the war. The War Production Board brought in businessmen, here, from big industries and businesses of the country, for the purpose of advising and consulting with them with reference to problems with which they were confronted.

Mr. MAYO. I would say quite properly.

The CHAIRMAN. Did any of those who were brought in here by the Children's Bureau gain any personal advancement or profit from their participation in this?

Mr. MAYO. None that I know of, sir; except—and I think you will understand this—except an opportunity to respond, in spite of a terrific pressure at home, to the call of some appropriate group within your Government to presumably be of some service, to which any person ought to respond with alacrity.

The CHAIRMAN. Really, then, these people who came in here were making personal sacrifices to aid in these problems and give their assistance?

Mr. MAYO. I could cite many instances, sir, in which that was literally true.

The CHAIRMAN. Subsequently, this group has expanded and organized under the name of the National Commission on Children and Youth?

Mr. MAYO. Correct.

The CHAIRMAN. It is functioning under that name, also, at the present time?

Mr. MAYO. That is correct.

The CHAIRMAN. What is it doing? Is it continuing its studies of these problems and giving advice to the Government in reference to these problems?

Mr. MAYO. Yes, advice as to the appropriate Government agencies and advice to appropriate State agencies and to private organizations that are concerned with the welfare and health of children and youth.

The CHAIRMAN. That organization was not built up for the purpose of perpetuating any officials in their term of office in the Children's Bureau; was it?

Mr. MAYO. Not at all; and I would say there is no one on the commission that has the least interest in such a matter.

The CHAIRMAN. They would continue to function regardless of who served in the Children's Bureau?

Mr. MAYO. Precisely.

The CHAIRMAN. What have you to say as to the operation of the Children's Bureau? Do you regard it as generally an effective and beneficial agency to the country in the care of health of children?

Mr. MAYO. I regard it very highly. I know of the work of the Children's Bureau quite intimately. I know the quality of its personnel. I know the earnestness and effectiveness of its endeavors. And I also know, sir, as one who gets around this country quite a bit, the great respect in which it is held. In my estimation, any time that any branch of the Government does anything to increase the respect of the people for it, to that extent is the respect of persons for the total Government increased.

I think in that way, as in specific ways set forth in the congressional act which set it up, it has been of untold service to the American people. In the saving of life alone, it has been worth twice its appropriations since its inception.

The CHAIRMAN. You never heard of it being adversely criticized by anyone as detrimental to the welfare of the country?

Mr. MAYO. The only criticism I have ever heard of the Children's Bureau is that it is sometimes, in the opinions, misguided opinions I would say, of some persons, been too earnest in its efforts, appropriate efforts I might add, to aid the welfare of children in this country.

That, of course, is not a criticism. It is a compliment.

The CHAIRMAN. Are you personally acquainted with Miss Katherine Lenroot, whose name has been mentioned here?

Mr. MAYO. Yes, indeed.

The CHAIRMAN. How do you regard her?

Mr. MAYO. I regard her very highly, as a professional person of the highest qualifications.

The CHAIRMAN. Do you believe that she is engaging in any sinister political activities for the purpose of benefiting herself or benefiting the Children's Bureau in any ulterior way?

Mr. MAYO. I am sure she is not.

The CHAIRMAN. Do you know also Dr. Eliot?

Mr. MAYO. I do.

The CHAIRMAN. How do you regard her?

Mr. MAYO. I regard Dr. Eliot with equally high regard, as probably the person in this Nation who is the most knowledgeable with respect to public health and medical care matters as they relate to children and youth.

The CHAIRMAN. She has a very comprehensive knowledge of this problem of children's care?

Mr. MAYO. Precisely so.

The CHAIRMAN. She testified before this committee a short time ago, and I consider her one of the most patriotic women in the United States.

Mr. MAYO. There is no question about that.

The CHAIRMAN. These people that were brought in here; in selecting them, what was the desire? Was it to select the best possible men qualified to serve on that committee and give advice and help to the Bureau?

Mr. MAYO. Precisely; people of experience and of tested and known professional competence and standing.

The CHAIRMAN. When people are called in here who are connected with some labor organization, some times they are referred to in a manner which would indicate they were not regarded with respect or considered as patriotic citizens.

I notice there was a man on here by the name of Boris Shishkin, of the American Federation of Labor. Do you know Mr. Shishkin?

Mr. MAYO. I do.

The CHAIRMAN. How do you regard him?

Mr. MAYO. I regard him very highly. Mr. Shishkin's views are, incidentally, available to a large number of people in the Nation, inasmuch as he participates in a very distinguished round table discussion on the air every Sunday.

I will not mention the program or anything more about it except to say that I think his views are very open to the general public, and I think he is a man of competence and good standing.

The CHAIRMAN. The name of Helmholtz—Dr. Helmholtz has been mentioned here too. Are you acquainted with Dr. Helmholtz?

Mr. MAYO. I know Dr. Helmholtz very well.

The CHAIRMAN. And in selecting him they were selecting a man of excellent reputation and great ability?

Mr. MAYO. Precisely.

The CHAIRMAN. And he was selected only on that basis; not for the purpose of carrying on any political activities or pursuing any ulterior motives?

Mr. MAYO. Not at all, sir.

The CHAIRMAN. Dr. Helmholtz is here today, and we will ask him some questions a little later on.

Now, do you think that this committee that you have mentioned is a committee that should be preserved and continued because of its interest in these problems of American children and youth?

Mr. MAYO. The commission, you mean, Senator?

The CHAIRMAN. Yes.

Mr. MAYO. Yes; I definitely do, and it was so voted by the commission on February 7, 1946.

The CHAIRMAN. And you find nothing ulterior in the motives of the Children's Bureau in bringing this group of people together, of any kind or character?

Mr. MAYO. Not at all.

The CHAIRMAN. Do you think they have performed a splendid service to the American people?

Mr. MAYO. I am convinced of it.

Senator DONNELL. May I ask just a few more questions: Doctor, on page 7 of your statement are estimates of the commission aggregating somewhere around \$75,000,000 that are advocated here as amounts that should be made available for the various purposes therein mentioned during the fiscal year 1946?

Mr. MAYO. Roughly that.

Senator DONNELL. Seventy-five million. Now, those funds in the main, if not entirely, would be administered by the Children's Bureau of the United States Department of Labor, would they not?

Mr. MAYO. That is correct; as the Children's Bureau now administers maternal and child health services.

Senator DONNELL. There is nothing, I think, stated, is there, Doctor, in your testimony as to the components of the commission, page 1 of your testimony, which I am looking at now, of the fact that the Children's Bureau is so closely identified with the National Commission on Children and Youth. That does not appear in what you state here, does it?

Mr. MAYO. Well, the first paragraph, I think, points out the genesis of this matter very clearly.

Senator DONNELL. Pardon me. The first paragraph, I think, Doctor, does not tell anything about the genesis of it.

Mr. MAYO. I beg your pardon. The second paragraph.

Senator DONNELL. The first paragraph calls especial attention to the fact that such groups as the American Association of University Women, the Child Welfare Division of the American Legion, the National Council of the Young Men's Christian Associations, the National Committee for Mental Hygiene, the National Congress of Parents and Teachers, labor unions, and the American Farm Bureau Federation are represented on the commission.

There is nothing stated in that paragraph to the effect that Miss Lenroot or anybody connected with the Children's Bureau ever had any connection with this, is there?

Mr. MAYO. Not at all.

Senator DONNELL. And indeed, when it gives the name of the commission as formerly the National Commission on Children in Wartime, the fact that the name, as stated in this publication here issued by the Children's Bureau, was the "Children's Bureau Commission on Children in Wartime," does not appear in your statement, does it?

Mr. MAYO. That does not appear in my written statement, but it was amply brought out in discussion.

Senator DONNELL. Now, Doctor, as to the second paragraph, I think that is the one in connection with the Children's Bureau: I respectfully call to your attention the fact that the only statement therein is that the original commission was appointed in March 1942 following a meeting called by the United States Children's Bureau of the Department of Labor to consider the critical emergency problems of children during wartime, and that at the close of that session, the group, acting upon its own initiative, moved to organize the Commission on Children in Wartime. I observe nothing there that apprises us of the fact that the head of the United States Children's Bureau of the Department of Labor, Miss Lenroot, was the one who had called these people together, or that there was any special connection of that Bureau with this organization.

Maybe you and I differ as to the interpretation of that language, but that is what your statement says, is it not?

Mr. MAYO. Senator, I think we both understand, from the questions that you and the chairman of this committee have asked, exactly the basis under which this was done and the purpose thereof. When per-

sons were invited to come to Washington and discuss the needs of children during wartime, it is my distinct recollection that during that meeting it was suggested by persons from the floor that a committee be appointed from the floor to determine whether a commission or something of that kind should be formed, and it certainly was a grass-root movement at that point, having brought together the move to organize.

Senator DONNELL. Doctor, you understand I am not criticizing the people who are on this commission. My point is directed at what I think is worth while; perhaps it is not, but it seems to me that when an organization comes out and testifies, and its chairman testifies, under the name of National Commission on Children and Youth—it just appears to me that with the close relationship that has been evidenced by the questions and answers here this afternoon between that organization and the Children's Bureau of the United States Department of Labor, it would certainly not be unfair to the public to express those facts in at least the name of the commission.

Maybe I am wrong, but that is the thought I had.

Now, I just wanted to say further: Do you have any stationery of the National Commission on Children and Youth?

Mr. MAYO. No; we do not have any special stationery.

Senator DONNELL. You do not have any special stationery at all?

Mr. MAYO. I write from my own office in the city of Cleveland on Western Reserve University stationery—which is agreeable to the president of the university, incidentally—and I use it for that purpose.

Senator DONNELL. Do you know how many organizations or approximately how many there are in existence which are as closely affiliated with the United States Department of Labor as is the National Commission on Children and Youth, the name of which, however, does not indicate any such connection?

Mr. MAYO. I know of one very good example of that, sir.

Senator DONNELL. What is that?

Mr. MAYO. In Westchester County, which has one of the best county departments of public welfare in the country, there was set up several years ago, in cooperation with the then commissioner of that department, a man by the name of Macy, a committee of private citizens with no administrative relationship existing between it and the department of welfare.

This committee of citizens, however, assumed some responsibility for presenting to the general public the broad goals and the purposes of that then developing department of welfare, and became in the county a private organization of private citizens but devoted to the long-range goals of the public department. The name bore no resemblance. Many people did not know that in the first instance the commissioner himself was cooperative and interested in the forming of such a citizens' committee, but he had no reason to hide it, and did not. The purpose was quite clear. He felt that citizens should be given an opportunity to participate, to criticize, and to take part, in a matter which was of public concern. The name of the new organization, which was the Children's Committee of Westchester County, bore no resemblance in name to the public department.

Senator DONNELL. I think, Doctor, perhaps I did not make myself clear. I was asking particularly about organizations that are affiliated with the United States Department of Labor.

Mr. MAYO. I am sorry.

Senator DONNELL. Do you know of any others, other than the National Commission on Children and Youth, which have as close a relationship to the Bureau of Labor, the Department of Labor, of the United States Government, as does your own organization, but the name of which does not indicate the fact that such other organization has that close affiliation with the Department of Labor? Can you tell us anything about that?

Mr. MAYO. I know of none.

Senator DONNELL. Very well.

The CHAIRMAN. Doctor, you have been questioned at great length about the alleged close relationship between this group and the Children's Bureau. What do you understand to be the precise nature of this "close relationship" between your organization and the Children's Bureau?

Mr. MAYO. I understand it to be a very close cooperative relationship, a relationship whereby at the request of the commission we use part time the services of a member of the Children's Bureau staff, the kind of relationship in which we consult regularly and frequently with staff members of the Children's Bureau in relation to goals and objectives we have in common.

Senator DONNELL. Pardon me, Doctor. May I be rude enough to interrupt you at that point? Approximately how many members of the staff of the United States Department of Labor does the National Commission on Children and Youth utilize in whole or in part?

Mr. MAYO. As far as I know, Senator, Miss Rockwood, and, of course, at times Miss Lenroot and Dr. Eliot; there may be others, but I do not know of them, and those are the principal people that we cooperate with.

The CHAIRMAN. Do you regard that as a sound, democratic policy in the United States?

Mr. MAYO. Highly so. It seems to me that if governmental bureaus did not seek participation from the public through such methods, and other appropriate methods, we ought to take notice of such dereliction.

The CHAIRMAN. Do you think it would be unfortunate for this country if an attempt was made to cast reflection upon groups of this kind that come here with the sole motive of giving patriotic support to legitimate activities of the Government?

Mr. MAYO. I do.

The CHAIRMAN. It would be very unfortunate?

Mr. MAYO. I think it would.

The CHAIRMAN. You have never heard before coming here today that your organization is regarded with suspicion by anyone, have you?

Mr. MAYO. I have not so heard; no.

The CHAIRMAN. And you think you have contributed a great deal to the Children's Bureau in your advice and your participation in the study of their activities and the making of recommendations?

Mr. MAYO. I think that every member of the commission has done his best, sir, to make that contribution, and with the exception of the chairman, I think great contributions have been made.

Senator DONNELL. Has the chairman ever urged any members of the National Commission on Children and Youth to get in touch with Members of Congress with respect to legislation, either pending or contemplated?

Mr. MAYO. I have done this, Senator: I have informed members of the commission of issues that were alive in the Nation and in their respective States, and have done my best to present material to them both pro and con, and urged them to take such action as their good judgment dictated in the matter.

Senator DONNELL. Did you mention, in connection with that action, that it will be helpful if they would get in touch with Members of Congress or members of the State legislatures?

Mr. MAYO. I have mentioned members of State legislatures particularly.

Senator DONNELL. Have you mentioned Congress also?

Mr. MAYO. I am not sure that I have ever mentioned Congress.

Senator DONNELL. Or the Members of the Senate or the House of Representatives?

Mr. MAYO. No; I do not think I have. I was asked by the commission at its February 7 meeting, as its chairman, to present to any appropriate public body—I think these were the words—such findings and recommendations of the commission which might, in the judgment of the chairman, be properly presented at proper times.

The CHAIRMAN. Do you consider that a sound democratic principle?

Mr. MAYO. I do; precisely, sir.

The CHAIRMAN. You have heard of other organizations that come to Washington and do a great deal of lobbying that are not criticized by some of the Members of the Senate very severely; for instance, we have had million-dollar lobbies down here for the power interests at times.

I remember that when we had the public holding-company laws up for consideration, I was bombarded from all over the Nation, and there was a group that came to Washington here with millions of dollars, and was distributing that money out every day, trying to influence Congress.

It does not seem to me to be very sound policy to criticize men who come here for no other motive than to help our democratic system operate.

Senator DONNELL. Your organization is financed, however, in large part by the United States Department of Labor, is it not; as you have stated?

Mr. MAYO. The printed material, which, as I have stated, Senator, certainly falls very clearly within the mandates of the Children's Bureau, has been paid for. A good part of the postage is paid for by my office and by the Child Welfare League; other expenses, by the Children's Bureau.

Senator DONNELL. And the services, as you have indicated, of Miss Rockwood and Miss Lenroot, have been made available?

Mr. MAYO. That is correct.

The CHAIRMAN. Might I ask if you know Monsignor O'Grady?

Mr. MAYO. Yes, I do.

The CHAIRMAN. Was he a member of your commission too?

Mr. MAYO. He was, and I believe still is. I cannot be sure of that. I know he was, and as a matter of fact, he was present, sir, at the February meetings, 1946, of the commission. He was present for a portion of them.

The CHAIRMAN. Yet he is no agent of the Children's Bureau, lobbying for the Children's Bureau, is he?

Mr. MAYO. On the contrary.

The CHAIRMAN. He has criticized them?

Mr. MAYO. He is very frank to criticize the Children's Bureau whenever he sees fit.

The CHAIRMAN. He has criticized S. 1318?

Mr. MAYO. Yes; vigorously.

The CHAIRMAN. And have you found that disposition on the part of all the members of your commission, to be very frank in their criticism of the Bureau whenever they think it is entitled to be criticized?

Mr. MAYO. I am in receipt of letters which were very frank in criticizing the commission—and even the chairman, I am glad to say. We urge those people to remain in membership and let their voice be heard.

The CHAIRMAN. I am trying in every way I can to save the reputation of this commission.

Mr. MAYO. You are doing very well, Senator.

The CHAIRMAN. I hate to see people treated so who come to Washington with no ulterior motives and no motives whatever except to aid in making our democracy operate. I think it would be an unfortunate thing if people were deterred from coming before these committees and undertaking worth-while programs of the greatest benefit to the country.

Mr. MAYO. I consider it a privilege to engage in such an activity.

Senator DONNELL. I would like to have it noted in the record that it would be much more preferable, when an agency of the United States Government is in large part financing such a body as this commission, that the name of the commission at least indicate the connection which the commission has with this body of the Department of Labor.

I think in frankness to the public, they are entitled to know that, and I do not think that the name of this commission indicates it. I am not criticizing these gentlemen and ladies who are devoting their time. I happen to notice here the name of Miss Emma Puschner, whom I have known for many years and for whom I have the highest regard.

Mr. MAYO. She is from Missouri?

Senator DONNELL. Yes, indeed.

Mr. MAYO. That is among her other good qualities.

Senator DONNELL. Certainly. But I do think it is a mistake to be coming out and advocating these appropriations here, and doing so, as I see it, in large part through an organization the connection of which with the Department of Labor is not even remotely suggested by the organization's name.

The CHAIRMAN. I would like to have your comment on that again.

Mr. MAYO. I think that is not an unfair request, Mr. Chairman.

Senator DONNELL. You mean you think my request is not unfair?

Mr. MAYO. I do not think it is unfair at all. I think it is also very clear on the record that at no time has this commission or any staff

member, including Miss Lenroot, of the Children's Bureau, ought to in any way keep from the public the origin, purposes, and methods of this commission. I think the Senator and the commission and the Children's Bureau are all in the clear, and I think an open discussion of a think like this is very good. I am for it.

The CHAIRMAN. And the Department of Labor is not paying any salaries to the members of this commission for their participation in this work at all?

Mr. MAYO. Not at all.

The CHAIRMAN. They are getting no personal advantage or benefit out of it except the advantage and benefit of being able to uphold a very good program in the country?

Mr. MAYO. Correct.

The CHAIRMAN. For the welfare of the people?

Mr. MAYO. Yes, sir.

The CHAIRMAN. Now, Doctor Helmholtz, you are the head of the section of pediatrics at the Mayo Clinic, Rochester, Minn.?

STATEMENT OF DR. HELMHOLZ, CHIEF OF SECTION OF PEDIATRICS, MAYO CLINIC, ROCHESTER, MINN.

Dr. HELMHOLZ. I am.

The CHAIRMAN. And you have been associated with this commission from its inception?

Dr. HELMHOLZ. Yes.

The CHAIRMAN. I wish you would tell me whether your work at the Mayo Clinic should be classified as the practice of medicine.

Dr. HELMHOLZ. I do not see how else you could classify it.

The CHAIRMAN. What is your work there?

Dr. HELMHOLZ. My work consists of seeing patients, some of them at their home, most of them at the clinic, as I would see patients in private practice anywhere.

The CHAIRMAN. Are you paid on a fee system or on a salary basis?

Dr. HELMHOLZ. I have been on a salary ever since I entered the Mayo Clinic in 1921.

The CHAIRMAN. Does the fact that you are on a salary instead of on a fee system have any effect of bringing about a deterioration in your services or your ability to render services?

Dr. HELMHOLZ. Only as 25 years may have decreased my efficiency. I might say that our department has grown from an original registration of about 1,800 to about 7,500.

The CHAIRMAN. That organization, the Mayo Clinic, is known all over the world, is it not?

Dr. HELMHOLZ. Pretty nearly.

The CHAIRMAN. And it has a reputation of the very highest character in this country and in other countries where it is known?

Dr. HELMHOLZ. Yes.

The CHAIRMAN. That is because of the high quality of service that is rendered, the high quality of the surgeons and specialists that it has there. People come from all over the country to Mayo's, do they not?

Dr. HELMHOLZ. They do.

The CHAIRMAN. Now, in coming there, they go through a clinic, and a doctor or a surgeon or a specialist is assigned to them?

Dr. HELMHOLZ. Every patient that comes to the Mayo Clinic sees a physician first of all to have a complete physical examination. No patient is seen originally by a surgeon. Surgery, in the words of Dr. Will Mayo, is a form of treatment, and that treatment is applied only after the physician has made a complete observation and diagnosis.

The CHAIRMAN. Usually the doctor in the home town makes the arrangements for the patient to come to the hospital?

Dr. HELMHOLZ. A great many arrangements are so made.

The CHAIRMAN. Yes. If they are not, and a patient comes to Mayo, he goes to a physician, and the physician examines him and then puts him through the clinic; is that right?

Dr. HELMHOLZ. Yes.

The CHAIRMAN. Doctor, you have given a great deal of study to the care of children, have you?

Dr. HELMHOLZ. Yes.

The CHAIRMAN. From your experience in the Middle West, do you think that children get all the medical care they need?

Dr. HELMHOLZ. No.

The CHAIRMAN. In what way is the care defective or deficient?

MEDICAL CARE FOR CHILDREN

Dr. HELMHOLZ. Well, I think probably as important as anything is the distribution of the pediatricians. There the pediatrician is in a dilemma, because he says that only the pediatrician can give good care to the child, and yet he as a group has taken care of only about 10 to 20 percent of the children of the country, and the other 80 to 90 percent are taken care of by the general practitioner. This distribution in rural communities, communities of 10,000 and less, contains 4 percent of the pediatricians. In cities of 10,000 and over, 96 percent of the pediatricians are practicing.

The CHAIRMAN. Are there other diagnostic clinics, like the Mayo Clinic, where children are seen by a pediatrician?

Dr. HELMHOLZ. Yes; university clinics are possibly the best example of places where good pediatric care is given. That is a point I think we should stress: That a university clinic is a clinic in which the best possible things are done and the attempt is made to do things better; another way of saying that research is one of the fundamental necessities for good medical care.

You will find wherever research is being done, there good medical care is being given.

The CHAIRMAN. And research of that character is being carried on at the Mayo Institute constantly?

Dr. HELMHOLZ. Yes.

The CHAIRMAN. Are there enough diagnostic clinics to meet the need for this kind of care for children?

Dr. HELMHOLZ. Well, I think that was very well covered before a senatorial committee that made its report, I think, in '44: That probably the entire country should be subdivided into units, the center of which would be a diagnostic clinic, in which all the very complete medical services can be given.

In extending to the periphery, where you finally meet the general practitioner, who has available a health center of some kind, there is a gradual increase in the availability of procedures that are helpful in diagnosis.

In other words, the entire country should have available a diagnostic clinic, wherever necessary. And I might say that according to Dr. Buchmeier, the director of the hospital survey, probably from 75 to 80 percent of medical care can be given at the level of the general practitioner. In other words, it is 25 percent that needs greater diagnostic facilities than are available to the general practitioner who is practicing in a small health unit.

The CHAIRMAN. Doctor, you regard the youth of this country as one of the greatest assets we have?

Dr. HELMHOLZ. The greatest asset.

The CHAIRMAN. You are familiar with the report on selective service, which shows that there was a very large percentage of the young people of this country rejected as unfit for service?

Dr. HELMHOLZ. May I just submit for the record? It shows something that has nothing to do with recent events, but was a study that was made by the American Health Association under the auspices of the Metropolitan Life Insurance Co. in New York City.

The CHAIRMAN. I think that would be very valuable to have.

Dr. HELMHOLZ. The upshot of this is that for the defects that were taken care of, namely, hearing defects, defective nutrition, dental defects, and those with respect to acuity of vision, 2 percent, two out of every hundred, corrections were made in vision, 2 percent of the dental defects, 5 percent of the hearing defects, and 9 percent of the nutritional defects as shown by a follow-up study.

In other words, that was the sad story of school examinations without some machinery for following through and giving care so that these defects could be repaired.

The CHAIRMAN. I would like to have that submitted for the record, if you permit it.

The CHAIRMAN. It is very valuable to hear from outside independent organizations such as the organization that has carried on the investigation that you have just mentioned, because sometimes governmental organizations such as the Selective Service might be criticized. I understand that the Selective Service was very generous in passing selectees for the service, and it was afterward discovered that many thousands of them had to be rejected and removed from the Army because of their liberality in accepting them.

Dr. HELMHOLZ. That is true.

The CHAIRMAN. Do you know anything about that?

Dr. HELMHOLZ. Only insofar as I have followed it. I have no personal information.

But I might say that one of the psychiatrists from the Navy, who was recently in Rochester, brought forward the fact, when he had an opportunity to study our Rochester child-health project, which represents as complete an attempt as possible to influence the conditions of childhood in producing good reliable citizenship, that it would be necessary to prevent many of the conditions that he saw in the Navy by work in early childhood.

WORK OF THE CHILDREN'S BUREAU

The CHAIRMAN. So you believe that it is of the greatest importance that this Bureau which we have been talking about, the Children's Bureau, should be preserved and expanded and protected in every way to continue its work in the field of child welfare?

Dr. HELMHOLZ. I feel that it is the organization in the Government that can bring together the various groups necessary to control all of the conditions affecting childhood; not only health. I realize that I have lived under a cloud for a long time in thinking that health was an object in itself; that it was of some use to keep a person healthy, if that was all you were going to do with the child.

A healthy criminal is worse than a sick criminal. In other words, in health we have a means to an end, a means to educate the child to responsible citizenship. We have to have that as a condition. But we must have many other factors in improving that child's environment, by educating his parents how to take care of him, by educating the school teachers as to what growth and development mean, by educating the community in gradually allowing the child to assume its responsibilities.

We go from the home, to the neighborhood, to the school, to the community, to the Nation. It may interest you to know that Mr. Sorokin in his book, The Prevention of War, said that we had to start with this education if we wanted to prevent war in the preschool period. It was one of the most illuminating articles from a man of that type that I have seen, in his appreciation of how early you have to start with the child in order to affect his relationship to his fellow men.

The CHAIRMAN. And in this field the Children's Bureau is rendering a great service to the Nation?

Dr. HELMHOLZ. I feel that it gathers together all of these different features which apply to the child.

The CHAIRMAN. This study that you have called to our attention was conducted by the Metropolitan Life Insurance Co. of New York?

Dr. HELMHOLZ. Under its auspices. My friend there was the chairman of the advisory committee, and he was the one who called my attention to it.

The CHAIRMAN. We are very glad to have that information for the committee, Doctor.

Now, do you believe that we should have some kind of a national system whereby medical care could be brought within the reach of people at the present time denied proper care because of financial conditions?

Dr. HELMHOLZ. I think very definitely.

The CHAIRMAN. You think so very definitely?

Dr. HELMHOLZ. As to how that shall be done, I will admit that in my study of it I have not been able to arrive at anything. It looks as though it could be done in a number of ways, but it always to me comes back to the fact that some agency other than the individual will have to step in and help if we are going to take care of all children and all mothers; and that is what we are trying to do.

In that connection, I think this might be interesting, because the Senator mentioned the study that is being made at the present time

by the Academy of Pediatrics; I might say that I was chairman of the Committee of Nine representing the Academy of Pediatrics, the American Pediatric Society, and the agency of the Children's Bureau.

I might say that that survey is presently being conducted and a study made of personnel, physicians, health officers, and technicians in all the counties of all the States in the country, as well as of all facilities, hospitals, health centers, health departments, in these same areas.

I think that is what you just referred to, Senator.

MATERNAL MORTALITY RATES

The CHAIRMAN. I understand that in the State of Minnesota a study has been made of the maternal mortality, and the conclusions of that study showed that 73 percent of the deaths of mothers were regarded as preventable.

Dr. HELMHOLZ. That is true. I have that right here.

The CHAIRMAN. I wish you would comment on that, if you will, please.

Dr. HELMHOLZ. I think we ought to go back to the Sheperd-Towner days when the Children's Bureau by its studies showed that the maternal mortality in the United States was down at the bottom of the list, or within two of the bottom of the list, with regard to, I think, 14 nations. It was then, in 1929, that a combined study was made by the Children's Bureau, by the American Medical Association, and by the American Child Health Association, which actually showed that, unfortunately, in our country maternal mortality was unusually high.

Now, there has been, fortunately, a very marked decrease in the maternal mortality, as you have just heard from Mr. Mayo's report; that is, that from 1925 to 1942 there was a 56 percent reduction in mortality.

I want to call attention to the fact that in the last 4 or 5 years the maternal mortality rate in Minnesota has been among the lowest three; that in 1943 it was the lowest. But I would also like to call your attention to the fact that when the maternal mortality in Minnesota was 19, which, as I recall, was third, in the national list, from the lowest, during a study made by the maternal mortality committee of the committee on maternal health of the Minnesota State Medical Association, the following summary of their work was given. I shall present this to you, but I want to read just 5 items of the 27 items in the summary. The fifth article, "Delivery occurred in a hospital in 61 percent of 112 instances":

8. The absence of any consultation in 56 percent of the cases, the presence of less than 10 percent of adequate consultation, and the inadequacy of two-thirds of the consultations which were obtained raises certain obvious questions.

3. According to the minimum requirements for adequate obstetrical care as adopted by this committee, adequate care was given in only 1.8 percent in the prenatal period, 6.3 percent in labor and before delivery, and 3.6 percent in post partum period.

The committee agreed that 82 deaths of the 112—73 percent—were preventable, and that in all but four instances the physician was wholly or partially responsible.

5. Deaths due to infection and to shock and hemorrhage made up 53 percent of the maternal deaths.

6. A surprising revelation is the general inadequacy of the therapy used to counteract puerperal infection.

I consider that a very brave statement to be put out by a State medical society—a society that is thinking of the best interests of the public—in showing that it was a State where the maternal mortality was the third lowest in the country, and yet by their own statement should have been 73 percent lower than it was.

This brings it within the range of what we have hoped for in this country: Maternal death rates of six or seven, as they are for Sweden. It is a surprising result of this study that it gives us an indication that under the circumstances we might have had just as good a maternal mortality rate as the best in the world.

The CHAIRMAN. Doctor, under title 1, part (b), of this bill, S. 1606, would there be an opportunity to continue to improve the quality of the care of mothers and children?

Dr. HELMHOLZ. Very decidedly. I think that is one of the things that possibly the Children's Bureau has been criticized for more than anything else—the insistence with which it has stood for improvement and the very highest standards of medical care.

I think Dr. Eliot is responsible, with Miss Lenroot, for this action.

The CHAIRMAN. Would there be adequate provision under this bill for professional education and research?

Dr. HELMHOLZ. Of course, it all depends upon how much money is appropriated, but the possibility is there, and I am sure, if the Children's Bureau was in charge, that would be one of the important things that they would pay attention to.

Already, with the small amount that they have had at their disposal, they have had educational courses for both obstetricians and pediatricians in the various States, through their grants-in-aid for this specific purpose.

The CHAIRMAN. You have cooperated with this Commission that has been referred to here several times during the testimony, the Commission on Children and Youth? Do you believe that that commission has contributed a genuine service to the Children's Bureau in aiding that Bureau in the study of the problems that it has?

Dr. HELMHOLZ. I do.

The CHAIRMAN. You do not consider that that group was used in any way for political purposes?

Dr. HELMHOLZ. If it was, I never heard of it.

The CHAIRMAN. And you have been active in it and have participated in their meetings and conferences?

Dr. HELMHOLZ. Yes.

The CHAIRMAN. That is all, Doctor.

QUALITY OF MEDICAL SERVICE IN EUROPE

Senator DONNELL. Dr. Helmholtz, do you know a gentleman by the name of J. G. Crownhart, secretary of the State Medical Society of Wisconsin?

Dr. HELMHOLZ. I have met him.

Senator DONNELL. He is dead now, is he not; but he published in the latter years of his life a book entitled "Sickness Insurance in Europe." Are you familiar with that publication?

Dr. HELMHOLZ. I am not.

Senator DONNELL. Doctor, have you been in Europe within the last few years yourself?

Dr. HELMHOLZ. Not since '37.

Senator DONNELL. Did you have occasion to examine hospital conditions in Europe at that time as compared with those, for instance, in the Mayo Clinic?

Dr. HELMHOLZ. I studied in Europe from 1907 to 1909, and in 1927, when I was over there, there was a very great deterioration after the war, and that was not much improved by '37.

Senator DONNELL. And '37 was the last time that you were over there?

Which ones did you have occasion to examine the hospital facilities and treatment in at that time?

Dr. HELMHOLZ. I saw hospital facilities in France, in Rome, Italy, in Austria, in Hungary, in Germany, and in Sweden.

Senator DONNELL. Did you see any in England?

Dr. HELMHOLZ. I saw just one.

Senator DONNELL. Just one. Now, generally speaking, Doctor—and, of course, I appreciate it is difficult to generalize, but in the interests of time, could you tell us, generally speaking, whether or not you regard the quality of the hospital service being furnished in any of those countries when you were there in 1937 as being up to the hospital service of the type that is generally furnished in this country?

Dr. HELMHOLZ. That, of course, is a very difficult question to answer, because the hospital services were essentially those of pediatric hospitals, university hospitals, and they were practically all university hospitals that I visited.

I do not think that I would feel that the deterioration was anywhere near the degree it would reach in a general hospital. I saw merely university pediatric hospitals, which would represent possibly the best that we could see. The deterioration was not so much in the care, as it was in the complete lack of any research activities going on in these hospitals.

Senator DONNELL. Now, Doctor, as to the pediatric hospitals connected with universities which you saw in Europe in 1937, would you say that they represented, generally speaking, on the average, as high a quality of service as do the hospitals furnishing a similar subject matter of treatment in this country; in other words pediatric hospitals in this country?

Dr. HELMHOLZ. I would think that there might be a shade of difference because we have better equipment. But as far as the physicians go, I may be prejudiced, because at the time that I studied medicine, I graduated from Johns Hopkins in 1906, and I went abroad because there was not a place in the United States where I could study pediatrics. I emphasize that so as not to appear to be bragging for American pediatrics. I studied with Dr. Channing in Breslau in 1909. He asked me where we were publishing pediatric research in the United States. He said, "I take your magazines. There are no scientific reports." I had to admit that there were none. In 1927, I visited him in Berlin when he was then professor of pediatrics there, and he said, "Today you in the United States are at the top"—without any solicitation of mine.

Senator DONNELL. That was what year?

Dr. HELMHOLZ. 1927, 18 years later. From the bottom, we had gone to the top.

Senator DONNELL. Doctor, that developed under a system of non-compulsory health insurance in this country?

Dr. HELMHOLZ. Yes.

Senator DONNELL. And they have had compulsory health insurance in substantially all of the European countries?

Dr. HELMHOLZ. Let me get that straight for the record.

Senator DONNELL. All right.

Dr. HELMHOLZ. I feel there are two things that are important in that connection.

Senator DONNELL. Yes, sir.

Dr. HELMHOLZ. The Johns Hopkins Medical School opened in September 1893 and the first class graduated in 1897. This was the turning point in medical education in the United States.

Senator DONNELL. The establishment of the Johns Hopkins University?

Dr. HELMHOLZ. Yes. For the first time medicine was considered a postgraduate study. Nobody was admitted to the medical school unless he had had a university education, with certain requirements of chemistry, physics, and biology, as well as German and French, which were the necessary languages required.

Shortly after that, we had the Flexner report on the state of medical education, and that for the first time opened our eyes as to what the state of medical education in the United States was. You may not know it, but there were in Chicago possibly half a dozen medical schools, night schools, so-called, where you could work during the day and go at night.

We had no State laws with regard to that. All you needed to do was to get a diploma from the so-called diploma mills at that time and hang out your shingle and practice medicine.

Well, that has been changed, and I think we must say that the medical profession, with these two starts, has developed to a degree that I think American medicine is outstanding in the world today.

Senator DONNELL. Take, for instance, Johns Hopkins, my old and esteemed friend Dr. Walter A. Dande, who died the other day, probably one of the outstanding brain surgeons in the world, of Johns Hopkins.

I do not know whether you were present this morning when I read an excerpt from Mr. Crownhart's report on sickness in Europe, and I was wondering whether you would be kind enough to tell us whether your general observation of compulsory insurance in Europe leads you to draw this same substantial conclusion:

Again and again, the observer is impressed that the standards of medical and hospital service in Europe are not generally those of America. The director of one of the large public health institutes in Denmark pointed to this fact and referred to a lessening in the quality of teaching service in their medical school as one of the byproducts.

"Sickness insurance is a leveling device," said this professor who had visited this country on occasion. "It assures the mediocre physician just about the same rewards as he who would give an outstanding service if he were to have time. The incomes tend to be leveled but that is not all—the tendency over the years is to level the services to something that is neither bad nor good. But the incentive is gone and we develop fewer brilliant minds in our teaching centers and America captures the lead in health and methods to regain it."

Does your observation tend to corroborate the statement drawn from Mr. Crownhart's monograph?

Dr. HELMHOLZ. Of course, I do not think the average man who has practiced is the one who is making the contribution to our developments and improvements in medicine. After all, the men that are doing that work are unusually in hospitals, are usually younger men, who are on salaries, which are sometimes pitifully small; and yet they are willing to do this work because of the love of it.

I think that as I read this bill, the frequency with which we have "quality of care" reiterated is the important thing. You talk about the freedom of choice. You go to Chicago. You do not know a soul in Chicago. You have perfect freedom in choice of your doctor. What good does it do you?

Senator DONNELL. Well, of course, I would have the opportunity of inquiring of friends, just as I would here in Washington, and as a person does when he goes into a strange city.

Dr. HELMHOLZ. But what do you know about the value of your friend's opinion of the doctor?

Senator DONNELL. I appreciate the fact that friends' information may be valuable or not valuable. But, for instance, if I were to go to Chicago, I happen to belong to the legal profession. I know quite a number of lawyers there, whose judgment may be wrong, but I think their judgment would be helpful in enabling me to get a physician in Chicago.

Dr. HELMHOLZ. Let me cite my case. I was in Cortina in the Dolomites when Mrs. Helmholtz suddenly got a severe abdominal pain. Then I found myself in the position that most people find themselves in when they want a doctor. All I could do was to go up the street and see if I could find a doctor's sign and trust to luck.

Senator DONNELL. That was quite different, was it not, than if you were in Denver, Colo.? You could then have found somebody very easily who could have given you some advice, could you not?

Dr. HELMHOLZ. Let me put it this way: The average opinion of the average lay person as to the qualifications of a doctor is worth practically nothing.

Senator DONNELL. I defer to your judgment on that. On the other hand, I believe, Doctor—

Dr. HELMHOLZ. I am saying that, only from the point of view that we have to raise the general level to a point that no matter whom you go to you are going to get someone that will do you good. That is why I am saying all this. It is just an example to indicate that only by raising the general standard can you really achieve. I might cite the case of infant feeding.

When I started as director of the medical society in Chicago in 1911, part of my duty was to go around and see all the physicians that practiced in the neighborhood of the infant welfare stations which we started, which were in the worst areas of infant mortality.

These doctors, as I said, were starting this infant welfare station, and some of the people were coming to these stations.

They asked, "Have you any objection to their coming? All we are going to do is feed them."

"Take them all." Nothing but a nurse or a grandmother or the directions on the can would tell you about the feeding of babies. But, "Give them to me when they are sick, and I will cure them."

I am citing that only as an example of the status of children's care in 1911. The average graduate of a class A medical school gives better care to children today. He is no pediatrician. But he gives more general care than did the average pediatrician, who in those days had had a 6-months or a 3-months' course at some graduate school in the East.

So that the level has come up. We do not see any badly fed babies any more. We do not see these little atrophic infants any more.

QUALITY OF MEDICAL CARE IN THE UNITED STATES

Senator DONNELL. And that level has risen in our own country more rapidly, has it not, than, generally speaking, in the other countries of the world?

Dr. HELMHOLZ. Exactly. Let me say this: The advantage of the German system, which was leading the world before World War I, was dependent not upon the good service that the average man was getting. I had an opportunity in Hardman's Clinic to see what I would have considered a fourth-year medical student at Hopkins, who stood there and did not know a thing.

The education they got was inferior even at that time to what we were getting at Johns Hopkins. But their system of assistanceships in the clinics developed a very superior group of men who were outstanding; who did the research of the time; who were leaders in their profession.

There were a dozen men in Germany that were way above anyone that we had in this country as to their contributions to medicine. But it was not the level of their general practice, even at that time.

Senator DONNELL. Doctor, getting back to our own country, there has been a very great advance in medicine in our own country, has there not?

Dr. HELMHOLZ. Yes.

Senator DONNELL. And today the medical profession in our country certainly compares favorably with the medical profession in any country in the world, does it not?

Dr. HELMHOLZ. Yes.

Senator DONNELL. And by "favorably" you mean, do you not, Doctor, that our medical profession in this country excels, generally speaking, the medical professions of the other nations of the world?

Dr. HELMHOLZ. As far as I know, they are giving better service.

Senator DONNELL. I am correct in my statement, am I not, that the medical profession does excell in the United States over the medical professions in other countries of the world? Is that correct?

Dr. HELMHOLZ. Yes. I would like to put it this way, though: That that is no reason for not continuing to do even better work. That is why I introduced that element of the Minnesota maternal mortality statistics.

SENATOR DONNELL. I think we can all agree that in the professions of law, medicine, and any other, we should strive for greater achievement than we have had in the past. The point I make is that the medical profession has, by the policy of personal initiative and enterprise and desire to excel in this country, shown the ability to make itself superior to the medical professions of other countries of the world. That is true, is it not, Doctor?

Dr. HELMHOLZ. Yes.

Senator DONNELL. Now, Doctor, I want to ask you, in regard to this study that is being conducted under the auspices of the National Committee of American Academy of Pediatrics: Now, that organization, the American Academy of Pediatrics, consists of quite a large number of members, does it not?

Dr. HELMHOLZ. About 1,800.

Senator DONNELL. About 1,800 all over the United States; is that right?

Dr. HELMHOLZ. Yes.

Senator DONNELL. There is being conducted at this time, is there not, this study that you have referred to in your testimony, a study of child health service? Is that what it is?

Dr. HELMHOLZ. Personnel and services.

Senator DONNELL. Has there been issued a document or a book called A Manual for Study of Child Health Services?

Dr. HELMHOLZ. Yes.

Senator DONNELL. That book contains a list of the national committee, under whose jurisdiction this study is being carried on; is that right?

Dr. HELMHOLZ. Right.

Senator DONNELL. And you and Dr. Butler and several other gentlemen aggregating in the entirety nine members, constitute the national committee; is that right?

Dr. HELMHOLZ. That is right.

Senator DONNELL. Among other members is Dr. Butler of Harvard University; is that right?

Dr. HELMHOLZ. Yes.

Senator DONNELL. There is an advisory committee, is there not, also, Doctor, composed of three persons, Dr. Joseph M. Wall, M. D., of the American Academy of Pediatrics, Dr. Martha M. Eliot of the United States Children's Bureau, and George St. John Perrott of the United States Public Health Service. That is correct, is it not?

Dr. HELMHOLZ. Right.

Senator DONNELL. So on that advisory committee two of three are connected with the United States Government at this time. That is correct, is it not?

Dr. HELMHOLZ. Yes.

Senator DONNELL. Now, the executive staff in charge of this study consists of seven persons, does it not?

Dr. HELMHOLZ. It is growing rapidly.

Senator DONNELL. Is it growing? Well, in March of this year there was issued this manual, and at that time the executive staff consisted of seven persons, did it not, namely Dr. Hubbard, Dr. Bain, Dr. Bair, Dr. Britten, Dr. Pennell, Dr. Spinney, and Dr. Williams; that is right, is it not? I may have attached the title "Doctor" to some who do not have it.

Dr. HELMHOLZ. Yes; I think some of those are statisticians.

Senator DONNELL. As a matter of fact, Doctor, of the seven persons whom I have mentioned there, five, namely Katherine Bain, M. D.; Rollo H. Britten, master of science; Marilyn Y. Pennell, master of scientific hygiene, Rachel E. Spinney, M. S., Ph. D.; and Charles Williams, M. D., Ph. D.: Five out of those seven are on the Government pay roll?

Dr. HELMHOLZ. Yes.

Senator DONNELL. And Charles Williams, who is on that staff, the man that I mentioned, is really the active head of the study, is he not?

Dr. HELMHOLZ. No.

Senator DONNELL. Who is the active head of it?

Dr. HELMHOLZ. John Hubbard.

Senator DONNELL. Well, does Charles Williams have any connection with that?

Dr. HELMHOLZ. Yes.

Senator DONNELL. What is his capacity?

Dr. HELMHOLZ. Well, he is one of the three: He represents the Public Health Service.

Senator DONNELL. That is, the department of the Federal Security Agency?

Dr. HELMHOLZ. I believe so; yes.

Senator DONNELL. The United States Public Health Service, in other words. He represents it; is that right?

Dr. HELMHOLZ. Yes.

Senator DONNELL. He is one of the men who is very active in making the study. That is correct, is it not?

Dr. HELMHOLZ. Yes.

Senator DONNELL. Travels around all over the United States, does he not, and examines here, there, and everywhere in making this study of health services and personnel; that is right, is it not?

Dr. HELMHOLZ. No; that is not right. He is in a supervisory capacity. This study is being made at the State level by the State medical societies under supervision of an executive secretary, furnished probably by local funds, obtained in a variety of ways. The National Infantile Paralysis Commission has requested its local groups to give every help to this study possible.

Senator DONNELL. Doctor, perhaps I was inaccurate in my statement. I indicated I thought he was doing more detail work than he is. He is the supervisor, but he does travel all over the United States, does he not?

Dr. HELMHOLZ. Oh, yes; he is helpful.

Senator DONNELL. And contacts these local persons in the States, and he is the man, as you say, who represents the United States Public Health Service on this board?

Dr. HELMHOLZ. Yes.

Senator DONNELL. And also, is it not true that Messrs. Britten and Pennell and Rachel Spinney are also on the Public Health Service staff? That is correct, is it not?

Dr. HELMHOLZ. Yes.

Senator DONNELL. And Katherine Bain is on the Children's Bureau staff, is she not?

Dr. HELMHOLZ. Assigned to this study.

Senator DONNELL. So those four, plus Miss Bain, make up five of the seven persons who in March of this year constituted the executive staff of that outfit having to do with the making of this study. That is correct, is it not?

Dr. HELMHOLZ. That is right.

Senator DONNELL. Now, Doctor, the address given, as I understand it, on this manual—I speak now not from seeing the manual but from

this copy—the address is 7950 Rockville Pike, Bethesda Station, Rockville, 14, Washington, D. C., telephone WIscnsin 0363? That is the research part of the United States Public Health Service, is it not?

Dr. HELMHOLZ. That is correct.

Senator DONNELL. I call your attention also to the fact that as I understand it, drawing an inference here—

Dr. HELMHOLZ. May I say—

Senator DONNELL. Let me finish first, please: It states in here in typewriting:

Headquarters for the study have been established at 7950 Rockville Pike, Bethesda Station, Rockville 14, telephone WIscnsin 0363. Here are located the offices of all the executive staff, including the consultants and assistants assigned by the Federal agencies.

Now, Doctor, as a matter of fact, those headquarters are actually those of the National Institute of Health in Bethesda, the research part of the United States Public Health Service. That is true, is it not?

Dr. HELMHOLZ. Yes.

Senator DONNELL. If you know, Doctor—and you being on the national committee I ask you this question—will you tell me why, if it be true that what I have said is in the manual, why does it not come right out and say that the address of this group that is making this study is the National Institute of Health in Bethesda, a part of the United States Public Health Service, a department of the United States Government? Why does it not say that?

Dr. HELMHOLZ. Well, we had our headquarters at the Tilton Hospital here in Washington. We tried everywhere in Washington to find headquarters. We were unable to do so.

Senator DONNELL. Yes?

Dr. HELMHOLZ. The Public Health Service offered us these quarters.

Senator DONNELL. And you took them?

Dr. HELMHOLZ. We took them.

Senator DONNELL. That is not the question I asked you, Doctor. The question I ask is: Why do you not show in this manual the fact that the headquarters are in a governmental body here in Washington? Why does that not appear?

I am going to amplify that a little. It is the same identical point that I was making a little while ago with Dr. Mayo; namely, that it appears to me that there should be—

The CHAIRMAN. Senator, I think it would be fair to give the witness an opportunity to answer. He wants to answer, and you diverted his attention to something else, and I do not think that is entirely fair.

Dr. HELMHOLZ. May I answer that, very simply: Dr. Fishbein, in an editorial, in the last number of the Journal of the A. M. A., gives his full approval of this project and asks every member of the American Medical Association to cooperate in every way with this project.

Senator DONNELL. That is not the answer to the question I asked you, Doctor.

Dr. HELMHOLZ. And in that he gives that address. Now, what would you want to be on the record?

Senator DONNELL. Doctor, I am not going to argue with you, because I think you see the point I am making. The point I am making,

to which I address my question now, is: Why is it that in the official manual for that study it is not disclosed, if such be the fact, that the address is the address of a governmental bureau here in Washington, instead of simply putting it "7950 Rockville Pike, Bethesda Station, Washington"?

Dr. HELMHOLZ. That I cannot answer. It is interesting to know, however, that the department of pediatrics requested the Children's Bureau and the Public Health Service to aid in this project. I do not know whether you know how much this project will cost, but it will probably cost in the neighborhood of \$400,000.

Senator DONNELL. I have no doubt of the great value that the project will have.

Dr. HELMHOLZ. The academy will probably spend \$40,000 or \$50,000. The Infantile Paralysis Commission has given us a hundred sixteen thousand dollars. They have considered it of sufficient importance. The Children's Bureau and the Public Health Service feel that for a basis on which to determine what is needed in every county of the 3,000 counties of the United States, what they have and what they have not, what they should have in order to give them good service, that will be it. It is the first time that a medical organization has ever interested itself sufficiently in a determination of the needs of children to spend its own money; after all, \$40,000 is pretty nearly all we have. But we feel that this thing is important enough so that it should be done. When we started out, we thought it might cost \$25,000 or \$30,000. Now, it has grown to \$400,000.

Senator DONNELL. Doctor, I have not even remotely criticized the expenditure of this money or the fine beneficent purposes.

Dr. HELMHOLZ. Well, I cannot answer that. The difficulty is that from the beginning we invited them to come in.

Senator DONNELL. Doctor, how widely distributed was this manual? Do you know?

Dr. HELMHOLZ. It goes to probably every State chairman in the country. The various leaflets will go to every practitioner in the country.

The CHAIRMAN. State chairman of what?

Mr. MAYO. State chairman of the Academy of Pediatrics. Now, the State medical societies are the ones, for instance in Minnesota, that are sending out these pamphlets to various members, so that we will be in a position, with their help, to put this over. This could not be put over by the Academy of Pediatrics without the help of the American Medical Association.

Senator DONNELL. Doctor, do you know whether those leaflets or any other literature disclose to the reader the fact that this study is being carried on out of headquarters which are in a United States Government department? And do the leaflets or any other literature disclose that Katherine Bain, Mr. Britten, Mr. Pennell, Miss Spinney, or Mr. Williams are connected, or that anyone of them is connected with the United States Government. Do you know?

Mr. MAYO. I would not know, but certainly the American Medical Association knows it.

Senator DONNELL. I am asking you about the leaflets gotten out here by your organization.

Mr. MAYO. I do not believe they would, because there is so much material on each leaflet that I do not believe they would put that on each leaflet.

The CHAIRMAN. Doctor, before you leave that point, I would like to ask if there is anything sinister in the activities of this organization that it might be sought to cover up by not mentioning the fact that this address also is the address of the National Health Service.

Mr. MAYO. From the beginning we invited them in. We asked their help.

The CHAIRMAN. Has the Public Health Service in this country rendered a great service to our country?

Mr. MAYO. Yes. After all, we are pediatricians. We are practitioners. Several of those people are statisticians who are invaluable, without whose help we could not possibly carry this on.

The CHAIRMAN. Has the United States Public Health Service made a genuine contribution to the improved medical care that we have in this country?

Mr. MAYO. I would say a tremendous contribution.

The CHAIRMAN. It has made it possible for this country to be one of the best countries in the world where people's health can be taken care of?

Mr. MAYO. On the side of prevention, they are the active organization.

The CHAIRMAN. That is what has contributed largely to the fine record of American medicine, is it not?—the fact that they live in a wealthy country? We are one of the wealthiest nations of the world, and we have this Public Health Service that has made a contribution to this problem, which has improved the public health. Is that not true?

Mr. MAYO. Yes.

The CHAIRMAN. And it is only natural that a country as wealthy as our country should contribute something toward the improvement of the health conditions in the Nation, which indirectly brings about a very splendid record of the medical profession. Is that not true?

Mr. MAYO. Yes.

The CHAIRMAN. Now, as to Europe, the last war had a very serious demoralizing effect upon the whole of Europe, did it not?

Dr. HELMHOLZ. It did indeed.

The CHAIRMAN. And ever since that war, Europe has been in a state of turmoil and unrest, economically and socially. Some of the largest countries over there abandoned the democratic system, did they not? First Russia went out, and then Germany and Italy, and probably other countries have followed them in leaving democracy. As a result, of course, conditions have developed over there that would not otherwise have developed if there had not occurred that war and the great economic developments that came after it. Is that not true?

Dr. HELMHOLZ. I think that is perfectly true.

The CHAIRMAN. The high quality, then, of medical care in this country is something that we are all proud of. But are you satisfied with the distribution of this high quality of medical care in this country?

Dr. HELMHOLZ. No.

The CHAIRMAN. You are not. You think something should be done about it. You think the modern medical care should be made available to everybody in the country regardless of their financial condition?

Dr. HELMHOLZ. Yes.

The CHAIRMAN. I think there is no question about that, and I think that that is one of the objects of this legislation, to bring about a better distribution of medical care; and I am glad to have you give that testimony here today.

Mr. MAYO. Senator, will you indulge me for a moment?

The CHAIRMAN. Certainly

Mr. MAYO. I want to say that Dr. Helmholtz and I came here today expressly to appear before this committee, and we are entirely and completely and deeply in earnest about this matter.

We were pleased and honored to be at the committee meeting and to subject ourselves to any questions, even to points that may have seemed rather remote, some of them, from the main and burning question at hand.

I would say that regardless of whether Dr. Helmholtz and I are appropriately or unappropriately affiliated with any organization, the fact remains that the children of America need more care than they are getting. Dr. Helmholtz and I make no difference at all. We are not important in this matter. Nor is it important as to what individuals do. The important matter is as to whether a program which has proved effective within a system of free enterprise, the social-security program of the Children's Bureau, is now going to be expanded. We know it works. We know it is needed. We know it has been effective.

For the moment, regardless of the insurance provisions—which I personally happen to agree with, I am not representing the commission at this point—quite regardless of those we earnestly urge that this committee with the eyes of the Nation on it, give its most earnest consideration to the development of further and extended plans for child-health services.

We are most sincere about that.

Senator DONNELL. Doctor Mayo, for the record, you are not in any way connected with the Mayo clinic?

Mr. MAYO. No, sir.

Dr. HELMHOLZ. We would like to claim him.

Senator DONNELL. Your degree of doctor was that of doctor of social science?

Mr. MAYO. That is right.

The CHAIRMAN. I would like to ask you whether you would feel embarrassed if, when your testimony reaches the floor, your views were criticized as biased, and you would have attributed to you some ulterior motive in not having in your literature announced the fact that the headquarters of your organization was also the headquarters of the Public Health Service? Would you feel disappointed if that kind of an argument were made against your statements here?

Mr. MAYO. I feel no embarrassment about having said what I said here today, and I certainly am not embarrassed at answering anything that was asked of me.

The CHAIRMAN. Would you feel that it would not be fair when the bill comes on the floor that an effort would be made to make the Senate feel that your testimony should not be given full weight and credence merely because the literature of your organization failed to state that your headquarters was the headquarters of the Public Health Service? You do not think that would be fair, do you?

Dr. HELMHOLZ. No, because we are making no secret of it. We have come out in our original statement that we want the help. We could not do this job without the help. And, as I say, the American Medical Association has given us their blessing, knowing that we are working with the Children's Bureau and the Public Health Service.

Senator DONNELL. I think Doctor Mayo indicated, near the conclusion of his testimony, that he had no objection to the suggestion which was implied or expressed in my questioning.

Mr. MAYO. I would assume, Senator Donnell, that any reference made to it would not be made in such a way as to prejudice my total testimony. That would be my assumption.

Senator DONNELL. The point I have in mind is that I understood in your testimony you stated that you saw no objection to the point which I was making; namely, that it would be fair and proper that the name or some indication should appear setting forth the connection with the United States Children's Bureau.

Mr. MAYO. My words, which I recall very distinctly, were that I thought that your request was not an unfair one.

Senator DONNELL. I think you have quoted that exactly.

The CHAIRMAN. But you do feel it was immaterial, so far as the quality of your testimony here was concerned, whether you had specified in this literature the fact that the Public Health Service was the headquarters?

Mr. MAYO. That is right.

The CHAIRMAN. You do not feel the fact that the Children's Bureau offices are there had any effect on your testimony?

Mr. MAYO. No, sir.

The CHAIRMAN. And the same with you, Doctor?

Dr. HELMHOLZ. That is correct.

The CHAIRMAN. I want to submit for the record a statement sent the committee by the Wisconsin State CIO.

(The statement is as follows:)

WISCONSIN STATE INDUSTRIAL UNION COUNCIL,
Milwaukee 3, Wis., May 2, 1946.

Senator GEORGE D. AIKEN,

Education and Labor Committee, Senate Office Building,

Washington, D. C.

DEAR SENATOR AIKEN: We are enclosing a copy of a statement on the Wagner-Murray-Dingell bill. This represents the position of the Milwaukee County CIO and the Wisconsin State CIO on this legislation, as expressed by Dr. Ortho Fiedler, of Sheboygan, Wis., in a speech carried recently over Station WTMJ, Milwaukee.

We ask that you make this statement a part of the record in the Senate Education and Labor Committee on this legislation.

Very truly yours,

LINUS LINDBERG,
Secretary-Treasurer, Milwaukee County CIO.
MEL J. HEINRITZ,
Secretary-Treasurer, Wisconsin State CIO.

SPEECH BY DR. ORTHO FIEDLER, OF SHEBOYGAN, REPRESENTING THE POSITION OF THE MILWAUKEE COUNTY CIO AND WISCONSIN STATE CIO ON THE WAGNER-MURRAY-DINGELL BILL

In his message to Congress in November of last year, the President of the United States requested legislation for the adoption of a national health program. In enumerating a proposed bill of rights, he stated that certain rights should be assured to every American citizen, but one of them was the right to adequate medical care and the opportunities to assure and enjoy good health. Another was the right to adequate protection from the economic fear of illness.

Mr. Truman did not originate this philosophy. It is an old idea and has an interesting and historic background. In the Declaration of Independence, Thomas Jefferson pointed out that man had certain inalienable rights, among which was life, liberty, and the pursuit of happiness, and in the preamble to the Constitution he stated that we form a new Government to secure to the people of that Government, life, liberty and the pursuit of happiness, and as early as 1798 the United States Government established hospitals and provided medical personnel to furnish medical care for the men of the merchant marine. The idea that the Government should do this was quite consistent. It is a historic fact that 57 other states in the world have already established a system of medical care for their citizens and noteworthy it is that once established, they have never been abandoned. Rather, their assistance has been extended to assure fuller coverage for a larger and larger proportion of the public. In a case of illustration is a Beveridge plan now being considered in the House of Commons, and already passed its first reading. The great statesmen of the world have always recognized that the first duty of the Government was to maintain the public health. Bismarck, Gladstone, Disraeli, among others, so stated, that the first system of medical care for large groups of the population was instituted in Germany in 1882. Then followed in succession most of the smaller states of Europe; England in 1911, France in 1920, Russia after the revolution. Until now, only the United States, China, and India of great peoples, are without such care.

A necessity for such a system has been brought to the attention of the people of America many times. As far back as 1908, President Theodore Roosevelt appointed a committee of 300, with Irving Fischer, of Yale, as chairman and made an exhaustive study during several years which clearly demonstrated that the fact that the people did not have adequate medical care which the medical profession was in a position to render, caused a waste in our vital human resources of something exceeding 3 million dollars, annually. From that time on, almost every President has had this problem before him. War prevented President Wilson from taking any action, but in the Harding-Coolidge administration, a committee of 500 with Ray Lyman Wilbur as chairman, after an exhaustive study of some 5 years, again demonstrated the need for a national health program. Mr. Hoover's committee in the social trends reach the same conclusion, and in recent surveys under the 20th century fund, and under the National Association of Public Health, officials again stressed the necessity for some such action. This matter has now been impressed upon the American people by the large proportion of draftees who are unfit for military service.

In the last war, about 40 percent of all draftees were found defective and rejected, and in spite of the fact that in a 20-year period from the last war to the recent war, the proportion of the number of draftees rejected at this time is fully as great as in the last war. Now, why do people not avail themselves of the knowledge and of the treatment which the medical profession is able and ready to extend to them? In a certain measure, it is due to the fact that the service is not available. There are 31 counties in the United States with a population of a thousand or more, who have not a single doctor within their borders. There are 1,200 counties in the United States in which there are no hospital facilities. This, to some extent, accounts for the failure to secure medical attention. Secondly, it is very probable that a considerable proportion of the population are not aware of what medical science is able to afford those who are suffering from illness, though it must be said that the American public is becoming more health conscious and in almost every advertisement now, there is some illustration to the fact that the product advertised is helpful or beneficial to their health. But a most important factor is the economic factor. People do not have medical care because they cannot afford to pay for it. Physicians' services are a commodity on the market just as any other commodity, and those who have the means purchase it; those who do not, do not. It is a known fact that people with an income of

\$3,000 a year spend 5 times as much for physicians' services and health as those with an income of \$1,000 and despite that fact, people with the lower incomes need more medical care. Illness among them is three times as frequent as among the higher income groups. The reason is self-evident. They do not have the same food, the same shelter, the same clothing, and generally the same biological necessities. The death rate is higher among those of low income than among those with higher incomes. Unskilled laborers live 8 years less than the clerical group. In Wisconsin, tuberculosis is $3\frac{1}{2}$ times as common in the low income groups as in those with adequate incomes. The argument is set forth that we have made great progress in the United States and that the longevity of our people has been greatly increased and sickness greatly reduced in the past 50 years, and that is an indisputable fact.

A little further study, however, will reveal that where we have made progress, as in the control of tuberculosis and typhoid fever, diphtheria, smallpox, and pellagra in the South, it has been because the health departments supported by taxes have introduced and practiced preventive medicine to accomplish their end. Infant mortality and mortality among obstetrics have been greatly reduced because of the Federal action of the Shepherd-Townley Act. We have prevented many cases of blindness in infancy because the State has provided silver nitrate that must be put into the eyes of the new-born child. Control over water and milk supplies has eliminated the typhoid fever. Vaccination in schools has almost eradicated diphtheria and smallpox, so that if we have made progress, it has been made in those fields in which tax-supported preventive measures have been employed. Moreover, the general principle of the use of funds for the alleviation of suffering and the care of the sick is an established practice. More than 60 percent of the hospital bills in the State of Wisconsin are tax-supported, and beds in the hospitals for the insane, for the tuberculous, for the blind, for the deaf, and to some extent for the crippled, and beds in the Wisconsin General Hospital and in the county hospitals are all tax-supported. Certainly no one would want to withdraw such Government support. The argument has been made that research work would suggest if doctors were paid out of tax funds. It is rather a ridiculous assertion, because most of the progress in medicine, most of the life-saving discoveries have been made not by the general practitioner but by the laboratory worker, who is working either in a public institution like the State universities or in great foundations. Insulin came out of the University of Toronto; penicillin out of the University of London; sulfa drugs out of England. It is hard to remember any great discoveries that came from the research work of practicing physicians. It just isn't done.

In the President's proposal he suggests that research work should be encouraged and funds provided so the scientists may be free to work more continuously and with a greater prospect of success. Pursuant to the President's recommendation, bills have been introduced in the Senate and in the House which would provide medical care for all of the American people simply as operation in the Social Security Act. Under the bill employed persons would pay $1\frac{1}{2}$ percent of their wages up to \$3,000 into an insurance fund. The employer would match this amount, and it is estimated that 3 percent of the total national wage would provide complete medical care for those in these groups. If necessary, the Government would augment the fund. Those self-employed and farmers and white-collared groups could pay into the fund of 3 percent and have the same coverage. Under this system, which in my opinion would operate very much as general accident insurance does, except that under the Social Security Administration for the insurance carrier, the patient chooses his own doctor, receives care as any other private patient would, and the only difference is that the patient doesn't pay the bill directly to the doctor. It is paid through the insurance carrier.

Now, who is in favor of such a health program in America? First, I think we may safely say that most industrialists are. At any rate, a very great number of them like the Kaiser shipyards, the Eastman Kodak Co., the Johnson Co., and Ivory Soap. But why go far from home? The employees of the Kohler Co., of the Garton Toy Co., and many of the industrial plants in this city have partial covering now under the insurance system. Many of these employees are covered by a policy which provides limited service and in some of them the total amount is paid by the employer, others it is paid by the employee, and in most of them by funds contributed to by both employee and employer.

A second group who favors this prepayment plan for care are the Protestant churches of America, who in their last meeting of the council went on record as

favoring such a plan. Practically all of the social agencies and social-welfare workers are in favor of the plan, and, of course, all organized-labor groups are back of the plan.

Many doctors and most of the eminent physicians are in favor of it. The president of the American College of Surgeons and the president of the Physicians College, feel it is high time that something is done about it.

Then who is opposed? Certain proportions of the doctors, insurance companies, pharmaceutical houses, and, under pressure by the National Physicians Committee, many of the druggists. The survey under the twentieth century fund of American medicine, shows that practically 71 percent of the doctors in the country, who are really not opposed to the plan, thought that some insurance system for payment would have to be devised. Only a few years ago, the medical society here opposed hospital insurance, but today almost 25,000,000 people in the United States have hospital insurance under one or another of the associated hospitals which give this service.

A few years ago, the medical society here opposed groups of doctors providing, on an insurance basis, medical care to certain groups of employees, and probably might still maintain such a position had the Supreme Court of the United States not prevented their continuing such an opposition. A few years ago, the American medical societies and the State societies were opposed to voluntary insurance for medical care. Now, suddenly, they come forward and suggest that this is the solution for the need for medical care for the people of the United States. Twenty-five years ago, Owen West stated that the most important pressing problem before the American medical societies was to provide an adequate and essential medical care for all the people at a price commensurate with their ability to pay. I wish Mr. Carey would tell us what they have done to meet that problem.

Personally, I do not think that voluntary insurance will solve the problem. I presume most of you who are listening to me this afternoon carry hospital insurance. Undoubtedly, many of you carry health insurance and accident insurance. But you know as well as I do that the very poor class will not take voluntary insurance because if they had any desire to do so, they would not always have the opportunity that has been available. If the opponents of this measure say why a policy plan? Why not leave it to the State governments? We have had some experience in leaving matters of this kind to the State governments. Those of us who are at all familiar with the facts, know that in the South, the appropriation from the taxes for this sort of thing is very meager. Even for education, the South spends less than a fifth per capita for education than what is spent in the North, and the South is more in need of it.

During the days of the depression, the grants of aid to those with low incomes was shamefully low. Thousands upon thousands of people in the South in eight of the States cannot afford 1½ dollars a year in payment of a poll tax, which will enable them to vote, and how can you possibly expect them to pay for health insurance?

In the State of Wisconsin, the medical society has just gone on record as approving the plan of voluntary insurance, under which seven or eight insurance companies will write a limited health policy. Its provisions are totally inadequate. It provides only for treatment in the hospital for surgical and obstetrical care, but leaves out entirely medical care either in the office or in the home or anywhere else, and the cost of this abbreviated, aborted program is almost as much as total coverage under a general Federal plan would be. This has caused a division in the State medical societies. The Milwaukee County Society had already entered its negotiations in the Blue Cross Hospital Association under which the associated hospitals would write a policy with about the same provisions and did not care to change. They did not accept the State plan, nor did the county society of Racine or Kenosha, and our own Sheboygan society has rejected the plan. The general idea of an insurance coverage for medical care is accepted by the Amerian people. Surveys made in all of the States of the Union have clearly demonstrated that the large majority of the people favor prepayment plans for complete coverage. Even the National Physicians Committee for the distribution of medical care, engaged in the surveys of public hospital research in New Jersey found, to their surprise, that 63 percent of the people that polled were in favor of a plan of medical care on an insurance basis.

My contention is that only a Federal system such as is outlined in the Wagner-Murray-Dingell bill will present needed medical care to all the people everywhere in the United States, and by doing so will help us to accomplish another

of the four freedoms—freedom from want—freedom from fear. This system will lead to a healthier, happier, less worried and more efficient citizenry.

Any questions that may be raised to this plan, I will be glad to answer in the question period.

There are two aspects of medicine. One has to do with the actual services of the physician and the other has to do with the business side of midicine, the payment of the bill. The system as I can envisage it, makes no difference at all with the practice of medicine as such that the patient chooses his own doctor, goes to him when he pleases, employs specialists as he may need, either in his own community or in any other place in the United States. The only change will be that when the bill is rendered, it will not be rendered to the patient, but to the insurance carrier, which in this case will be the United States Government. It operates exactly as the hospital benefits do, that when the patient leaves the hospital, the bill is rendered not to the patient but to the insurance carrier, or as in accident insurance where the bill is submitted to the insurance company and not to the patient, but the practice of mediine remains the same.

The CHAIRMAN. We shall reconvene on May 23 at 10 a. m.

(Whereupon at 5 p. m., Tuesday, May 7, 1946, the committee recessed until 10 a. m., May 23, 1946.)

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